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The end of indefinitely renewable leave of absence in Scotland: the impact of the Mental Health (Patients in the Community) Act 1995

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ABSTRACT The Mental Health (Patients in the Community) Act 1995 restricted leave of absence (LOA) for detained patients in Scotland to 12 months. This study looked at the impact on patients who were affected by this restriction. A total of 266 patients were identified from Mental Welfare Commission records: 194 reached the new maximum, 47 were 'transitional', 16 were on improperly long LOA and 9 were on community care orders (CCOs) following LOA but not maximum LOA. Of this 194, 12 were transferred to guardianship and the remainder became voluntary patients. The responsible medical officers (RMOs) would have liked to renew LOA for 71% of patients. In 90% of cases RMOs renewed LOA to ensure compliance with medication. Patients were significantly more likely to be compliant with medication while on LOA than post-LOA. A minority (28%) were recorded as being involved in 'incidents' post-LOA. There were 37% who were known to have a substance use problem in their management. The results suggest that RMOs may have been conservative in using LOA.

Keywords: leave of absence, Mental Health Act 1995, detention, compliance, violence, substance abuse

The Mental Health (Patients in the Community) Act 1995 was introduced against a background of highly publicized incidents involving patients living in the community, a hasty debate about the community management of such patients, concern about the appropriateness of mental health legislation based on inpatient hospital care and a growing concern over civil liberties (Ritchie *et al.*, 1994). The Act introduced new community provisions: supervised discharge (SD) in England and Wales; community care orders (CCOs) in Scotland. Leave of absence (LOA) was standardized at 12 months maximum in all countries. This represented an increase of 6 months in England and Wales and a restriction of indefinite renewal in Scotland.

The view of the Scottish Office was that indefinitely renewable LOA was not sustainable on civil liberties grounds and was open to challenge under the European Convention of Human Rights. Only a very small minority of consultant psychiatrists professed themselves concerned by this (Atkinson, Gilmour *et al.*, 1997). In England and Wales in 1986 it was ruled unlawful to use renewal of detention (and, thus, LOA) as a mechanism to ensure that a patient who did not need to be in hospital could be treated without consent (*R. v Hallstrom*).

This paper considers the impact of the change to LOA in Scotland only. The change was brought in against a background of increasing use of LOA, particularly LOA of 12 months, over the previous decade (Atkinson, Gilmour *et al.*, 1999) and against the wishes of the majority of consultant psychiatrists (Atkinson, Gilmour *et al.*, 1997). Consultants were concerned that without indefinite LOA the most vulnerable and/or volatile patients would become voluntary, many would cease their medication with subsequent deterioration in their mental health and predictable and preventable relapse would hence not be treated until the patient was again detainable. The proposed CCOs were not supported because of their perceived lack of power to compel medication. A further survey after the introduction of the new legislation indicated that there was little change in consultants' views (Atkinson, Garner *et al.*, 2000).

Ambiguity over the relationship between LOA, compulsion to take medication and recall to hospital had led many to view LOA as a *de facto* community treatment order. Consultants' support of LOA appears to be attached to the belief that it allows patients to be compelled to take medication while in the community (Atkinson, Gilmour *et al.*, 1997). The Mental Welfare Commission for Scotland (MWC) interprets the law as being that patients on LOA may only be recalled to hospital following deterioration in their mental health (which may, of course, follow non-compliance) and not simply for

refusing medication. The impact of this ambiguity may be that patients on LOA believe they are compelled to take medication. Although there is no published evidence for this sufficient concern was expressed through various channels anecdotally for it to form a background to the research and it will be explored further in the discussion.

Leave of absence can be for patients who are on s.18 of the Mental Health (Scotland) Act 1984 (MHA) or a hospital order under the Criminal Procedure (Scotland) Act 1995. If over 28 days LOA must be reported to the MWC. It may now be granted for any length of time up to 6 months and may be renewed for a period of up to a further 6 months. If a patient is recalled to hospital during LOA the period of LOA is not continuous and the legal limit would be calculated as 12 months from the next time the patient is discharged to LOA.

