MENTAL HEALTH ACT
SECTION 117 POLICY

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| Consultation Groups          |                   |
| Approved by (Sponsor Group)  | Quality Committee |
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| Executive Director lead :    | Mason Fitzgerald  |
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## Version Control Summary

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<td>Guy Davis</td>
<td>Draft</td>
<td>Originally developed in partnership with Tower Hamlets Clinical Commissioning Group, London Borough of Tower Hamlets, Newham Clinical Commissioning Group, London Borough of Newham, City of London</td>
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<td>1.1</td>
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<td>Guy Davis</td>
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<td>2.1</td>
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<td>Guy Davis</td>
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1.0 Introduction

1.1 This document sets out the Trust’s policy agreed with partner organisations in respect of the legal duty to provide after-care services for certain patients who have been detained for treatment under the Mental Health Act 1983.

1.2 The policy should be read in accordance with the Mental Health Act 1983 ('the Act'), the Care Act 2014, the Mental Health Act Code of Practice 2015, the Care and Support Statutory Guidance 2014, associated legislation, case-law and relevant Trust policies and guidance; notably the Care Programme Approach Policy.

1.3 Local Authorities and clinical commissioning groups have been developing localised processes to discharge their section 117 duties and will be developing a jointly agreed procedure identifying responsibilities and decision-makers. Please contact the relevant manager in the CCG, local authority or ELFT for more details on this.

2.0 The Legal Framework

2.1 Section 117 states that it shall be the duty of the clinical commissioning group and local social services authority (in cooperation with relevant voluntary agencies) to arrange for the provision of (or in the case of the local social services authority, provide) after-care services for any person to whom section 117 applies, until such time as both of those organisations are satisfied that the patient concerned is no longer in need of any such services (the duty can never end for as long as the patient remains subject to a Community Treatment Order under section 17A).

2.2 The duty under section 117 applies to people of all ages, including children and young people who are detained under sections 3, 37, 45A, 47 and 48, and who are subsequently released from hospital.

2.3 The effect of this is that the duty under section 117 applies to the above qualifying patients if they are:

a) discharged from detention and remain in hospital as an informal patient for a period after that;

b) discharged from detention and leave hospital;

c) authorised to leave hospital by virtue of section 17 (for a material period of time; i.e. overnight);

d) released from prison having spent some time of their sentence detained in hospital under a qualifying section listed above;

e) readmitted to hospital informally or detained under a section of the Act for which the duty under section 117 does not apply; for example sections 2, 4, 5(2), 5(4), 35, 36, 38, 44, 135(1) and 136, and the need for after-care services continues.
2.4 The duty under section 117 does not automatically apply to patients who are subject to Guardianship under section 7 unless they were also previously detained under one of the qualifying sections above.

2.5 Section 117 does not appear in the list of provisions set out in Schedule 3 of the Nationality, Immigration and Asylum Act 2002, which means that social services authorities are not released from the duty under section 117 to provide relevant support to patients who are refugees or asylum seekers (nor are CCGs). Please see section 9 for more details.

2.6 Where a patient is eligible for services under section 117 these should be provided under section 117 and not under NHS continuing healthcare. It is possible however, for a patient in receipt of after-care services under section 117 to have on-going care or support needs that are not related to their mental disorder. These needs would fall outside of the scope of section 117 and they would be assessed for NHS continuing care eligibility, or joint funding, in the usual way. A patient receiving services under section 117 could also develop physical health needs which are distinct from their s117 needs. Again, this may trigger NHS continuing healthcare considerations in relation to these separate needs.

2.7 Section 117 is a ‘stand-alone’ duty; it is not a ‘gateway’ for providing services under other legal mechanisms, and because there is no explicit power to charge patients for services provided under it, those services must be provided free of charge as per the Stennett case.¹ This also means that patients cannot be charged indirectly via any state benefits that they might be entitled to; for instance if supported accommodation is part of their after-care service, housing benefit may not be able to be used to fund that service unless it was already in place prior to admission and is deemed to continue.

