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CASE REPORT

Clinical stability in the community associated with long-term approved leave under the Mental Health Act 2001

E. Bainbridge[1,2,*], F. Byrne[1,2], B. Hallahan[1,2] and C. McDonald[1,2]

[1] *Department of Psychiatry, National University of Ireland Galway, Galway, Ireland*
[2] *West Galway Mental Health Services, Health Service Executive West, Galway, Ireland*

Introduction. We present the case of a 27-year-old man with a background diagnosis of treatment resistant schizophrenia and absent insight who for the last 3 years has been residing in a high support residential setting on approved leave under the Mental Health Act (MHA) 2001. The case demonstrates how this man achieved clinical stability in the community with the assistance of long-term involuntary admission under the MHA 2001, in contrast to the previous years of his illness in which he had suffered multiple relapses of his psychotic illness with ssociated distress, poor self-care and repeated in-patient re-admissions. We discuss the equivalent use of community treatment orders in other jurisdictions and how the judicious use of approved leave under the MHA 2001 may be used as an alternative in Ireland where community treatment orders are not currently available.

Method. Case Report.

Conclusion. The case report highlights how the use of long-term approved leave under the MHA2001 may be used as alternative in Ireland to mimic CTOs for certain difficult to treat patients with psychotic illness who would benefit from ongoing treatment, but lack capacity to engage in such treatment due to persistent symptoms and lack of insight.

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Introduction

We present the case of Mr AB, a 27-year-old single, unemployed man with a background history of paranoid schizophrenia. He has resided in a high support residential setting in the West of Ireland on approved leave under the Mental Health Act (MHA, 2001) since 2010. During this time, his mental state has been predominantly stable relative to the preceding years, where frequent relapses of his psychosis were associated with multiple lengthy admissions, poor self-care and a progressive decline in social functioning.

Case report

Mr AB was admitted as an involuntary patient to the Department of Psychiatry, University Hospital Galway for the first time in 2005 at 19 years of age under the Mental Treatment Act (MTA) 1945. He was referred to the Emergency Department by his general practitioner and attended accompanied by his mother. At that time symptoms had been present for ~4 weeks. He presented with florid psychotic symptoms. These included grandiose delusions that he was God, and that he could make people move by looking at them. He also demonstrated paranoid delusions and experienced auditory hallucinations. He was preoccupied and disorganised in behaviour, and demonstrated prominent formal thought disorder. He remained an in-patient for 3 weeks and responded well to the second-generation antipsychotic agent olanzapine. Before his admission, he had been smoking cannabis on an almost daily basis for a period of 1 week but denied using other psychoactive substances. He previously had used a number of psychoactive substances including MDMA (ecstasy), psilocybin (magic mushrooms) and cannabis. After discharge from hospital, he did not engage in any out-patient follow-up. He had a brief admission to a private facility where he was noted to be experiencing persecutory delusions, second person auditory hallucinations, disorganised speech and formal thought disorder. He engaged minimally and did not attend out-patient appointments. He suffered a further exacerbation of psychosis ~6 months later and was admitted and treated again as an involuntary patient in Galway for a period of 3 months. He presented with paranoid, grandiose and somatic delusions, and expressed a belief that his 'brain was sliding down

* Address for correspondence: Dr E. Bainbridge, MRCPsych, Clinical Research Fellow, Department of Psychiatry, National University of Ireland Galway, Galway, Ireland.
(Email: emma.bainbridge@nuigalway.ie)

his head' and described second person auditory hallucinations. He admitted to the ingestion of daily cannabinoids, as well as less frequent use of ecstasy, cocaine and alcohol. He also admitted to non-adherence with prescribed olanzapine in the weeks preceding admission. During this admission his medication was changed from olanzapine to amisulpiride and he gradually demonstrated an improvement in his psychotic symptoms. On discharge he displayed a number of negative symptoms, most notably amotivation.

Over the next 3 years, he was re-admitted as an involuntary patient on five further occasions under the MTA 1945 and subsequently MHA 2001 presenting on each occasion with florid psychotic symptoms, with these admissions lasting between 2 and 10 months in duration. The effectiveness of the prescribed antipsychotic medication in alleviating his psychotic symptoms attenuated with each admission. He was prescribed several different antipsychotic agents including olanzapine, quetiapine, amisulpiride, haloperidol, trifluperazine, paliperidone and clozapine, with clozapine discontinued secondary to neutropenia. Depot medication was offered to Mr AB at various intervals but was consistently refused initially by both himself and his family and when his family eventually were agreeable Mr AB was not and for this reason Depot medication was never trialled. During a 10-month psychiatric in-patient admission in 2008, he absconded from the in-patient ward on a number of occasions without approved leave, and attempted suicide as an in-patient by inflicting deep lacerations with a razor blade to his forearm while in the ward, which required surgical repair under general anaesthesia. During this admission he was discharged on approved leave to attend a day hospital, however, this was unsuccessful owing to non-compliance with medications and he was subsequently re-admitted to the approved centre.