This research describes the population of patients who were affected by the limitation to LOA as recorded in MWC records and the outcome of ceasing to be on LOA as described by the patients' RMOs. Patients' own views on these changes are described elsewhere (Atkinson, Garner *et al.*, in press a). A small number (36) of patients were transferred to CCOs and a description of them and the other patients on CCOs and the outcome of time on a CCO is described elsewhere (Atkinson, Garner *et al.*, in press b).

METHOD

There are three parts to the method: (1) the identification of the population through MWC records; (2) the use of MWC records to describe the population; and (3) the use of a named-patient postal survey of consultant psychiatrists to identify outcome.

Population

There were three main groups of patients to be identified.

New maximum LOA patients: although the new legislation limited LOA to 12 months, preliminary investigation of the records indicated that a straightforward count of 365 days from the first day of the patient's LOA was not appropriate. For example, someone starting LOA on 5 April one year may be recorded as being discharged on 5 April the following year, rather than 4 April. There was some suggestion that if the supporting s.18 was due for renewal just before the 12-month limit on LOA was reached it was not considered appropriate to renew s.18 to secure an additional fortnight of LOA. This would be especially true if the main motivation to maintain LOA was to ensure compliance with medication and the medication was given by monthly or 3-weekly injection. Thus, for this study, patients were

included as 'new maximum LOA' patients if they had been on LOA continuously for between 351 and 366 days. This allows for inclusion of those patients who were likely to be expected to reach the maximum LOA without being overly inclusive.

Maximum transitional LOA patients: the Act came into force on 1 April 1996. To ease the transition from the old LOA arrangements to the new limit special consideration was given to those patients who were on 6 months or longer continuous LOA before 1 October 1995. It was possible for the LOA to be renewed for another 6-month period after the end of the LOA that spanned 1 October 1995. The patients to whom this renewal applied are referred to hereafter as maximum transitional LOA patients. There was evidence that RMOs and medical records departments did not always fully understand how to calculate maximum transitional LOA. Patients who were eligible for the transitional 6 months but were discharged earlier are not included because it was not possible to determine if they were discharged purposively or because of error in calculating the transitional period.

CCO patients: all patients who were put on a CCO between 1 April 1996 and 31 December 1998 were included regardless of their previous LOA status.

In addition, during the course of patient identification a number of patients were identified who were on improperly long LOA. These have been included.

MWC records

Patient identification: the data system at the MWC was not designed as a research tool. To identify patients who met the above criteria, lists of patients with a discharge to and a discharge from LOA separated by more than 351 days were generated. This was then manually checked for a period of continuous detention of between 351 and 366 days. The same process was repeated with appropriate days to identify those on maximum transitional LOA. This period is referred to as the study LOA and the last date on LOA is the period from which follow-up was calculated. A checklist was designed to collect demographic and outcome data from MWC records, both computer and paper files. MWC files are not organized in a standard way and not all issues are covered in all files.

Named patient survey

The named patient survey covered the period of the study LOA and the follow-up period from the end of LOA until the date of the survey and was, thus, a different length of time for each patient. The RMO at the end of the LOA was identified from MWC records. These RMOs were sent a

questionnaire on 24 May 1999 and a reminder on 24 June 1999. The RMO may have changed subsequently and many patients had more than one RMO during the study period. Questionnaires were sent to each RMO as they were identified through previous RMOs and other staff and patients themselves. Many RMOs had more than one patient in the study (range 1–10 patients). Thus, 308 questionnaires were sent to 146 RMOs about 266 named patients.

Two questionnaires were designed, one for patients who had been/were on a CCO and one for all other patients. The first part of the questionnaires was identical, diverging in respect to outcome and use of CCOs. As well as closed questions, consultants were asked their views. These were analysed for themes. Consultants were asked to complete questionnaires from memory if they did not have time to consult files and to return blank forms rather than no form at all.

RESULTS

The information describing the population came predominately from MWC records but is enhanced in places by information from the named patient survey and, where appropriate, this will be included. Otherwise, the two sources of data will be described separately but with cross-reference where one enhances the other.

Response rate

The study population of 266 people identified from MWC computer records is assumed to identify everyone fulfilling the criteria and is taken as a baseline. A search of 181 paper files (68%) was made for additional information to describe the population.

