IN THE UPPER TRIBUNAL **Case No.** HM/2258/2019
ADMINISTRATIVE APPEALS CHAMBER

Save for the cover sheet, this decision may be made public (rule 14(7) of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI No. 2698)). That sheet is not formally part of the decision and identifies the patient by name.

This decision is given under section 11 of the Tribunals, Courts and Enforcement Act 2007:

The decision of the First-tier Tribunal under reference MP/2019/18423, made on 15th August 2019, involved the making of an error of a point of law. However, I do not set the decision aside because the Appellant is no longer subject to the compulsory powers of the Mental Health Act 1983 (as amended), having been discharged by her responsible clinician from her CTO on 18th November 2019.

REASONS FOR DECISION

1. Introduction

1.1. The Appellant, to whom I will refer as **"Miss M"**, has been known to psychiatric services since 1984. She has had numerous hospital admissions associated with mental disorder and has a longstanding diagnosis of schizoaffective disorder. She has also had periods in the community when her mental health has been stable.

1.2. Miss M's most recent admission to hospital was on 16th April 2019 under section 3 of the Mental Health Act 1983 (as amended) (the **"MHA"**). During her admission she was started on long-acting depot anti-psychotic medication (Aripiprazole at a dose of 300mgs, to be administered monthly). She received two doses, the first on 17th May 2019 and the second on 21st June 2019, with the plan that she should continue on the depot on the third Friday of each month.

1.3. She was discharged from hospital detention subject to recall under the terms of a Community Treatment Order (**"CTO"**) on 5th July 2019.

1.4. Other than the compulsory conditions, Miss M's CTO carried conditions which required her:

(i) to allow monitoring of her mental state by healthcare professionals; and
(ii) to allow administration of her prescribed psychotropic medication.

1.5. On the day of her discharge from hospital Miss M made an application to have her CTO reviewed by a tribunal. Her application was heard by a panel of the First-tier Tribunal sitting at The Redwoods Centre on 15th August 2019 (the **"Tribunal"**).

1.6. Miss M challenged her CTO on the basis that, other than some difficulties with stress, she did not suffer from any mental disorder and never had done. She did not accept any need for medical treatment or any input from mental health services. Miss M's representative argued that from 17th August 2019 (two days after the date of her tribunal hearing) the administration of Miss M's depot would not be lawful because the certificate requirement was not then met and there was no likelihood of it being met by the time the certificate requirement would apply. On this basis he submitted that appropriate medical treatment could not properly be said to be available.

1.7. As at the date of her hearing before the Tribunal there had been only telephone and written contact between Miss M and mental health services. Her stated position was that she would not allow any visits from members of the community mental health team and would not accept her depot medication until a review by a "second opinion approved doctor" (**"SOAD"**) had taken place.

1.8. At the hearing before the Tribunal the responsible clinician acknowledged that Miss M had not complied with the conditions of her CTO. He said that he had considered whether to exercise his section 17E power to recall Miss M to hospital but had not yet decided to do so.

1.9. The responsible authority opposed Miss M's application for discharge of her CTO, maintained that all of the conditions set out in section 72(1)(c) MHA were satisfied, and argued that the Tribunal should uphold the CTO.

1.10. The Tribunal decided to uphold the CTO (the **"Tribunal's Decision"**). This appeal is an appeal against the Tribunal's Decision.

2. The Permission Stage

2.1. Miss M's representative, Mr John Lancaster of GHP Legal, applied to the First-tier Tribunal for permission to appeal to the Upper Tribunal. He argued that the Tribunal should not have been satisfied in relation to the criteria set out in section 72(1)(c)(i), (ii), (iii) or (iv) of the MHA, and that its finding that those criteria were satisfied involved the making of errors of law.

2.2. On 19th September 2019 Judge Fyall of the First-tier Tribunal granted permission to appeal to the Upper Tribunal on limited grounds.

2.3. Miss M applied to the Upper Tribunal seeking to broaden the scope of her permission to appeal to include additional grounds. I was not persuaded that these additional grounds were arguable with a realistic prospect of success because they amounted in substance to a disagreement with the Tribunal's evaluation of the evidence and its findings of fact, which were open to it on the evidence. I explained my reasons for refusing permission to appeal on those additional grounds in my decision notice of 25th October 2019. I directed that the parties provide submissions.