In November, 2009 he was admitted for the eighth time as an involuntary patient, under the MHA 2001, to the Department of Psychiatry, University Hospital Galway with florid psychotic symptoms on a background of non-adherence with the prescribed medication paliperidone and misuse of both alcohol and cannabis. During this admission he was recommenced on clozapine in addition to lithium. He suffered a tonic–clonic seizure during the clozapine retrial and was also commenced on sodium valproate. At this time he was taking 500mg daily of clozapine but a clozapine plasma level was not measured. After 10 months in the acute in-patient unit he was discharged on approved leave to a high support seven bedded community residential unit where he has remained since on approved leave. Before his move to the hostel, he had been an involuntary patient in the Department of Psychiatry, University Hospital Galway for 34 months between 2005 and 2010. Over the last 3 years, his status has remained that of an involuntary patient under the MHA 2001. He has fulfilled terms of approved leave and administration of his medical treatment is supervised by hostel staff. He has not required transfer back to in-patient care at any point over the entire period. He continues to suffer some paranoid delusions; however the frequency and intensity of his psychotic symptoms have substantially reduced. He continues to display minimal insight into his illness, and on occasion when on approved leave from the hostel with family members, has been non-adherent with psychotropic medication for brief periods with consequent deterioration of paranoid beliefs and heightened distress and disorganised behaviour, which have settled after return to the hostel and reinstitution of medication. He continues to display negative symptoms, including amotivation and blunted affect. His overall functioning, both occupationally and socially has gradually increased over the last 3 years. He attends daily activities, successfully completed a University Access course and he intends to pursue a third level University course next year. He has misused alcohol on occasion but has remained abstinent from cannabinoids for the last 3 years. He continues to lack insight into his psychotic illness and repeatedly states that if his involuntary order was revoked, he would immediately seek independent accommodation and discontinue psychotropic medication.

Since his move to the high support residential setting, Mr AB has had five mental health review tribunals each of which have affirmed the involuntary admission order and accepted the evidence from the clinical team that if the order was revoked, Mr AB would likely suffer a serious deterioration in his condition. The mental health commission have not given any specific feedback in relation to the long-term approved leave but each tribunal agreed that Mr AB continues to suffer from a mental disorder as defined by the act. Given the information and history presented they have acknowledged that it would be in the patients' best interest to remain on approved leave as it was felt that Mr AB has the potential to further improve and it has been recognised by the tribunal that he is progressing well in his current environment.

In the past he was discharged to the care of either his mother or father who had been separated for a number of years. His parents though initially were not very accepting of the fact that he had a major mental illness requiring treatment, over time they became more accepting of this, and have in recent years been very keen for Mr AB to remain on approved leave and in the high support hostel. They have expressed this wish to the team on a number of occasions. They have

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expressed concerns that Mr AB will discontinue medication and subsequently deteriorate if he is discharged from approved leave.

In relation to his personal history, Mr AB was a normal full-term delivery and attained normal developmental milestones. He was described by his family as a 'shy and creative' child. Mr AB had some conduct difficulties at school as a 12 year old. He commenced using illicit substances at ~15 years of age including cannabis, psilocybin and ecstasy. He successfully completed his leaving cert attaining three honours. He engaged in some travelling around Europe and some administrative work, before the onset of his psychosis in 2005. He has been unable to engage in employment since then. There are a number of third degree relatives who have schizophrenia, however he is unaware of any first or second degree relatives with any major psychiatric pathology.

Discussion

This case study demonstrates how clinical stability has been achieved for this gentleman due to his involuntary detention under the MHA 2001 over the last 3 years, when, although an involuntary patient, he has resided outside hospital on approved leave in a high support residential setting. Previously, he suffered multiple relapses of his psychotic illness with significant levels of psychopathology, including suicidal ideation, poor self-care, high levels of distress for himself and his family, and prolonged periods of stay in an acute in-patient psychiatric ward. He has gradually demonstrated over the last 3 years an amelioration in both positive and negative symptoms and a greater level of occupational and social functioning, which has been facilitated by his ongoing involuntary detention under the MHA 2001 and the consequent sustained administration of clozapine and of rehabilitative care that this has enabled.