For the named patient survey 130 (89%) consultants replied for at least 1 patient. Of the questionnaires sent out, 250 (81%) were returned, of which 18 were blank and 1 was too late for inclusion, leaving 231 (75%) available for analysis. Information is available for 211 (79%) patients, although this may not cover the full period from the end of maximum LOA. This is because the responding consultant may not have been the relevant RMO at the time. The number of patients for whom there are data are given for each set of results.

Description of population

The total of 266 patients was made up of 194 new maximum LOA, 47 on maximum transitional LOA (range 410–2,368 days), 9 on a CCO who had not reached the limit of LOA (range 0–350 days) and 16 on improperly long

LOA (368–432 days). Of the total population, 183 (69%) were men and 83 (31%) women. The age range for men was 21–82 years (median 37 years) and for women 23–86 years (median 46 years). Details of ethnicity were provided by consultant for 208 patients, of whom 199 (96%) were white, 2 were black African/Caribbean, 2 were from the Indian subcontinent, 1 was Chinese and 4 were of mixed race.

Diagnosis came both from MWC records and from consultants. The majority, 174 (65%), had schizophrenia. If patients with schizophrenia and an additional diagnosis of schizo-affective disorder or other ‘schizophrenia-type’ disorders are included the figure rises to 206 (77%). There were 22 (8%) patients who had bi-polar disorder and only 6 (2%) who had a learning disability with another condition. The remaining diagnoses were individual. According to MWC files, 10 patients had had a brain injury, although this was not always recorded as part of a diagnosis. Only 2 patients were recorded as having dementia.

From consultants’ information on 211 patients, 56 (27%) patients shared accommodation with family or partners, 144 (68%) did not and for 11 (5%) no information was known. There were 98 (46%) who had a ‘significant input’ from an informal carer and 92 (44%) who did not; and for 21 (10%) no information on this point was known.

Outcome at end of LOA

Of the 257 patients reaching maximum LOA, 36 (14%) were transferred to a CCO, 12 (5%) were transferred to guardianship and the rest became voluntary patients at least for a time.

Follow-up of population

All 266 patients were followed up until 27 June 1999. The period of follow-up was variable with a range of 6 to 36 months; there was a mean length of 21 months for men and 24 months for women. Details of formal admissions under the MHA were obtained from MWC records and are given in Table 1.

‘Survival time’ was calculated as the time between discharge from study LOA and the first involuntary admission of over 7 days (there were seven detentions of less than this and one 7-day admission for assessment). There were 79 patients (30%) who had at least one formal admission. The median time to admission was 228 days, with a range of from 10 to 1,144 days. Figure 1 shows a Kaplan Meier plot of the probability of staying free from detention during the follow-up period, with no significant difference between men and women.

Table 1 All patients in study with at least one formal detention between end of study LOA and 27 June 1999 (not controlled for length of follow-up), N = 266

<i>Detentions</i>	<i>Men</i>	<i>%</i>	<i>Women</i>	<i>%</i>	<i>Total</i>	<i>%</i>
No detention	125	69	50	60	175	66
At least one detention	56	30	31	37	87	33
Died	2	1	2	2	4	1
Total	183	100	83	100	266	100

Note Three patients died of heart disease and one in a nursing home, aged 84, cause of death not given.

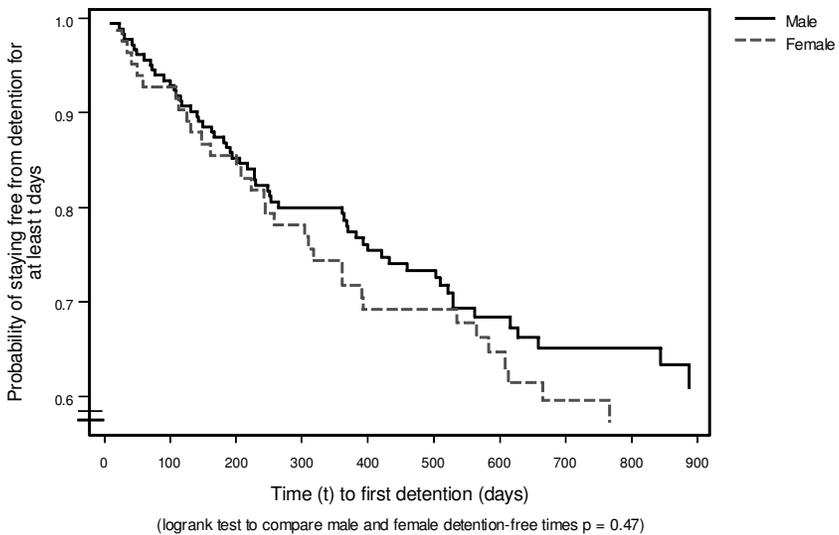


Figure 1 Probability of staying free from detention for males and for females, N = 266

Table 2 gives details of informal admissions supplied by consultants for 211 patients.