3. Further Developments

3.1. On 18th November 2019 Miss M was discharged from her CTO and the section 3 to which it attached.

3.2. Miss M indicated that she nonetheless wished to pursue her appeal as she considered that it was important for other patients on CTOs for the Upper Tribunal to address the proper interpretation of the provisions relating to appropriate medical treatment as they apply to community patients.

3.3. Mr Lancaster provided written submissions on behalf Miss M and Ms Emma Pollard of Capsticks provided written submissions on behalf of the Respondent. I am grateful to them for the care they each took with their submissions.

4. The Issue in this appeal

This appeal is about whether (as Judge Fyall put it in her grant of permission) a tribunal "can find medical treatment to be available and/or appropriate if within the immediate near future and for an indeterminate period, it cannot be given to a patient under the authority of the Mental Health Act".

5. The Oral Hearing

5.1. The appeal was listed for an oral hearing in Birmingham on 14 January 2020.

5.2. Miss M attended the oral hearing supported by Mr Curtis from Voiceability, who had been her Independent Mental Health Advocate at numerous hearings in the past but her representative did not attend. The Respondent was not represented at the hearing.

5.3. At the hearing Miss M made submissions which centred on her disagreement with her diagnosis, criticisms of Dr Rice (her responsible clinician), criticisms of her treatment, and criticisms of the treatment of psychiatric patients by mental health services generally. Regrettably, they didn't build on the written arguments that had been made by her representative.

6. The statutory framework relevant to this appeal: The MHA

6.1. The decision to detain Miss M for treatment was governed by section 3 MHA, which provides as follows:

"Admission for treatment

3. – (1) A patient may be admitted to a hospital and detained there for the period allowed by the following provisions of this Act in pursuance of an application (in this Act referred to as "an application for treatment") made in accordance with this section.

(2) An application for admission for treatment may be made in respect of a patient on the grounds that –

(a) he is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and

…

(c) it is necessary for the health and safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section; and

(d) appropriate medical treatment is available for him.

(3) An application for admission for treatment shall be founded on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in subsection (2) above are complied with; and each such recommendation shall include-

(a) such particulars as may be prescribed of the grounds for that opinion so far as it relates to the conditions set out in paragraphs (a) and (d) of that subsection; and

(b) a statement of the reasons for that opinion so far as it relates to the conditions set out in paragraph (c) of that subsection, specifying whether other methods of dealing with the patient are available and, if so, why they are not appropriate.

(4) In this Act, references to appropriate medical treatment, in relation to a person suffering from mental disorder, are references to medical treatment which is appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case."

6.2. The decision to discharge Miss M from hospital detention subject to a CTO was governed by section 17A MHA, which provides as follows:

“Community treatment orders
17A.-(1) The responsible clinician may by order in writing discharge a detained patient from hospital subject to his being liable to recall in accordance with section 17E below.
(2) A detained patient is a patient who is liable to be detained in a hospital in pursuance of an application for admission for treatment.
(3) An order under subsection (1) above is referred to in this Act as a “community treatment order”.
(4) The responsible clinician may not make a community treatment order unless –
(a) in his opinion, the relevant criteria are met; and
(b) an approved mental health professional states in writing –
(i) that he agrees with that opinion; and
(ii) that it is appropriate to make the order –
(5) The relevant criteria are –
(a) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;
(b) it is necessary for his health and safety or for the protection of other persons that he should receive such treatment;
(c) subject to his being liable to be recalled as mentioned in paragraph
(d) below, such treatment can be provided without his continuing to be detained in a hospital;
(d) it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) below to recall the patient to hospital; and
(e) appropriate medical treatment is available for him.
(6) In determining whether the criterion in subsection 5(d) above is met, the responsible clinician shall, in particular, consider, having regard to the patient’s history of mental disorder and any other relevant factors, what risk there would be of a deterioration of the patient’s condition if he were not detained in a hospital (as a result, for example, of his refusing or neglecting to receive the medical treatment he requires for his mental disorder).
(7) In this Act –
“community patient” means a patient in respect of whom a community treatment order is in force;
“the community treatment order”, in relation to such a patient, means the community treatment order in force in respect of him; and
“the responsible hospital”, in relation to such a patient, means the hospital in which he was liable to be detained immediately before the community treatment order was made, subject to section 19A below.”

