The Care Programme Approach and the end of indefinitely renewable Leave of Absence in Scotland

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**Abstract**

**Objective**

To consider the relationship between the restriction of leave of absence (LOA) to 12 months, the

introduction of community care orders (CCOs) and the implementation of the Care Programme

Approach (CPA).

**Design**

Multiple methods were employed: scrutiny of Mental Welfare Commission for Scotland (MWC)

records; questionnaire to consultant psychiatrists and mental health officers (MHOs) regarding

attitudes; survey of psychiatrists in respect of outcomes for named patients.

**Setting**

Scotland

**Subjects**

Two hundred and sixty six patients who were affected by the changes introduced by the Mental

Health (Patients in the Community) Act 1995.

**Results**

Information was available for 195 (73%) patients in relation to CPA. Of these 113 (58%) were

included on CPA and for 63/113 (56%) (63/195 (32%)) CPA was considered to have enhanced

patient care.

Where CPA was considered useful it was because it was seen as bringing people together,

enhancing the patient’s role in treatment and managing difficult situations. Negative comments

regarding CPA were that it was unnecessary as the patient’s needs were straightforward, it

duplicated current practices or it was too bureaucratic.

**Conclusions**

Despite concerns expressed by professionals about the restriction to LOA and the guidance that

patients should be on CPA, for only a minority of patients was CPA described as enhancing care.

Questions are raised about the low use of CCOs and CPA by psychiatrists for patients who reached

the new limits of LOA.

The CPA is designed to ensure good interagency collaboration thus facilitating care and or

supervision in the community for people with severe, long-term and complex mental health

problems[[5]](#footnote-5). It has had a chequered history of development and implementation in Scotland and in

many areas was reported as being underdeveloped[[6]](#footnote-6).

Patients in Scotland can be subject to compulsion in the community in three ways: leave of

absence (LOA), Community Care Orders (CCO) and Guardianship. The latter is not used in

relation to enforcing medication and is not discussed here. The Mental Health Act 1984 allows

patients detained on a Section 18 to live in the community on LOA. The understanding was that

this allowed similar treatment without consent in the community as Section 18 allowed in hospital.

LOA was renewable indefinitely in Scotland until the Mental Health (Patients in the Community)

Act 1995 which restricted it to 12 months. This Act also introduced CCOs which required patients

to comply with conditions approved by a sheriff. These conditions could include where the person

lived, where they spent time and the requirement to give access to staff. Although it was believed

that CCOs did not allow patients to be compelled to take medication, the majority of CCOs

contained conditions that implied or directly stated that patients should comply with medication[[7]](#footnote-7).

The Scottish Office guidelines[[8]](#footnote-8) indicate that good practice requires that all patients on LOA or a

CCO should have care plans that comply with the Care Programme Approach (CPA)[[9]](#footnote-9).

A questionnaire survey indicated that almost all mental health officers (MHO)[[10]](#footnote-10) and three-quarters

of consultants agreed with this, although there were some reservations about its appropriateness in

all cases[[11]](#footnote-11).

As part of a wider study evaluating the impact of the Mental Health (Patients in the Community)

Act 1995 in restricting LOA and introducing CCOs, the relationship of these new measures to

CPA was investigated. Details of the full study including methodology are given elsewhere[[12]](#footnote-12),[[13]](#footnote-13). Since

this study was started community-based compulsory treatment orders (C-B CTOs) have been

introduced in the new Mental Health (Care and Treatment) (Scotland) Act 1995[[14]](#footnote-14). This also

introduces the need for care plans to be approved by mental health tribunals for patients subject

to compulsory treatment. Possible implications of this are discussed.

**METHODOLOGY**

Information for the study comes from three sources, records of the Mental Welfare Commission

for Scotland (MWC) to identify patients, a follow-up survey to consultant psychiatrists about

named patients and an anonymous questionnaire to consultants and MHOs about the 1995 Act.

**Population**

The MWC receives details of all patients in Scotland detained under the Mental Health (Scotland)

Act 1984. Their records were scrutinised to find all patients whose LOA reached the new limits

between 1 April 1996 when the Act was implemented and 31 December 1998 and all those who

were placed on a CCO between these dates.