There were 58 admissions between 40 (19%) patients. Of these, 21 admissions were for 16 patients (15 men and 1 woman) who did not also have a formal detention.

At the time the new legal limit for LOA was reached RMOs would have liked to renew LOA for 119 of the 167 (71%), did not want to renew for 34 (20%) and in 14 (8%) cases did not know. The reasons for keeping the patient on LOA are given in Table 3. Reasons were not mutually exclusive.

Table 2 Informal admissions reported in named patient survey between end of study LOA and spring 1999, N = 211 patients

<i>No. of admissions per patient</i>	<i>No of patients</i>	<i>%</i>
0	137	65
1	28	13
2	8	4
3	2	1
4	2	1
Missing	34	16
Total	211	100

Table 3 Reasons for keeping patients on LOA, N = 167 patients

<i>Reason for keeping patient on LOA</i>	<i>n</i>	<i>%</i>
Ensure compliance with medication	151	90
Ensure residence at a particular address	30	18
Facilitate early recall to hospital	89	53
Other	25	15

The 'other' reasons were commented on and fell into three groups; LOA provided continuity of care (11); LOA ensured greater control of patients about whom there were particular concerns (9); and non-specific comments (5).

Table 4 gives the consultants' views on compliance with medication for patients while on LOA. Comments were made about any problems with compliance and how they were managed for 41 of the 43 partially or non-compliant patients. The main theme was persuasion and negotiation (14); others were assertive management (7), additional service input (5), readmission or threat of readmission (4) and input from families (2). The remaining comments either were ambiguous, did not give sufficient detail to understand the situation or simply described the problem.

Compliance post-LOA for 172 people who became voluntary patients or were on guardianship is given in Table 5.

Tables 4 and 5 describe slightly different populations although the vast majority of the patients were the same. The difference reflects the complexity of having multiple data sources (i.e. a number of RMOs) for some patients but not for others which influences the completeness of the record for each patient's 'LOA career'. There was a large statistically significant difference indicating that patients were more likely to be compliant with medication while on LOA (73%) than post-LOA (38%) ($\chi^2 = 65.8, p < 0.0001$).

Table 4 Compliance with medication while on LOA, N = 167

	<i>Number compliant on LOA</i>	<i>%</i>
Compliant with medication	121	73
Not compliant with medication	2	1
Partially compliant	41	25
Not prescribed medication	2	1
Don't know/not relevant	1	< 1
Total	167	100

Table 5 Compliance with medication for non-CCO patients after LOA, N = 172

<i>Post-LOA compliance with medication</i>	<i>n</i>	<i>%</i>
Compliant with medication	66	38
Not compliant with medication	37	22
Partially compliant with medication	43	25
Not prescribed medication	1	1
Don't know/not relevant	25	15
Total	172	100

For the 37 patients who were not compliant post-LOA, comments about management were made for 33. There are two main categories describing efforts to maintain or increase contact (16) or describing events leading up to the next detention (10), plus 7 comments that were unclassifiable. For the 43 patients who were partially compliant there were two main themes: increased resources, exhortation and encouragement (22) and changes to medication (10); the remainder being pressure from family (2) or unclassifiable (8).

Shortage of at least one service contributing to management problems was reported for 88 (42%) of the 211 patients for whom RMOs responded. The two main needs identified were lack of social activities for 45 (21%) and lack of employment opportunities for 43 (20%). Comments were made for 57 patients, the main themes being pressure of staff workload, housing problems, lack of forensic services, and patient non-co-operation, plus services and lack of other specific services (e.g. assertive outreach, support for particularly aggressive outpatients).

For patients who did not move onto a CCO, the RMOs' satisfaction with care arrangements is given in Table 6.