6.3. Section 17E MHA sets out the circumstances in which the responsible clinician may recall a community patient to hospital:

“**Power to recall to hospital**
17E. – (1) The responsible clinician may recall a community patient to hospital if in his opinion –

(a) the patient requires medical treatment in hospital for his mental disorder; and
(b) there would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled to hospital for that purpose.

(2) The responsible clinician may also recall a community patient to hospital if the patient fails to comply with a condition specified in section 17B(3) above.

(3) The hospital to which a patient is recalled need not be the responsible hospital.

(4) Nothing in this section prevents a patient from being recalled to a hospital even thought he is already in the hospital at the time when the power of recall is exercised; references to recalling him shall be construed accordingly.

(5) The power of recall under subsections (1) and (2) above shall be exercisable by notice in writing to the patient.

(6) A notice under this section recalling a patient to hospital shall be sufficient authority for the managers of that hospital to detain the patient there in accordance with the provisions of this Act."

6.4. Section 58 MHA sets out requirements for additional safeguards in respect of certain types of treatment. It provides as follows:

"Treatment requiring consent or a second opinion

58. - (1) This section applies to the following forms of medical treatment for mental disorder –

(a) such forms of treatment as may be specified for the purposes of this section by regulations made by the Secretary of State;
(b) the administration of medicine to a patient by any means (not being a form of treatment specified under paragraph (a) above or section 57 above or section 58A(1)(b) below) at any time during a period for which he is liable to be detained as a patient to whom this Part of his Act applies if three months or more have elapsed since the first occasion in that period when medicine was administered to him by any means for his mental disorder.

(2) The Secretary of State may by order vary the length of the period mentioned in section 1(b) above.

(3) Subject to section 62 below, a patient shall not be given any form of treatment to which this section applies unless –

(a) he has consented to that treatment and either the approved clinician in charge of it or a registered medical practitioner appointed for the purposes of this Part of this Act by the regulatory authority has certified in writing that the patient is capable of understanding its nature, purpose and likely effects and has consented to it; or
(b) a registered medical practitioner appointed as aforesaid (not being the responsible clinician or the approved clinician in charge of the treatment in question has certified in writing that the patient is capable of understanding the nature, purpose and likely effects of that treatment or being so capable has not consented to it but that it is appropriate for the treatment to be given.

(4) Before giving a certificate under subsection 3(b) above the registered medical practitioner concerned shall consult two other persons who have been professionally concerned with the patient's medical treatment, but, of those persons –

(a) one shall be a nurse and the other shall be neither a nurse nor a registered medical practitioner; and

(b) neither shall be the responsible clinician or the approved clinician in charge of the treatment in question.

(5) Before making any regulations for the purposes of this section the Secretary of State shall consult such bodies as appear to him to be concerned."

6.5. Section 62 MHA sets out certain circumstances in which the additional safeguards set out in sections 57 and 58 MHA do not apply. It provides as follows:

"Urgent treatment

62. – (1) Sections 57 and 58 above shall not apply to any treatment –

(a) which is immediately necessary to save the patient's life; or

(b) which (not being irreversible) is immediately necessary to prevent a serious deterioration in his condition; or

(c) which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; or

(d) which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others.

(1A) Section 58A above, in so far as it relates to electro-convulsive therapy by virtue of subsection (1)(a) of that section, shall not apply to any treatment which falls within paragraph (a) or (b) of subsection (1) above.

(1B) Section 58A above, in so far as it relates to a form of treatment specified by virtue of subsection (1)(b) of that section, shall not apply to any treatment which falls within such of paragraphs (a) to (d) of subsection (1) above as may be specified in regulations under that section.

(1C) For the purposes of subsection (1B) above, the regulations –

(a) may make different provision for different cases (and may, in particular, make different provision for different forms of treatment);

(b) may make provision which applies subject to applies subject to specified exceptions; and

(c) may include transitional, consequential, incidental or supplemental provision.