2.8 Section 117 responsibility is restricted to those services necessary to meet a need arising from a person’s mental disorder. The statutory definition (see below) must be met. In respect of accommodation, this means that ‘ordinary housing’ will not usually be provided under section 117. That is bare housing which does not meet a need which results from a person’s mental disorder at all.²

2.9 It should be noted that this right to free services does not extend to carers of patients receiving section 117 after-care.

3.0 Changes brought about by the Care Act 2014

3.1 The Care Act 2014 (the 2014 Act) updates and amends the law in relation to adult social care. Part 1 of that Act applies to Local Authorities and came into effect on 1st April 2015. Not all sections of the Care Act 2014 are in full force; some provisions of the Act will take effect from April 2016, those sections relate to the cap on care costs, independent Personal Budgets and appeals.

3.2 The 2014 Act places a number of general duties on Local Authorities which must be taken account of when it is exercising its duties and powers under Part 1 of the Act. Those general duties are set out in sections 1 to 7 of the 2014 Act.

¹ R. v Manchester City Council Exp p. Stennett [2002] UKHL 34
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3.3 Of particular relevance to section 117 cases it is worth noting the following general duties:

- s.1 promoting individual well-being
- s.2 preventing needs for care and support
- s.3 promoting the integration of care and support with health services etc.

3.4 Section 117 is amended by section 75 of the 2014 Act in 3 significant ways:

- Inserts a statutory definition of ‘after-care’
- Amends the position so that the Local Authority whose area a person is ‘ordinary resident’ is responsible for the after care
- Makes provision for regulations to be made to allow a choice of accommodation

4.0 What are After-Care Services?

4.1 After-care was previously not defined in the MHA. There is now, however, a statutory definition of what s117 aftercare services encompass. It states that this means services which have both of the following purposes:

(a) Meeting a need arising from or related to the person's mental disorder; and

(b) Reducing the risk of a deterioration of the person’s mental condition (and, accordingly, reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder)."

The new definition is one which is already commonly understood as it represents a modified version of the first two requirements set out by the Court in R (Afework) v London Borough of Camden [2-13] EWCH 1637 (Admin) (although it does not repeat the third requirement as set out by Mostyn J).

When the local authority is providing or arranging for the provision of accommodation for the person concerned and the person concerned expresses a preference for particular accommodation, and any prescribed conditions as set out in The Care and Support and After-care (Choice of Accommodation) Regulations 2014 are met - provision of the person’s preferred accommodation must be provided (if there is a difference in cost, the person can then pay for the difference of the additional cost in prescribed cases unless no other suitable accommodation is available at the amount stated in the personal budget in which case the local authority will need to consider adjusting their budget).

4.2 Whilst the case of Clunis v Camden and Islington Health Authority (1998) 1 CCLR, is pre- Care Act 2014, it is still useful guidance in that it confirms that after-care "would normally include social work, support in helping with problems of employment, accommodation or family relationships, the provision of domiciliary services and the use of day centre and residential facilities." Stennett (mentioned above) also established that "psychiatric treatment" is after-care.

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3 Section 30, Care Act 2014
4.3 Jones⁴ states that the patient’s need for such services will usually change over time, and the fact that the services currently being provided differ from those which were provided at the time of the service-user's discharge, does not have the effect of extinguishing the duty to provide after-care under section 117.

4.4 In Stennett it was agreed that "caring residential accommodation" that meets a patient’s mental health needs is within the scope of after-care services under section 117. It should be noted that the high court⁵ has established that the provision of ‘ordinary’ accommodation that meets a basic human need does not fall within the scope of section 117 but assistance in obtaining such accommodation may well fall within its scope.

5.0 Who does the duty under section 117 fall upon? - Clinical Commissioning Groups

5.1 Section 117(3) empowers the secretary of state to publish regulations to establish clinical commissioning group responsibility and these have been amended a number of times.

5.2 For patients leaving hospital since 1st April 2016, the duty to provide after-care services falls to the clinical commissioning group for the geographic area in which the patient was ordinarily resident immediately prior to being detained under one of the qualifying detention sections. This will continue to be the case even if the patient relocates.