Of the 211 (28%) patients, 59 were recorded by their RMO as being involved in a total of 95 incidents 'involving injury or attempted injury to self or others or reckless behaviour likely to cause injury to self or others' (Tables

Table 6 RMOs' satisfaction with care arrangements at the end of LOA for non-CCO patients, N = 157

<i>RMO views on care arrangements</i>	<i>No.</i>	<i>%</i>
Solely positive about arrangements	59	38
Positive about arrangements, concern re compliance	4	2
Solely negative about arrangements	9	6
Compliance with medication sole problem mentioned	17	11
Patient not accepting of all services offered (not necessarily non-compliant)	20	13
Unclassifiable	35	23
Don't know	13	8
Total	157	100

7 and 8). This figure should be treated as a minimum as, for 48 (23%) patients, information was not available from the current RMO. Also, the follow-up period for patients is variable.

Although descriptions of the incidents were not asked for, a number of respondents volunteered information on 'reckless behaviour' which included damage to property, verbal aggression, use of alcohol and street drugs and disruption of community events.

Details of the RMOs' perception of the part alcohol and non-prescribed drugs play in patient management is given in Table 9.

Alcohol and/or street drugs are recorded as a problem in the management of 79 (37%) patients; alcohol with or without drugs is a problem for 55 (26%) patients and drugs with or without alcohol for 45 (21%) patients.

Of the 79 known to have a substance use problem in their management, 35

Table 7 Number of patients for whom there is response reported as involved in 'incidents' after the end of study LOA, N = 211

<i>No. of reported incidents for each patient</i>	<i>No. of patients</i>	<i>%</i>
0	152	72
1	37	18
2	15	7
3	3	1
4	2	1
5	1	< 1
6	1	< 1
Total	211	100

Table 8 Location of ‘incidents’ for all patients during study period, N = 59 patients

	<i>Hospital</i>	<i>Domestic</i>	<i>Wider community</i>	<i>Location unknown</i>	<i>Total</i>
Injury to other	5	3	2	0	10
Attempted injury to other	0	3	2	1	6
Injury to self	0	7	1	0	8
Attempted injury to self	1	2	2	0	5
Reckless behaviour likely to cause injury to self or other	4	25	37	0	66
Total	10	40	44	1	95

Table 9 Number of patients for whom alcohol and non-prescribed drugs are perceived as a problem in relation to managing the patient in the community, N = 211 patients

<i>Type of drug</i>	<i>n</i>	<i>%</i>
Alcohol only	34	16
Cannabis only	9	4
Other drugs only	6	3
Alcohol and cannabis	5	2
Alcohol and other drugs	3	1
Cannabis and other drugs	9	4
Alcohol and cannabis and other drugs	13	6
Substance abuse not perceived as a problem in management	108	51
Missing/don't know	24	11
Total	211	100

(44%) were detained at least once in the follow-up period compared with 43 (33%) of the remaining 132 who did not have substance problem, which is not statistically significant. In the follow-up period, of those with alcohol as a problem in their management, 26 (47%) were involuntarily detained, 15 (42%) of those with cannabis a problem in their management were involuntarily detained and 17 (55%) of those with ‘other drugs’ as a problem in their management were involuntarily detained. Compared with those not using substances there is no significant difference for those using alcohol or cannabis but there is for those using other drugs ($\chi^2 = 5.35, p = 0.02$).

DISCUSSION

Patient identification and definition of cases

The MWC files were essential to identify the population as reliance on information from consultants or hospital records would have been open to respondent bias. Even so, patients may have been missed if the discharge form was not recorded on the MWC computer files. A few instances of this were noted and included because, by chance, the file contained other information which meant that it was included in the list of possible cases.

Cases were defined as outlined in the methods section. Informal concern was expressed that some patients on LOA were briefly admitted to hospital to allow continued detention on LOA. Although it would be possible to use MWC data to look at admissions that might fit this pattern this was outwith the remit of this study. Such data would only suggest this as a possibility; confirmation from another source that this had been the reason for the admission would still be required.