**Named patient survey**

A questionnaire was designed to collect follow-up data on all these patients. This was sent to the

patient’s Responsible Medical Officer (RMO). The RMO at the time of discharge from LOA was

identified from the MWC case records. For many patients the RMO had changed and RMOs were

asked to indicate to whom care had been transferred. Thus, 308 questionnaires were sent to 146

RMOs regarding 266 named patients. The questionnaires were sent in May 1999 and a reminder in

June 1999.

**Questionnaire to consultants and mental health officers**

A postal questionnaire was designed to obtain consultants and MHOs views about the changes

brought about by the Mental Health (Patients in the Community) Act 1995 and their views on

CPA. Questionnaires were sent to all adult general psychiatrists in Scotland and a sample of

currently practising MHOs. MHOs were more likely to agree with the Scottish Officer guidance

regarding CPA than psychiatrists and more positive regarding the limitation of LOA and the

introduction of CCOs. Both groups of professionals however made similar assessments of

resources available for patients. Peay discusses in detail the differing attitudes of approved social

workers and psychiatrists in relation to decisions around detention in England & Wales.[[15]](#footnote-15)

Full details of the survey and views about the Act are reported elsewhere[[16]](#footnote-16), however the detailed

comments regarding the development of CPA across Scottish Local Authorities are reported here.

**Ethics approval**

Ethical approval was granted by the Multi-Centre Research Ethics Committee for Scotland and

Local Research Ethics Committees.

**RESULTS**

Patients

Two hundred and sixty-six patients were identified from MWC records. The details of the

numbers in each health board and estimated rates per 100,000 population are given in Table 1. Any

patients from Orkney or Shetland on LOA are included in Grampian Health Board

|  |  |  |  |
| --- | --- | --- | --- |
| **Health Board** | **No of patients** | **Population of Health Board 1998** | **Rate per 100,000** |
| Ayrshire and Arran | 11 | 375,400 | 2.9 |
| Argyll and Clyde | 16 | 426,900 | 3.7 |
| Borders | 4 | 106,300 | 3.8 |
| Dumfries & Galloway | 5 | 147,300 | 3.4 |
| Fife | 30 | 348,900 | 8.6 |
| Forth Valley | 10 | 275,800 | 3.6 |
| Greater Glasgow | 50 | 911,200 | 5.5 |
| Grampian (+ Shetland & Orkney) | 23 | 567,660 | 4.1 |
| Highland | 10 | 208,300 | 4.8 |
| Lanarkshire | 21 | 560,800 | 3.7 |
| Lothian | 54 | 773,700 | 7.0 |
| Tayside | 32 | 389,800 | 8.2 |
| Western Isles | 0 | 27,940 | 0 |

*Table 1. Study population by health board n=266*

*Source of population figures: ONS Population Estimates PE no1 (1999)*

*Development of CPA across Scotland*

The data in Table 2 comes from the questionnaire to MHOs and consultants. There were 246/293

(84%) responses from consultants and 259/315 (82%) responses from MHOs. Of those

professionals working with detained patients, 202/244 (83%) of MHOs and 160/208 (77%) of

consultants responded to the question about how well was CPA developed in their area. Details by

local authority are given in Table 2. Although CPA is largely health led, MHOs are employed by

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Local Authority** | **MHOs n=202** | | **Consultants n=160** | |
| **Negative** | **Positive** | **Negative** | **Positive** |
| Aberdeen City | 0 | 13 | 2 | 10 |
| Aberdeenshire | 2 | 0 | 1 | 3 |
| Angus | 0 | 4 | 0 | 3 |
| Argyll and Bute | 2 | 3 | 4 | 1 |
| City of Edinburgh | 17 | 19 | 5 | 4 |
| Clackmannanshire | 3 | 1 | 0 | 3 |
| Dumfries and Galloway | 0 | 5 | 0 | 7 |
| Dundee | 3 | 1 | 5 | 1 |
| East Ayrshire | 5 | 0 | 0 | 1 |
| East Dunbartonshire | 0 | 3 | 1 | 4 |
| East Lothian | 4 | 3 | 0 | 1 |
| East Renfrewshire | 2 | 0 | 2 | 0 |
| Falkirk | 4 | 0 | 3 | 3 |
| Fife | 0 | 7 | 2 | 9 |
| Glasgow | 6 | 19 | 7 | 25 |
| Highland | 6 | 1 | 7 | 1 |
| Inverclyde | 1 | 1 | 1 | 2 |
| Midlothian | 2 | 0 | 2 | 1 |
| Moray | 1 | 2 | 2 | 1 |
| North Ayrshire | 3 | 1 | 0 | 0 |
| North Lanarkshire | 8 | 7 | 2 | 3 |
| Orkney | 1 | 0 | 0 | 0 |
| Perth and Kinross | 3 | 1 | 3 | 0 |
| Renfrewshire | 4 | 0 | 7 | 0 |
| Scottish Borders | 1 | 6 | 0 | 6 |
| Shetland | 1 | 0 | 0 | 0 |
| South Ayrshire | 6 | 1 | 2 | 1 |
| South Lanarkshire | 2 | 2 | 4 | 2 |
| Stirling Council | 0 | 5 | 0 | 1 |
| West Dunbartonshire | 1 | 2 | 0 | 2 |
| West Lothian | 2 | 5 | 0 | 2 |
| Western Isles | 0 | 0 | 0 | 1 |