5.3 For patients leaving hospital prior to 1st April 2016 but after 1st April 2013, the duty to provide after-care services falls to:

- the clinical commissioning group responsible for the area where the patient is registered with a GP; or
- if there is no registration with a GP, the clinical commissioning group responsible for the geographic area where the patient was usually resident (usual residence is the patient’s perception as to where they are resident in the UK; either currently or most recently. So where the patient gives an address, if correct they should be treated as usually resident at that address. Where a patient cannot, or chooses not to give a current or recent address, and an address cannot be established by other means, they should be treated as usually resident in the place where they are present).

5.4 For patients leaving hospital prior to 1st April 2013, the duty to provide after-care services falls to the clinical commissioning group where the patient was resident immediately prior to being detained under one of the qualifying detention sections.

6.0 Who does the duty under section 117 fall upon? – Local Social Services Authorities

6.1 Since the Care Act 2014 came into effect on 1 April 2015, for Social Services Authorities, the responsibility lies with the area in which the patient concerned is ordinarily resident or to which the patient is sent on discharge by the hospital in which the patient was detained. It is therefore necessary to identify

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⁴ Para 1-1099 Mental Health Act Manual, 16th edition, Jones R. Sweet & Maxwell 2013  
Mental Health Act Section 117 Policy

the area in which the discharged patient was ordinarily resident immediately before they were detained in hospital, even if that patient is not going to return to that area on discharge. Responsibility will only fall to the Social Services Authority in the area where the patient is to reside on discharge if no previous residence can be established.⁶

6.2 The courts have confirmed that the term ordinary residence should be given its ordinary and natural meaning⁷. The concept of ordinary residence involves questions of fact and degree. Factors such as time, intention and continuity (each of which may be given different weight according to the context) have to be taken into account.

6.3 The leading case is that of Shah v London Borough of Barnet (1983) 1 All ER 226. In this case, Lord Scarman stated that:

'unless … it can be shown that the statutory framework or the legal context in which the words are used requires a different meaning I unhesitatingly subscribe to the view that “ordinarily resident” refers to a man’s abode in a particular place or country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or long duration.'

6.4 Local authorities should always have regard to this case when determining the ordinary residence of people who have capacity to make their own decisions about where they wish to live. Ordinary residence can be acquired as soon as a person moves to an area if their move is voluntary and for settled purposes. There is no minimum period in which a person has to be living in a particular place for them to be considered ordinarily resident there, because it depends on the nature and quality of the connection with the new place.

6.5 If a patient was at the relevant time, placed “out-of-borough” in residential care under section 18 of Care Act 2014 (part of the new regime, previously section 21 of the National Assistance Act 1948) by another local authority, whilst the patient is at the out-of-borough care home, the deeming provision in Section 39 and 40 of the Care Act 2014 apply - he remains ordinarily resident in the placing local authority. If subsequently, the patient’s mental health deteriorates and he is detained in hospital for treatment under section 3 of the 1983 Act, consideration will need to be given to the provision under which his accommodation and support needs are given as this will impact his ordinary residence. Some examples are provided below, however, careful consideration should be given to cases where following discharge P is provided with a package of support which includes elements of both s.117 support and elements of Care Act 2014 support.

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Responsibility</th>
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<td>LA1 places P at a care home in LA 2 under s18 CA 2014. Whilst at the care home P is detained under the MHA 1983 and is then to be discharged and requires after care.</td>
<td>LA1 – this is in light of the deeming provisions which apply to s18 CA 2014.</td>
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⁶ R (on the application of M) v Hammersmith and Fulham LBC and Sutton LBC [2010] EWHC 562 (Admin)
⁷ As above
LA1 places P at a care home in LA2 under s18 CA 2014. Whilst at the care home P is detained under the MHA 1983 and later discharged with s.117 accommodation to LA3 (LA1 have to this point been responsible re. s117). P’s mental health then deteriorates and he is again detained in hospital pursuant to the MHA. P is then discharged and requires after care. LA3 – that is the area in which the patient was ordinarily resident prior to detention.\(^3\)

The deeming provisions do not apply to s.117 after care accommodation.