Community treatment orders (CTO's) are in operation in several countries including the United Kingdom, Canada and Australia and are designed to reduce re-admission rates to and durations of stay in acute in-patient psychiatric units and improve adherence to medication by introducing conditions that aim to ensure continuation of treatment and engagement with services (Walsh, 2010). Their introduction was aimed at promoting recovery from mental illness outside the in-patient setting (Kisely *et al.* 2011), allowing greater independence while providing individuals with a sense of security in relation to their mental health (Gibbs *et al.* 2005). The first country internationally to introduce CTOs as part of psychiatric care was Australia in 1986. Since then, New Zealand, Canada (Cambell *et al.* 2006) and over half of the states in the United States of America have introduced CTOs as a component of psychiatric care (Torrey & Kaplan, 1995).

In the United Kingdom, CTOs (hospital and community) were first introduced in Scotland in 2005 under The Mental Health Care and Treatment (Scotland) Act 2003 where an application for a CTO is presented to a mental health tribunal by the responsible clinician (RC) in conjunction with a detailed care plan (Walsh, 2010). It is important to note that in Scotland CTOs can be placed on people who are living in the community as well as on those discharged from hospital. CTOs were subsequently introduced into England and Wales in November 2008, following the MHA 2007, which added sections 17 A-G to the MHA 1983. This amendment allowed for supervised community treatment and was aimed primarily at those individuals who had repeated involuntary admissions to acute psychiatric units (Woolley, 2010, Lally, 2013). Before the introduction of CTOs, earlier initiatives in the United Kingdom, included extended leave for patients under the MHA 1983 and a 'Supervision Register' on discharge from involuntary status (Sensky *et al.* 1991, Rugkåsa & Burns, 2009). The powers of these supervised discharge orders were considered too limited to ensure adequate adherence to treatment in the community and were felt to be unsuccessful in achieving a reduction in acute in-patient psychiatric admissions to hospital under the MHA 1983 (Sensky *et al.* 1991, Rugkåsa & Burns, 2009). It should also be emphasised that even if there is a CTO authorising treatment in place for the individual that if the individual subsequently refuses the treatment then they must be conveyed back to hospital for the treatment to be enforced. This is the case in England and Wales. The criteria in England and Wales that must be satisfied in order to place a patient on a CTO are presented in Box 1.

Criteria in accordance with section 17A (5) of the Mental Health Act, 2007.

Once a CTO is in place, the patient can be recalled to hospital temporarily for assessment (i.e. for general assessment or if there is a suspicion that the individuals' mental health has deteriorated; Lawton-Smith *et al.* 2008; Walsh, 2010; Manning *et al.* 2011 by their RC. On assessment, the CTO can be revoked to resurrect their involuntary detention, the person can be released back onto the CTO, or the patient can be discharged from the CTO. CTOs are under the remit of the mental health review tribunal board and certain criteria must be fulfilled [i.e. its necessity must be supported by an approved mental health practitioner (AMHP) (another team member) in addition to the RC]. Initially a CTO lasts for a 6 month period, after which, it can be extended for 6 months and then 1 yearly intervals', after review by the RC and AMHP.

Conflicting evidence exists at present in relation to the potential benefit of CTOs despite their putative

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Box 1 Criteria for attaining a CTO in England and Wales

- The patient is suffering from mental disorder of a nature or degree that makes it appropriate for them to receive medical treatment
- It is necessary for the patient's health or safety or for the protection of other persons that he should receive such treatment
- Subject to their being liable to be recalled, such treatment can be provided without his continuing to be detained in a hospital
- It is necessary that the RC should be able to exercise the power to recall the patient to hospital
- Appropriate medical treatment is available for him

advantages of ensuring greater support and treatment adherence in the community. For example, in Victoria, Australia an increase in acute psychiatry in-patient stay, and initial re-admission rates (albeit reduced subsequent re-admission rates) have been reported (Burgess *et al.* 2006, Segal & Burgess, 2006) with their use. Similarly, a systematic review including two randomised controlled trials and three controlled before and after studies, three based in the United States and two based in Australia demonstrated no significant reduction in bed-days between patients under CTO compared with those who were not, with no significant difference in social functioning or quality of life detected. However, individuals subject to CTOs were less likely to be the victims of violent or non-violent crimes (Kisely *et al.* 2007).