(2) Sections 60 and 61(3) above shall not preclude the continuation of any treatment or of treatment under any plan pending compliance with section 57, 58 or 58A above if the approved clinician in charge of the treatment considers that the discontinuance of the treatment or of treatment under the plan would cause serious suffering to the patient.

(3) For the purposes of this section treatment is irreversible if it has unfavourable irreversible physical or psychological consequences and hazardous if it entails significant physical hazard."

6.6. Section 62A MHA sets out provisions applying to the treatment of community patients who have been recalled to hospital or whose CTO has been revoked:

“Treatment on recall of community patient or revocation of order
62A. – (1) This section applies where –
(a) a community patient is recalled to hospital under section 17E above; or
(b) a patient is liable to be detained under this Act following the revocation of a community treatment order under section 17F above in respect of him.
(2) For the purposes of section 58(1)(b) above, the patient is to be treated as if he had remained liable to be detained since the making of the community treatment order.
(3) But section 58 above does not apply to treatment given to the patient if –
(a) the certificate requirement is met for the purposes of section 64C or 64E below; or
(b) as a result of section 64B(4) or 64E(4) below, the certificate requirement would not apply (were the patient a community patient not recalled to hospital under section 17E above).
(4) Section 58A above does not apply to treatment given to the patient if there is authority to give the treatment, and the certificate requirement is met, for the purposes of section 64C or 64E below.
(5) In a case where this section applies (and the Part 4A certificate falls within section 64C(4) below), the certificate requirement is met only in so far as –
(a) the Part 4A certificate expressly provides that it is appropriate for one or more specified forms of treatment to be given to the patient in that case (subject to such conditions as may be specified); or
(b) a notice having been given under subsection (5) of section 64H below, treatment is authorised by virtue of subsection (8) of that section.
(6) Subsection (5) above shall not preclude the continuation of any treatment or of treatment under any plan, pending compliance with section 58 or 58A above or 64B or 64E below if the approved clinician in charge of the treatment considers that the discontinuance of the treatment, or of the treatment under the plan, would cause serious suffering to the patient.
(6A) In a case where this section applies and the certificate requirement is no longer met for the purposes of section 64C(4A) below, the continuation of any treatment, or of treatment under any plan, pending compliance with section 58 or 58A above or 64B or 64E below shall not be precluded if the approved clinician in charge of the treatment considers that the discontinuance of the treatment, or of treatment under the plan, would cause serious suffering to the patient.
(7) In a case where subsection (1)(b) above applies, subsection (3) above only applies pending compliance with section 58 above.
(8) In subsection (5) above –
“Part 4A certificate” has the meaning given in section 64H below; and
“specified”, in relation to a Part 4A certificate, means specified in the certificate.”

6.7. Part 4A MHA deals with the treatment of community patients who have not been recalled to hospital pursuant to section 17E, which provides as follows:

"Meaning of "relevant treatment"
64A. – In this Part of this Act "relevant treatment", in relation to a patient, means medical treatment which –
(a) is for the mental disorder from which the patient is suffering; and
(b) is not a form of treatment to which section 57 above applies.

Adult community patients
64B. – (1) This section applies to the giving of relevant treatment to a community patient who –
(a) is not recalled to hospital under section 17E above; and
(b) has attained the age of 16 years.
(2) The treatment may not be given to the patient unless –
(a) there is authority to give it to him; and
(b) if it is section 58 type treatment or section 58A type treatment, the certificate requirement is met.
(3) But the certificate requirement does not apply if –
(a) giving the treatment to the patient is authorised in accordance with section 64G below; or
(b) the treatment is immediately necessary and –
(i) the patient has capacity to consent to it and does consent to it; or
(ii) the done or deputy of the Court of Protection consents to the treatment on the patient's behalf.
(4) Nor does the certificate requirement apply in so far as the administration of medicine to the patient at any time during the period of one month beginning with the day on which the community treatment order is made is section 58 type treatment.
(5) The reference in subsection (4) above to the administration of medicine does not include any form of treatment specified under section 58(1)(a) above.