*Table 2. Views on the development of CPA by local authority from MHOs and consultants who treat new patients detained under the MHA 1984*

local authorities who therefore co-determined the implementation of the policy at the smallest unit

at which it was possible to gather opinion on its success.

Small numbers in some areas make comparisons difficult but there is broad agreement between the

two professions as to the development of CPA in their area. Only a minority of local authorities,

9/32 (28%), were described as having well developed CPA by both sets of professionals and 6/32

(19%) were described as having poorly developed CPA.

*CPA and individual patients*

Replies were received to the named patient survey from 130/146 (89%) consultants for at least

some patients. Of the 308 questionnaires, 250 (81%) were returned, of which 231 (75%) were

analysed (the remainder being blank or the patient was unknown to the RMO). There is some

information available for 195/266 (73%) of the patients in relation to the impact of CPA. Details

are given in table 3. For 8% of the patients for whom forms were returned, the RMO either missed

out the questions on CPA or reported they did not know the impact of CPA on that patient’s care.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Health Board** | **Not included on CPA** | **Enhanced Care** | **Not affected care** | **Impaired care** | **Number of patients** |
| Ayrshire & Arran | 5 (63%) | 1 (13%) | 2 (25%) | 0 (0%) | 8 (100%) |
| Argyll & Clyde | 8 (80%) | 0 (0%) | 2 (20%) | 0 (0%) | 10 (100%) |
| Borders | 0 (0%) | 1 (25%) | 3 (75%) | 0 (0%) | 4 (100%) |
| Dumfries | 0 (0%) | 0 (0%) | 5 (100%) | 0 (0%) | 5 (100%) |
| Fife | 2 (7%) | 19 (66%) | 8 (28%) | 0 (0%) | 29 (100%) |
| Forth Valley | 2 (29%) | 2 (29%) | 3 (43%) | 0 (0%) | 7 (100%) |
| Greater Glasgow | 18 (50%) | 16 (44%) | 2 (6%) | 0 (0%) | 36 (100%) |
| Grampian | 10 (63%) | 4 (25%) | 2 (13%) | 0 (0%) | 16 (100%) |
| Highland | 5 (56%) | 1 (11%) | 3 (33%) | 0 (0%) | 9 (100%) |
| Lanarkshire | 3 (38%) | 3 (38%) | 1 (13%) | 1 (13%) | 8 (100%) |
| Lothian | 18 (42%) | 12 (28%) | 12 (28%) | 1 (2%) | 43 (100%) |
| Tayside | 11 (55%) | 4 (20%) | 5 (25%) | 0 (0%) | 20 (100%) |
| **Total** | **82 (42%)** | **63 (32%)** | **48 (25%)** | **2 (1%)** | **195 (100%)** |

*Table 3 Views on the impact of CPA by Health Board from consultants with patients who reached the legal limit of LOA n = 195*

Of the 195 for whom information is known 82 (42%) were not included on CPA. If only the 113

(58%) patients who were included on CPA are considered, for 63 (56%) consultants considered the

patient’s care was enhanced, for 45 (42%) CPA made no difference and in 2 (2%) cases CPA

impaired care. For 82 patients psychiatrists said that to their knowledge they had not been included

on CPA. Thus for the group as a whole, only one third had enhanced care from CPA.