A greater engagement in out-patient services has, however, been demonstrated with the use of CTOs in the first year after an individuals' involuntary admission (Preston *et al.* 2002). This finding is supported by a survey of psychiatrists in the United States, that reported that CTO's made ongoing contact with patients and detection of relapse of acute psychiatric illness easier, improved medication adherence and allowed for a greater involvement of families in the care of their relatives (Romans *et al.* 2004). The OCTET study recently published is a large non-blinded parallel arm randomised controlled trial carried out in the United Kingdom evaluating whether the use of CTOs reduced admission compared with the use of section 17 leave where both groups received similar levels of clinical contact but differing lengths of compulsory supervision. Authors, however, did not find that the use of CTOs reduced the rates of re-admission of psychotic patients (Burns *et al.* 2013). It is probable that longer term studies are required to elucidate accurately if CTOs confer a benefit in quality of life or reduce the number or duration of acute in-patient psychiatric admissions.

The significant variations in the use of CTOs across different jurisdictions, has led to criticism by some groups that their use is arbitrary and poorly linked to clinical need (Lawton-Smith, 2005). Groups opposed to the use of CTOs suggest that if an individual is well enough to live in the community, they are also well enough to make their own decisions regarding treatment, and should not be coerced into taking treatment (Eastman, 1997). It has also been highlighted that CTOs are questionable from a legal perspective as to whether or not they are the least restrictive and coercive form of management possible, particularly as they can be extended for prolonged periods of time (Ajzenstadt *et al.* 2001). Concerns have thus been expressed that without more restrictions and clearer guidelines for their use that the potential exists for CTOs to be overused and perhaps may be viewed as the 'easy option' for managing more difficult clinical patients (Eastman, 1997).

In Ireland, at present CTOs do not exist, and to our knowledge there are no plans to introduce them, however, patients may potentially spend up to 364 days on 'approved leave' from an acute psychiatric in-patient setting before the review by a mental health tribunal under the MHA 2001. Section 26-1 of the MHA 2001 states that 'the consultant psychiatrist responsible for the care and treatment of a patient may grant permission in writing to the patient to be absent from the approved centre concerned for such period as he or she may specify in the permission being a period less than the unexpired period provided for in the relevant admission order, the relevant renewal order or the relevant order under section 25'. Thus, despite the absence of CTOs in Ireland, the MHA 2001 can operate in a similar fashion with the use of approved leave and regular independent reviews by mental health tribunals of same and in addition to this including the individual and their family and taking their preferences into consideration. Treatment is never forced in the community with approved leave under the MHA, it can only be forced in hospital but leave can be withdrawn and it is the possibility of this that ensures adherence with the care plan.

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The conflicting findings in relation to the putative benefit of CTOs may be explained to some extent by the fact that previous studies predominantly evaluated the use of CTOs in individuals living in community setting without intensive supervised support (Preston *et al.* 2002; Burgess *et al.* 2006), unlike Mr AB who continues to reside in a high support hostel.

Conclusion

The case report highlights how the use of long-term approved leave under the MHA 2001 may be used as an alternative in Ireland to mimic CTOs for certain difficult to treat patients with psychotic illness who would benefit from ongoing treatment, but lack capacity to engage in such treatment due to persistent symptoms and lack of insight. In this case, the utilisation of the MHA 2001 in this fashion to facilitate a sustained care plan in the community has had a substantial beneficial effect in relation to this gentleman's level of symptomotology, and overall social and occupational functioning for the last 3 years, in dramatic contrast to the distress and dysfuction that characterised the first 4 years of his illness. Approved leave under the MHA 2001 has facilitated the individual in question receiving the treatment needed in a manner similar to the way one might receive treatment under a CTO. An important principle of care is that it is given in the least restrictive environment. That is so in the case described since care is being delivered in the community rather than an in-patient unit. However, continued in-patient admission under MHA 2001, albeit on approved leave, is a more restrictive legislative option than a CTO. Given the important emphasis on community care in the development of Irish mental health services, we contend that there should be specific legislation to facilitate involuntary community treatment for those patients who lack insight and who refuse treatment but who require treatment to alleviate symptoms, hence reducing risk and improving quality of life and functioning; but whose care would be best delivered in a community setting. In the meantime this case highlights how the judicious use of long-term approved leave from in-patient care under the MHA 2001 can be utilised by clinicians to achieve a similar aim.

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