Section 64B: supplemental
64C. – (1) This section has effect for the purposes of section 64B above.
(2) There is authority to give treatment to a patient if –
(a) he has capacity to consent to it and does consent to it;
(b) a donee or deputy or the Court of Protection consents to it on his behalf; or
(c) giving it to him is authorised in accordance with section 64D or 64G below.
(3) Relevant treatment is section 58 type treatment or section 58A type treatment if, at the time when it is given to the patient, section 58 or 58A above (respectively) would have applied to it, had the patient remained liable to be detained at that time (rather than being a community patient).
(4) The certificate requirement is met in respect of treatment to be given to a patient if –
(a) a registered medical practitioner is appointed for the purposes of Part 4 of this Act (not being the responsible clinician or the person in charge of the treatment) has certified in writing that it is appropriate for the treatment to be given or for the treatment to be given subject to such conditions as may be specified in the certificate; and
(b) if conditions are so specified, the conditions are satisfied.

(4A) Where there is authority to give treatment by virtue of subsection 2(a), the certificate requirement is also met in respect of the treatment if the approved clinician in charge of the treatment has certified in writing that the patient has capacity to consent to the treatment and has consented to it.
(4B) But, if the patient has not attained the age of 18, subsection (4A) does not apply to section 58A type treatment.
(5) In a case where the treatment is section 58 type treatment, treatment is immediately necessary if –

(a) it is immediately necessary to save the patient's life; or
(b) it is immediately necessary to prevent a serious deterioration of the patient's condition and is not irreversible; or
(c) it is immediately necessary to alleviate serious suffering by the patient and is not irreversible or hazardous; or
(d) it is immediately necessary, represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or others and is not irreversible or hazardous.

(6) In a case where the treatment is section 58A type treatment by virtue of subsection (1)(a) of that section, treatment is immediately necessary if it falls within paragraph (a) or (b) of subsection (5) above.
(7) In a case where the treatment is section 58A type treatment by virtue of subsection (1)(b) of that section, treatment is immediately necessary if it falls within such of paragraphs (a) to (d) of subsection (5) above as may be specified in regulations under that section.
(8) For the purposes of subsection (7) above, the regulations –

(a) may make different provision for different cases (and may, in particular, make different provision for different forms of treatment);
(b) may make provision which applies subject to specified exceptions; and
(c) may include transitional, consequential, incidental or supplemental provision.

(9) Subsection (3) of section 62 above applies for the purposes of this section as it applies for the purposes of that section.
…

Emergency treatment for patients lacking capacity or competence
64G. – (1) A person is also authorised to give relevant treatment to a patient as mentioned in section 64C(2)(c) or 64E(6)(b) above if the conditions in subsections (2) to (4) below are met.
(2) The first condition is that, when giving the treatment, the person reasonably believes that the patient lacks capacity to consent to it or, as the case may be, is not competent to consent to it.
(3) The second condition is that the treatment is immediately necessary.
(4) The third condition is that if it is necessary to use force against the patient in order to give the treatment –

(a) the treatment needs to be given in order to prevent harm to the patient; and
(b) the use of such force is a proportionate response to the likelihood of the patient's suffering harm, and to the seriousness of that harm.

(5) Subject to subsections (6) to (8) below, treatment is immediately necessary if –

(a) it is immediately necessary to save the patient’s life; or
(b) it is immediately necessary to prevent a serious deterioration of the patient’s condition and is not irreversible; or
(c) it is immediately necessary to alleviate serious suffering by the patient and is not irreversible or hazardous; or
(d) it is immediately necessary, represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or others and is not irreversible or hazardous.

(6) Where the treatment is section 58A type treatment by virtue of subsection (1)(a) of that section, treatment is immediately necessary if it falls within paragraph (a) or (b) of subsection (5) above.

(7) Where the treatment is section 58A type treatment by virtue of subsection 1(b) of that section, treatment is immediately necessary if it falls within paragraphs (a) to (d) of subsection (5) above as may be specified in regulations under section 58A above.