Comments were made by psychiatrists for a minority of patients (76, 36%). Of the 63 consultants

who said CPA enhanced their patient’s care, 25 (40%) made comments. The main themes were in

the usefulness of bringing people together, enhancing the patient’s role in their treatment and

managing difficult situations. eg:

*“CPA has allowed/enabled clear interaction between members of a complex package of care who*

*would not otherwise meet, eg consultant in X psychiatry, consultant in Y psychiatry, consultant in*

*Z, plus housing and social work etc.”*

*“CPA has brought everyone together and has enabled (patient) to remain a priority despite being*

*quiet and undemanding.”*

*“Has allowed the patient to become a partner in their care rather than a passive recipient.”*

*“CPA here is successful, increasing inpatient bed days but reducing community chaos and*

*‘revolving door’ situations.”*

Where consultants believed CPA had added nothing to patient care, 19 (40%) made comments.

Most reflected the view that CPA was unnecessary as the patient’s needs were straightforward or

CPA reflected what was already happening, eg:

*“(Patient) needs are relatively simple and would have been met with or without the CPA.”*

*“(Patient) wants are minimal (house is his/her own, income is adequate, self care is basic but*

*adequate) as long as he/she receives his/her medication.”*

*“CPA ensures good staff liaison – no difference to management.”*

Two consultants, however, raised different issues:

*“Patient him/her self refused to be included on CPA.”*

*“CPA unsuccessful as scuppered by patient’s behaviour and failure to comply with conditions of*

*CCO.”*

In the two cases where CPA was believed to have impaired care only one comment was made:

*“CPA also is too unwieldy to cope with patient’s changeableness.”*

CPA was not necessarily available or well developed in all areas but only one comment made

reference to this. This relates to a patient who moved between health boards. The end of study

LOA RMO, who was also once again RMO at time of the survey, said “*CPA was not available in*

*this area until [after time of discharge from LOA] but I don’t think it would have made any*

*difference*.”

The RMO for a period of inpatient treatment in another health board for the same patient said,

*“CPA ensured that contact was maintained with patient while in the area but progress after*

*his/her return to X last year is unknown.”*

For the patients who were not included in CPA a further 25 (total 32%) comments were made.

There were three themes. Firstly, CPA was described as too bureaucratic, eg:

*“The staff involved know the problems with the patient and the CPA would just create*

*unnecessary bureaucracy.”*

Secondly, that CPA is seen as pointless as it cannot enforce medication:

*“CPA of no value in ensuring compliance with medication so not used.”*

*“Compliant by the time we introduced CPA.”*

The third theme indicated that the patient already had co-ordinated care and that CPA did not add

anything to this, eg:

*“CPA not used as patient seeing members of team who meet regularly with patient and has own*

*private accommodation and occupation is through [X] dept with whom [patient] has regular*

*contact. Non NHS agencies not involved with this patient.”*

*“Decision was made not to proceed to CPA as patient was settled at end of LOA. Also, all*

*professionals involved meet on a regular basis anyway to discuss his/her problems with him/her*

*and appropriate action taken from there.”*

**DISCUSSION**

The response rate from psychiatrists to the named patient postal survey was sufficiently high for

us to assume that the data is representative as there is no real reason to suppose the sample is

biased in any particular way.

The figure of 58% of patients being on CPA compares well with the 61% estimated by consultants

in the postal questionnaire of their LOA patients on CPA but is slightly less than the MHOs’

estimate of 71%[[17]](#footnote-17). The two populations are not entirely similar in that the named patient survey

was for predominately post-LOA patients. Nevertheless, this is a group of patients for whom there

is considerable concern about their continued management and for whom, despite the Scottish

Office good practice guidelines, somewhat under two-thirds were on CPA. There are probably two

main reasons why a patient was not on CPA.