Prior to detention, P had been living for many years in LA1 but had spent the last three or so months at his mother’s as she was poorly and he did not wish to leave her unattended. LA1 - temporary absence does not deprive a person of their ordinary residence

Prior to detention, P has been dividing his time living at his own home in LA1 and his partner’s home in LA2. This will be subject to an assessment of all of the circumstances to establish which of the two homes the person has the stronger link.

P lacks capacity to make a decision as to where he wishes to live. This involves considering P’s ordinary residence as if he has capacity. All the facts of P’s case must be considered, including physical presence in a particular place and the nature and purpose of that presence but without requiring P to have voluntarily adopted the place of residence.

If P’s period of actual residence is sufficiently settled with his care giver then P’s ordinary residence is determined by that care giver.

Where P has been a looked after child until the age of 18 and is to transfer to Adult Social Care, his ordinary residence will continue to be at the LA which had a duty to care for him when he was a child irrespective of where he lives.

P is a child and has been released from hospital post a MHA detention. Prior to his detention he resided with his parents who reside in LA1. LA1 – a child’s ordinary residence is determined by that of his parents

P has been street homeless for the last year and has been detained under the MHA and is due to be discharged and requires after care. Where there is no settled residence, the duty to make provision will fall on the “local authority of the moment” i.e. where P is physically present.

6.6 Even if the patient was only living in an area because they were placed there, the court has held that the primary question is not whether someone was previously placed in an area, but whether they were living there prior to detention in hospital for settled purposes as their “home”. The types of factors that are relevant to determine whether the patient is still resident in the placing authority’s area, or in the new area, for the purposes of section 117, include length of time in the placement, whether the placement was intended to be long-term and whether the patient still has somewhere to live in the placing authority’s area.

6.7 If responsibility changes as above, practitioners should ensure that appropriate transfer arrangements are made, including in accordance with the

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\(^3\) See paragraph 19.44 of the Care and Support Statutory Guidance.
Care Programme Approach Policy and that the receiving organisation is aware of the duty under section 117 towards that patient. The needs assessment will clearly specify which part of the package relates to the provision of section 117 after-care to enable this to occur.

6.8 Often, establishing a person’s ordinary residence will be a straightforward matter. However, this is not always the case and each case should be considered on its own merits. Particular grey areas will be cases where there have been temporary absences on a person’s ordinary residence, cases where the person has more than one place of residence and cases where the person lacks capacity to decide where to live. Legal advice should be sought from the appropriate authority Legal Advisors in respect of the cases which are not so straightforward.

7.0 Planning of Section 117 After-care

7.1 The planning of after-care needs to start when the patient is admitted to hospital. The Code of Practice states that after-care for all patients admitted to hospital for treatment for mental disorder should be planned within the framework of the Care Programme Approach in accordance with policy. A written care plan, based on a full assessment of the patient’s needs, and which specifies after-care arrangements in respect of the patient’s mental disorder, must be in place before:

a) Discharge from hospital;

b) A period of Section 17 leave - except for short periods of leave, when “a less comprehensive review may suffice, but the arrangements for the patient’s care should still be properly recorded” (Code of Practice 27.10). Any period of leave which includes an overnight stay necessitates a full after-care plan;

c) A Mental Health Tribunal or Managers Hearing - after-care arrangements should be considered in all cases.

7.2 Practitioners will need to be mindful of and utilise both section 117 criteria and the national eligibility threshold for adult social care. Assessments will need to clearly set out which needs relate to section 117 duties and which needs (if any) relate to the adult social care national eligibility threshold.

7.3 The section 117 after-care plan should normally be formulated at a multi-disciplinary meeting; this meeting will also identify the care co-ordinator. The Code of Practice contains detailed guidance about the practitioners who should be involved in this process and the considerations to be taken into account (Code of Practice chapter 27.12). The care plan should clearly identify the interventions that are related to after-care under section 117 and those that are not (including those that meet the adult social care national eligibility thresholds), and the patient should be given a copy. It should be regularly reviewed in accordance with the Care Programme Approach.

8.0 Choice of Accommodation and Direct Payments

8.1 Section 117A, inserted by the 2014 Act, empowers the Secretary of State to make Regulations requiring a Local Authority to comply with a preference by a person eligible for after care for particular accommodation. This may require the person paying a top-up fee if the preferred accommodation is more- than the Local Authority’s usual cost.
8.2 In meeting the duty under section 117 the person is permitted to receive the support through a direct payment.