(8) For the purposes of subsection (7) above, the regulations –
(a) may make different provision for different cases (and may, in particular, make different provision for different forms of treatment);
(b) may make provision which applies subject to specified exceptions; and
(c) may include transitional, consequential, incidental or supplemental provision.

(9) Subsection (3) of section 62 above applies for the purposes of this section as it applies for the purposes of that section.”

6.8. Section 72 MHA sets out the powers and duties of a mental health tribunal when considering an application by or in respect of a patient liable to be detained under MHA, or who is a community patient. It provides, insofar as relevant to a community patient such as the Appellant:

“Powers of tribunals
72. – (1) Where application is made to the appropriate tribunal by or in respect of a patient who is…a community patient, the tribunal may in any case direct that the patient be discharged, and –
…
(c) the tribunal shall direct the discharge of a community patient if it is not satisfied –
(i) that he is suffering from mental disorder or mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment; or
(ii) that it is necessary for his health or safety or for the protection of other persons that he should receive such treatment; or
(iii) that it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) above to recall the patient to hospital; or
(iv) that appropriate medical treatment is available for him; or
(v) in the case of an application by virtue of paragaraph (g) of section 66(1) above, that the patient, if discharged, would be likely to act in a manner dangerous to other persons or to himself.”

6.9. Section 145(1) MHA defines “medical treatment” as follows:

““medical treatment” includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care”.

6.10. Section 145(4) MHA explains how references to medical treatment should be construed:
“Any reference in this Act to medical treatment, in relation to mental disorder, shall be construed as a reference to medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms, manifestations”.

7. Analysis – the Part 4A Regime

7.1. Part 4A MHA deals with the provision of “relevant treatment” of patients who, like Miss M, have been discharged from hospital detention subject to a CTO and who, like Miss M, have not been recalled to hospital under section 17E MHA.

7.2. The law relating to the administration of medication to such patients is somewhat complex (as can be seen from the provisions extracted above), but the upshot of the provisions in Part 4A is that such patients can only be given relevant treatment if there is authority to do so and, if the treatment falls within section 58 or 58A MHA, the “certificate requirement” is met. “Authority” to give treatment derives either from (a) the consent of a capacitous patient, or (b) consent given on behalf of an incapacitous patient from a donee or a deputy or the Court of Protection, or (c) from section 64D MHA (treatment for patients who lack capacity) or 64G MHA (emergency treatment for patients who lack capacity).

7.3. The certificate requirement provides a degree of formality and oversight, after an initial period, in respect of certain types of treatment.

7.4. The certificate requirement does not apply to all relevant treatment. It only applies to the extent that the treatment in question falls within section 58 or 58A MHA.

7.5. The administration of medicine that is prescribed treatment for a patient’s mental disorder is (subject to certain exceptions which do not apply to the facts of this case) treatment falling within section 58 MHA, so generally speaking the certificate requirement must be met for such treatment to be provided lawfully.

7.6. However, the certificate requirement does not apply to the administration of such medicine in certain defined circumstances, including:

(a) if such medicine is administered to the patient at any time during the period of one month beginning with the day on which the CTO is made (section 64B(4)-(5) MHA) or within three months from the first date that the medication for the patient’s mental disorder was first given to the patient during an unbroken period of detention and discharge onto a CTO or an unbroken succession of periods of detention and CTO, whichever is the later (section 58(1)(b) MHA); and

(b) if the treatment is immediately necessary and the patient (being capacitous) consents to it (section 64B(3)(b) and 64C(5)-(7) MHA).

7.7. By whom a certificate is to be provided, and the required content of the certificate, differs depending on whether the patient to whom it relates has capacity to consent or withhold their consent to the proposed treatment.

7.8. A certificate in respect of a patient who has capacity and has consented to the treatment in question must be provided by the approved clinician in charge of the patient's treatment and it must certify that the patient has capacity and has consented to the proposed treatment (a **"Part 4A Consent Certificate"**).

7.9. A certificate in respect of a patient who lacks the relevant capacity must be provided by a SOAD appointed by the Care Quality Commission (or, in relation to Wales, Healthcare Inspectorate Wales) and must certify that the treatment is appropriate (a **"Part 4A Certificate"**)

7.10. It was common ground between the parties that the date from which the certificate requirement would apply to the Appellant's case was 17th August 2019 (two days after the date of the hearing before the Tribunal).