Firstly, CPA development varied across Scotland and may not have been available for some

patients. Secondly, although most psychiatrists agreed with the Scottish Office guidelines, 22% of

consultants actively disagreed with the recommendation[[18]](#footnote-18). It is unlikely that the 42% of patients

in the named patient survey who were not on CPA were all patients of this group of psychiatrists

or in areas where CPA development was poor. There were probably other reasons why patients

were not placed on CPA. For some it would seem the guidance was regarded as inappropriate. At

the end of LOA, these patients’ needs were not seen as complex and, thus, CPA was seen as

unnecessary. This may be either because the period of LOA allowed the situation to be stabilised

or because LOA was an over cautious response. In other cases patients may have benefited from

CPA but consultants chose not to use it. This may have been because it was seen as overly

bureaucratic or because it could not compel or ensure compliance with medication. These were the

same failings psychiatrists attributed to CCOs[[19]](#footnote-19). CPA was described as useful, however, for some

patients who declined services. It could ensure monitoring of mental state and allow appropriate

measures to be taken before a crisis developed thus preventing further complications in patients’

affairs.

The variation in the use of LOA across the country is of note, but appears to follow no particular

pattern in relation to Health Board. Previous research[[20]](#footnote-20) looked at the variation in the use of LOA

between health boards over time. There is no apparent relationship between use of LOA and

deprivation. Studies of those patients for whom psychiatrists in England would have liked to use

a hypothetical community treatment order showed that not all psychiatrists with adult community

care patients used LOA[[21]](#footnote-21).

Lack of CPA may not indicate that the principles of collaboration were not being adhered to but

rather that this was not done in the formal name of CPA. A number of comments indicated that

CPA would add nothing to current management. In some cases this would seem to account for the

suggestion that CPA had made no difference to the patient’s care. This should not necessarily be

interpreted as saying CPA is redundant. A safety net may still be appropriate even if no one falls.

The comments about bureaucracy, echoing as they do comments made about CCOs, require

further consideration. What is being complained about? Is it an administrative load and additional

paperwork or is ‘bureaucracy’ a euphemism for all the meetings involved and the time taken by

multi-disciplinary care and consultation? Comments indicated both meanings but numbers are too

small for conclusions to be reached. In depth interviews would be required to elucidate this issue.

The administrative load carried by consultants with multiple patients on section, LOA, CCO and

CPA, however, should not be underestimated[[22]](#footnote-22).

There is some evidence of patients having positive views on their experience of CPA[[23]](#footnote-23), but how, if

at all, this relates to their status in relation to the Mental Health (Scotland) Act 1984 is not known.

Before the introduction of the 1995 Act the use of lengthy LOA was on the increase[[24]](#footnote-24). There was

consistent opposition to its restriction by psychiatrists on the grounds that it would mean that they

would not be able to maintain high risk and vulnerable patients in the community without it[[25]](#footnote-25).

It is therefore important to understand why the CPA that was intended to ensure that these

patients did not fall through the gaps between agencies was not extensively used. Community Care

Orders were also little used[[26]](#footnote-26). It is not possible to tell from this research if the low use of formal

non coercive collaborative methods is due to lack of resources such as clinical time or to antipathy

to the philosophy behind these approaches. Alternatively LOA is seen as justified when the only

need perceived by services is that the patient continues to take their medication.

The Mental Health (Care and Treatment) (Scotland) Act 2003 raises the prospect of renewed

requirements for formal care plans. It will be the MHOs duty to prepare a care plan in conjunction

with the patient’s psychiatrist after consulting with a wide group of involved and interested parties.

The Act lays out what the care plan will need to specify. These plans will be presented to a mental

health tribunal who will have the power to authorise or reject them. For patients who are to be

placed on a C-B CTO this can be seen as enforcing CPA on psychiatry. Since this will now be a legal

responsibility Health Boards and Local Authorities as well as individual consultants and MHOs

will have to take it on board. The MHO will have a stronger role in the new legislation in relation

to care planning than under current arrangements for CPA. Whether this, the time scale involved

for application for compulsory treatment, and the legal imperative will make any difference to

attitudes remains to be seen. It might be expected that areas which have well integrated CPA might

be better placed to introduce C-B CTOs.

What does seem clear is that the paperwork required by the Act will increase and that given the

views on ‘bureaucracy’ presented in these surveys this is unlikely to be welcomed. A scoping

exercise carried out for the Royal College of Psychiatrists Scottish Division[[27]](#footnote-27) includes this in

contributing to the need for a substantial increase in the number of consultants in Scotland. The

number of additional MHOs required to fulfil the needs of the Act is likely to be even higher.

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