8.3 The position aligns after-care provision with other aspects of social care which may be available to the person. The Local Authority is able to delegate responsibility for providing direct payments to a person.

9.0 Register of Patients and Review of Section 117 After-care

9.1 Team Managers should ensure that a register is maintained on the Trust’s electronic patient record system (RiO) or on the local authority Framework-I system, of all patients for whom there is a duty under section 117 (see also 9.5 below). Dates for proposed reviews should also be indicated.

9.2 The review should specifically consider whether the patient continues to have a need for after-care and if there is it should again be made clear which parts of the care plan form part of the duty under section 117. Any amendments to the s117 arrangements should be reflected within the Trusts register.

9.3 It should be noted that after-care plans may change and new elements of care, if they are needs that arise from a patient’s mental disorder, will form part of the duty under section 117.

10.0 Determining that the duty under section 117 has ended

10.1 There is no mechanism in the Act to ‘discharge’ from section 117; it is a duty that ends when both the responsible clinical commissioning group and social services authority are satisfied that the patient concerned is no longer in need of any after-care services.

10.2 The Code of Practice at 33.20 states that “the most clear-cut circumstance in which after-care will end, is where the patient’s mental health has improved to a point where they no longer need services because of their mental disorder.”

10.3 The Code confirms at 33.20 – 33.23 that after-care services under section 117 should not be withdrawn solely on the grounds that the patient has been discharged from the care of specialist mental health services, or an arbitrary period has passed since the care was first provided, or the patient is deprived of their liberty under the Mental Capacity Act 2005, or the patient has returned to hospital informally or under section 2, or the patient is no longer on CTO or section 17 leave.

10.4 The Code goes on to state that even where the provision of after-care services has been successful in that the patient is now settled in the community, he/she may still continue to need after-care services to prevent a relapse or further deterioration in their condition.

10.5 The effect of the above is that if for instance the patient was discharged from the care of the Trust’s specialist mental health services but continued to reside in accommodation provided as part of after-care, the duty under section 117 remains for both the clinical commissioning group and the social services authority albeit that the duty on the clinical commissioning group may become dormant. So for as long as the patient resides in that accommodation, if he/she were to require specialist mental health services in

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9 Including parents if the person is a child
the future, the responsible clinical commissioning group would have a duty to provide those services. Similarly, the duty would continue if the patient was discharged from Trust specialist services but was prescribed medication for their mental disorder by their General Practitioner.

10.6 Some patients will have other community care needs not associated with treatment of a mental disorder (for example in respect of their physical illness or disability). Such patients should be assessed under the Care Act 2014 to determine if they have any eligible needs for services provided under other legislation. If the patient does appear to have other needs, the treating team should identify that those needs are distinct from after-care services that might form part of the duty under section 117.

10.7 In order to minimise the risk of legal challenges, if the Trust stops providing after-care covered by section 117 to a patient, confirmation of this and details of their other care arrangements should be forwarded to the responsible clinical commissioning group/GP and social services authority.

11.0 No Recourse to Public Funds

11.1 Unlike the provision of many community care services, the duty to provide after-care services under section 117 applies to patients irrespective of their country of origin or immigration status. A patient with no recourse to public funds (NRPF) in the United Kingdom must be provided with after-care services when they leave hospital after detention under one of the qualifying sections.

11.2 In the event that an individual is:

a) to be discharged from s117 after-care; and

b) likely to require services pursuant to a Care Act 2014 compliant needs assessment,

consideration will need to be given to the individual’s immigration status and entitlement to support in the UK. A Human Rights assessment must be undertaken together with a needs assessment under section 9 of the Care Act, when the individual is subject to immigration control and has no recourse to public funds pursuant to s115 of the Immigration and Asylum Act 1999, and where the individual falls within the restricted categories in Schedule 3 of the Nationality, Immigration and Asylum Act 2002 (NIAA).