7.11. Although the Respondent had requested a review by a SOAD on 15 July 2019 as at the date of the Tribunal hearing no such review had been completed and no certificate had been issued. The timing of the SOAD review was not within the Respondent's control and it was unable to predict when a review would take place.

8. Analysis – the "medical treatment" found by the Tribunal

8.1. The Tribunal accepted the responsible clinician's evidence that "psychotropic medication tends to attenuate the patient's symptoms" (paragraph 10 of the Tribunal's decision with reasons). It can be inferred from what the Tribunal said that it accepted that the medication was prescribed for this purpose. In all the circumstances, based on the evidence before it, the Tribunal was entitled to find that the administration of Miss M's depot medication amounted to "medical treatment".

8.2. The written submissions made on this appeal on behalf of the Respondent included an argument that the monitoring of Miss M's mental health by healthcare professionals, which she was required to allow under the first of her CTO conditions, also amounted to "medical treatment" for the purposes of section 72(1)(c)(iv) MHA. The significance of this is that if such activities could be separated from "the administration of medicine by any means" (section 58(1)(b) MHA) then such activities might amount to medical treatment which falls outside the ambit of section 58 or 58A MHA, meaning that the certificate requirement would not apply to it.

8.3. Monitoring would not, in and of itself, *necessarily* qualify as "medical treatment" for the purposes of section 145(1) MHA (as construed in accordance with section 145(4) MHA). For example, if monitoring were by way of observation of a patient via a CCTV feed, that monitoring (as opposed to any intervention made in response to what was observed) could not be said to be done with therapeutic intent. Such monitoring would fall into the category identified by Stanley Burnton J. in *R. (on the application of O'Reilly) v Blenheim Healthcare Ltd* [2005] EWHC 241 (Admin) at [14] as "acts carried out for the purpose of treatment, or with a view to deciding on treatment", rather than treatment itself.

8.4. It is possible, though, that activities incidental to monitoring, such as telephone calls and visits from members of the multidisciplinary team, *might* themselves qualify as "medical treatment".

8.5. However, it is clear from the Tribunal's decision with reasons that the only medical treatment the Tribunal relied upon in deciding to uphold Miss M's CTO was the administration of her prescribed depot antipsychotic

medication. Further, the Tribunal did not make findings as to the activities involved in monitoring Miss M or as to the purpose of those activities which would have been sufficient to support a decision that the monitoring activities themselves amounted to medical treatment. I therefore restrict my analysis in the rest of this decision to the proposed medical treatment that the Tribunal did rely on: the administration of prescribed psychotropic medication.

9. Analysis - was the medical treatment "appropriate"?

9.1. The guidance provided in section 3(4) MHA on the meaning of "appropriate medical treatment" is frustratingly circular:

> "In this Act, references to appropriate medical treatment, in relation to a person suffering from mental disorder, are references to medical treatment which is appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case."

9.2. So, what does "appropriate" actually mean? The obligation to take into account the nature and degree of the patient's mental disorder indicates that "appropriateness" is a clinical concept. But what are we supposed to take from "all other circumstances of his case"?

9.3. *SH v Cornwall Partnership NHS Trust* [2012] UKUT 290 (AAC), concerned a patient who, like Miss M, was a community patient who had not been recalled to hospital. Judge Jacobs considered the relevance of a patient's consent to the question whether treatment was "appropriate" and "available" for the purposes of section 72(1)(c) MHA. He said at [14] that:

> "The delivery of treatment, and the related issue of consent, is practically and conceptually distinct from the issue whether it is appropriate and available. Treatment may be appropriate, whether or not the patient consents. And it may be available, whether or not the patient is willing to receive it. Appropriateness and availability are issues that arise prior to the decision whether to give the treatment. It is only at that later stage that the patient's consent arises."

Judge Jacobs later underlined the position that the tribunal has no jurisdiction under section 72(1)(c) to deal with issues of consent to treatment while a patient was subject to a CTO in *GA v Betsi Cadwaladr University LHB* [2013] 280 (AAC).

