Authors' reply: Our research indicates that patients' length of stay in medium security may be reduced by the use of Section 17 trial leave from minimum to medium security and is thus in the interests of patients in support of the well recognised aim of caring for them in the least restrictive environment.

Although geographically isolated from the Responsible Medical Officer, it is a comfort for patients to know that their local consultant psychiatrist remains in touch rather than feeling isolated from mainstream services. Zigmond is incorrect in saying that only the RMO can alter medical treatment as this can be delegated and the Consent for Treatment can be assessed before leave commences. It is unlikely that trial leave from the medium secure environment will be necessary in the early states and this can still be authorised by the RMO from a distance.

Although the word 'grant' can imply giving consent to a request, it can also mean 'allowed to have'. The alternative to our system is a full transfer and in this case a patient is allowed to have a period of leave in its place providing an easier route back through the system and a bed in the local unit.

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Sir: I read, with interest, the paper by James *et al* (*Psychiatric Bulletin*, **20**, 201–204) on the constructive use of trial leave, using Section 17 of the Mental Health Act 1983. However, shortly after receiving the *Bulletin*, I also received a set of health service guidelines, from the NHS Executive, (NHS Executive, 1996), which recommend that Section 17 should not be used for trial leave between hospitals, arguing that issues of clinical and managerial responsibilities could become clouded.

'Therapeutic jurisprudence' (Wexler, 1996) recognises that the application of the law can have therapeutic as well as anti-therapeutic consequences. If a patient is transferred to a second hospital on trial leave (under Section 17, MHA) and that requires the first Responsible Medical Officer to remain actively involved regarding treatment or attending tribunals, thus helping to promote continuity of care and assisting in the rapid transfer of the patient back to the first hospital at the appropriate time, then the law seems to be acting therapeutically for the patient. It is also adhering to one of the principles of the 1983 Mental Health Act of providing treatment in the 'least restrictive alternative' and ensuring it is for no longer than is required on clinical grounds.

Trial leave cannot be extended beyond the period of detention. Thus for patients detained under time unlimited, restricted hospital orders (ss 37/41, MHA), trial leave can be, and not infrequently is, extended more than once. It is often used when a patient is moved from, say, maximum to medium security and it allows for the prompt return of the patient if the trial is unsuccessful. It seems illogical to deny its use in the reverse direction or when the transfer is only intended for a time limited period and an equally rapid return to the original unit is desirable.

NHS EXECUTIVE (1996) *The Use of "Trial Leave" under Section 17 of the Mental Health Act 1983 to Transfer Patients Between Hospitals*. (HSG (96)28). Leeds: NHSE.
WEXLER, D. B. (1996) Therapeutic jurisprudence in clinical practice. *American Journal of Psychiatry*, **153**, 453–455.

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