Previous research (Atkinson, Gilmour *et al.*, 1998) had identified 129 patients who had been on LOA for more than 12 months at the end of 1994. Only 22 of these patients appeared in the current population. There are a number of possible reasons to explain this: (1) missing data meant they could not be identified; (2) they were in the group for whom readmission may have been found possible; (3) they had been readmitted due to relapse; (4) they had become voluntary patients; (5) they had been discharged from mental health services; (6) they had left the country; (7) they had died. The most likely explanation is that most of those 107 patients are in categories (3) and (4). The number of patients in the previous study who were on LOA for long periods of time was low and would most probably be in the group of 47 maximum transitional LOA patients. Given the time interval between the two studies, different patient populations might be expected.

This study looked only at patients who reached maximum LOA and excluded those who were recalled to hospital before reaching 12 months. Such patients may be discharged to LOA and again recalled under s.18 and, thus, may spend a substantial amount of time under the restrictions of mental health legislation. There are, currently, no estimates of the size of this population nor whether the numbers are changing.

The population

As might be expected, just over two-thirds of patients are male and the most common diagnosis is schizophrenia. This is in line with the previous description of the population (Atkinson, Gilmour *et al.*, 1999). Comparatively few (27%) live with their family and slightly less than half are believed by

consultants to receive a 'significant input' from informal carers. For a group of patients who are particularly vulnerable these figures might appear low although it is not possible from this research to know whether this represents a progressive step towards independence or a family breakdown due to unacceptable management pressures. Consultants do, however, raise housing as one of the areas of lack of services for patients.

The figure for members of the population who were from a non-white ethnic background was 4%, which compares with 1.25% in Scotland as a whole (OPCS, 1991). This would seem to indicate that ethnic minorities are not being over-targeted in the use of community restrictions under mental health legislation. The very small numbers involved and the potential difference between self-declared ethnicity (OPCS, 1991) and ascribed ethnicity in this study suggest care should be taken in extrapolating from these figures. Details of ethnicity are not recorded in MWC files which makes monitoring of the use of mental health legislation in ethnic groups extremely difficult. Given the concern regarding the over-use of mental health legislation with people from ethnic minorities (Davies and Thornicroft, 1996) some consideration should be given to monitoring this.

Alcohol and street drugs are identified by consultants as a management problem for 37% of patients, which may seem low for such a vulnerable group. It compares favourably, however, with other British surveys. Menezes *et al.* (1996) estimated 36% co-morbid substance abuse in patients with a functional psychosis and Cantwell *et al.* (1999) estimated 37% drug or alcohol misuse in people with a first episode psychosis. The prevalence of misuse problems may relate in a complicated way to LOA. Substance misuse may contribute to risk factors leading to detention and use of LOA but may also contribute to an individual's not maintaining 12 months in the community on LOA. Patients on LOA recalled to hospital before 12 months may have greater misuse problems. Only misuse of drugs other than cannabis and alcohol was statistically significantly linked to readmission following LOA.

The impact of restricting LOA

The previous questionnaires of consultants and mental health officers (Atkinson, Gilmour *et al.*, 1997; Atkinson, Garner *et al.*, 2000) might have led to a conclusion that placing a time limit on LOA would lead to widespread disaster. This does not appear to have happened, although the impact on some individual patients may have been severe. Very few patients were transferred to a CCO and even fewer to guardianship when LOA ended. Nor is there any indication that measures have been taken under the Criminal Procedures (Scotland) Act. This low use of other restrictive measures suggests that either psychiatrists reassessed the risk posed to or by the patient as low or that the perceived effort in setting up new orders (particularly CCOs) was not worth

the potential benefits for managing risks, as there appear to be no sanctions for patients who default from conditions contained in the CCO such as taking medication (Atkinson, Garner *et al.*, in press b).

Readmission to hospital is one way of measuring the impact of community management. It is misleading if it is always seen as a 'failure' of community services when it might be both appropriate and welcomed at the time. Not all relapse is preventable, even when using LOA. With the comparatively small numbers involved it is not possible to understand whether there was an increase in readmission to hospital. To do this would require more detail than is available in the MWC files. Informal as well as formal detentions and follow-up for patients over a standard length of time and plotted against expected relapse patterns for each patient would be required.

'Survival time' offers a crude measurement of maintenance in the community for the study population. Although the results suggest that hospital admissions are fewer for those who were compliant with medication this is complex and admission may occur for reasons other than non-compliance with medication.