11.3 Schedule 3 of the NIAA bars local authorities from providing support and assistance under specified statutory provisions to the four categories of person subject to immigration control (European Economic Area (EEA) nationals and any dependents; persons granted refugee status by another EEA state and any dependents; refused asylum seekers who have failed to comply with removal directions, and any dependents; persons unlawfully present in the UK - this includes people who have overstayed their visa or failed asylum seekers who have made their initial asylum claim in-country).

11.4 The Children and Families Act 2014 (Consequential Amendments) Order 2015 states that the prohibitions on people with NRPF extends as far as it is not a breach of their human rights - the Order clarifies that Part 1 of the Care Act 2014 is included in the list in Schedule 3 of the NIAA. This means that those specified groups will not be able to access assistance under Part 1 of
the Care Act, unless the exercise of a power or performance of a duty is
necessary for the purpose of avoiding a breach of a person's rights under the
European Convention on Human Rights or European Community Treaties.

11.5 The human rights assessment must ensure that decisions are made within
the context of a human rights approach, considering people's needs not just
in terms of physical functionality but in terms of a universal right to dignity and
respect. As a minimum, the assessment should seek to consider the
following:

- Whether the prohibition of services to the individual is likely to breach
  their human rights (the relevant articles of Schedule 1 of the Human
  Rights Act 1998 are likely to be:

  Article 3 (prohibition on torture or inhuman or degrading treatment or
  punishment);

  Article 8 (respect for private and family life); and

  Article 6 (right to a fair and public hearing) in cases where the person
  is involved in criminal or civil proceedings in the UK, this extends to
  immigration proceedings.

  It is important to note that some articles are absolute and so must not
  be breached and others are qualified and so can be breached when
  certain conditions are met.

- Whether the individual could return to his/her country of origin or
  whether there is either any legal, medical or practical reason why this
  is not an option.

11.6 For further information see the No Recourse to Public Funds Network
guidance at http://www.nrpfnetwork.org.uk/Documents/Practice-Guidance-
Adults-England.pdf

12.0 Refusal of Section 117 After-care

12.1 Section 117 only places a duty on the clinical commissioning group and local
social services authority to provide after-care services and gives the patient
an entitlement to such services to meet their assessed needs; there is no
power to require a service user to accept the after-care offered.

12.2 However, an unwillingness to accept services does not mean that the service-
user has no need of them, nor does it make them ineligible to receive
after-care services under section 117 should they subsequently change their
mind.
Appendix 1

**Glossary of Terms**

The table below sets out a brief explanation of the terms used in this policy. It should be noted that these are not legal definitions but are instead intended to explain the main terminology used in the policy as applicable to this policy.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Trust</td>
<td>East London NHS Foundation Trust</td>
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<tr>
<td>Local Authority</td>
<td>London Borough of Tower Hamlets</td>
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<tr>
<td>Patient</td>
<td>The person who falls under section 117 or to whom this section applies. The Mental Health Act 1983 uses the term “patient” to mean someone who is or appears to be suffering from mental disorder.</td>
</tr>
<tr>
<td>Carer</td>
<td>The person who provides unpaid care (e.g. a friend or relative) for the patient (as described above)</td>
</tr>
<tr>
<td>Practitioner</td>
<td>The member of staff employed by the Trust or Local Authority with responsibilities in accordance with this policy (e.g. a Social Worker)</td>
</tr>
<tr>
<td>Detained for treatment</td>
<td>Being “detained” broadly means that someone would be stopped from leaving if they tried to do so.</td>
</tr>
<tr>
<td>After-care</td>
<td>This broadly means community care to help someone to settle back into the community after being in hospital. This policy defines ‘after-care’ as it applies to section 117 in more detail.</td>
</tr>
<tr>
<td>Ordinary residence</td>
<td>This broadly refers to the place where a person normally lives voluntarily and where the settled routine of their life is. The term has a specific legal meaning which is set out in this policy.</td>
</tr>
</tbody>
</table>
### Appendix 2

**Record of Jointly Agreed Local Procedures**

<table>
<thead>
<tr>
<th>Locality</th>
<th>Manager Responsible</th>
<th>Date Procedure Agreed</th>
<th>Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tower Hamlets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City &amp; Hackney</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newham</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>