Compliance with medication

According to the survey of psychiatrists, about three-quarters of patients were compliant with medication and the majority of the rest were partially compliant when on LOA. Only about 1% were not compliant. Although LOA might have contributed to patients' compliance it may also be true that it is the 'naturally' more compliant patients who will survive to 12 months on LOA. Those patients who are not compliant with medication despite being on LOA may have been recalled to hospital earlier. To understand the real relationship between LOA and compliance would require consideration of both groups of LOA patients and a detailed understanding of the factors surrounding relapse and readmission. Patients' views about medication are presented elsewhere (Atkinson, Garner *et al.*, in press a) as are details of the relationship between compliance and CCOs (Atkinson, Garner *et al.*, in press b).

Incidents following LOA

Care is needed in extrapolating from these figures as the follow-up time is variable and figures in each category are small. That half the injuries to others took place in a hospital setting would seem to indicate the appropriateness of the admission. The behaviour defined as 'reckless' is most likely to occur in community settings and from consultants' descriptions may include behaviour which is disruptive to others rather than dangerous.

Some psychiatrists may have filled in questionnaires from memory rather

than consulting patient records and this may have contributed to some under-reporting. Nevertheless, it is likely that the figures of incidents and reckless behaviour are reasonably accurate at least as far as major incidents are concerned. There is no real reason to believe that the 55 (21%) patients for whom no form was returned by 16 (11%) psychiatrists are different from those for whom responses were received. Indeed, given the psychiatrists' general unhappiness with the reduction of LOA it might be expected that those with extremely negative outcomes for patients would be keen to take this opportunity of recording the problems and bringing them to more public attention.

It should not be assumed that all incidents are avoidable by medication compliance or that a similar group of non-psychiatric patients would have a zero score of incidents. This is especially likely to be true of the reckless behaviour category. To really understand the impact of LOA and CCOs in preventing incidents requires a prospective study following a cohort of 'high-risk' patients. This would allow close monitoring of relevant variables including medication and external factors which are not available retrospectively.

Service provision

In general, lack of resources was not a major complaint although consultants in the named patient survey had less of at least one service or resource than they would have liked for almost half of the patients. This does not always represent a lack of services but is frequently the result of patients not being willing to accept more.

Despite not being a focus of the research, housing emerged as an issue although not necessarily as a result of changes to LOA. Since information was neither systematically available nor collected, only a cautious general comment can be made about funding being the core of most housing problems.

CONCLUSIONS

Despite the concerns expressed by consultants about the impact of restricting the limit on LOA, the widespread disasters gloomily predicted do not appear to have happened. A note of caution here is, however, appropriate. Hospital admission may have been found to be possible for patients about whom there was considerable concern and LOA re-started. It is also possible that the highest-risk patients do not fall into this group as they are unable to maintain 12 months in the community even if on LOA. A study of patients on LOA of less than 12 months would identify patients with repeated hospital admission and detentions and enable an analysis of why community living is not sustained.

It is not possible to compare these findings with similar groups of patients elsewhere. The difference between LOA in England and Wales and LOA in Scotland before the Act means that the two populations were not the same.

Protecting both patients and the public is the main purpose of mental health legislation and, since risk assessment is not an exact science, it is inevitable that some patients will be detained unnecessarily (false positives) and some will be not detained when appropriate (false negatives). That the majority of patients who were discharged from long-term LOA were not admitted to hospital in the follow-up period and were not involved in any adverse incidents, might suggest that consultants have been overly conservative in their assessment of risk. This suggests that consideration needs to be given to the reasons why consultants practise defensive psychiatry and how this might be changed, both to the benefit of patients' civil liberties and human rights and to a more positive practice of psychiatry.

The limitation to LOA introduced by the 1995 legislation has been more successful than was anticipated by psychiatrists. Although management of a group of patients (many of whom are non-compliant with medication) remains a problem, most patients were not transferred to other orders (CCOs or guardianship). This may be because psychiatrists reassessed the risk posed to or by the patient or because of lack of faith in the protection offered by the alternative provisions. Only a minority of patients were readmitted to hospital in the follow-up period, suggesting patients may have posed a lower risk than previously thought.

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