9.4. This appeal raises the issue whether the lawfulness of administering medication to a Part 4A patient is relevant to a tribunal's assessment of whether the medical treatment proposed by the responsible authority was appropriate and available, or whether such a consideration, like consent, is something that comes into play only at the later stage of deciding whether to give the treatment.

9.5. As at the date of the hearing before the Tribunal the certificate requirement had not yet arisen, so if the administration of the prescribed antipsychotic medication was clinically appropriate it could at that stage have been administered lawfully as long as Miss M consented to it, and *SH v Cornwall Partnership NHS Trust* tells us that consent is not something that should be weighed in the balance when assessing either the appropriateness or the availability of treatment under section 72 MHA.

9.6. The Respondent does not appear to have had any concrete plans to seek to administer the proposed medication before the certificate requirement would arise, and the Tribunal's decision was not made on the basis that it would:

> "The Tribunal found that appropriate medical treatment (currently an injected antipsychotic) is available to the patient notwithstanding the position regarding the SOAD; it is well known that there is a heavy backlog of SOAD referrals however (and particularly as RC could access emergency powers) the lack of a SOAD opinion is not relevant to the term "appropriate"" (paragraph 12 of the Tribunal's decision with reasons).

9.7. I must consider, therefore, whether the Tribunal was entitled to take the position that the "lack of a SOAD opinion" (i.e. the certificate requirement not being met) was "not relevant to the term "appropriate"".

9.8. A Part 4A Consent Certificate (in relation to a capacitous consenting patient) relates solely to the consent of the patient and the patient's capacity to give that consent. Given that consent is not a matter which is to be weighed in the balance in determining appropriateness, whether or not such a certificate has been produced will not be relevant to the issue of the appropriateness of treatment.

9.9. A Part 4A Certificate is quite different, though, because the issue of such a certificate requires an independent clinician to apply his or her mind to the question whether the treatment proposed for the patient is clinically appropriate. As such it is evidence of the expert opinion of the certificator as to the clinical appropriateness of the treatment described. This is something that will be relevant to a tribunal's own assessment of whether the treatment is "appropriate" for the purposes of the section 72(1)(c) MHA criteria.

9.10. What about the absence of a Part 4A Certificate in circumstances where one is required to be in place for treatment to be administered lawfully? This may, but will not always, be relevant to the issue of appropriateness. It all depends on the facts of the case. If, for example, a SOAD had reviewed a patient and then declined to issue a Part 4A Certificate and given reasons for such refusal, the fact of the refusal and the reasons given for the refusal would be likely to be evidence relevant to appropriateness which a tribunal considering the section 72(1)(c) criteria would have to weigh in the balance.

9.11. In this case a SOAD review was requested on 15th July 2019 but as at the date of the Tribunal hearing no such review had yet taken place. In these circumstances the fact of the certificate requirement not having been met is not evidence relevant to appropriateness. It simply means that the expert opinion of the responsible clinician has been neither supported nor contradicted by another expert. As such the Tribunal was entitled to say that the absence of the certificate was not relevant to the issue of appropriateness in this case.

9.12. There was evidence before the Tribunal that the patient had, following several hospital admissions (in 1984, 1986, 1992, 1993 and 1994), been treated successfully in the community for a period of 20 years when she engaged with community mental health services and was concordant with prescribed antipsychotic medication and outpatient reviews. The Tribunal had before it evidence that the administration of two doses of her

prescribed depot antipsychotic (Aripiprazole at a monthly dose of 300mg) had led to “a degree of amelioration of [the Appellant’s] agitation and paranoia such that discharge could be planned” (see the responsible clinician’s report page 37 of the appeal bundle). Given this, and in all the circumstances, the Tribunal was entitled to decide that the Appellant’s prescribed antipsychotic medication amounted to “appropriate medical treatment” despite the Appellant’s passionately held view to the contrary.

10. Analysis - was the Tribunal entitled to find that appropriate medical treatment was “available”?

10.1. The MHA does not define “available” and it is not a word which has been given a substantial amount of judicial consideration either by the Upper Tribunal or the courts in the context of the MHA.

10.2. The Oxford English Dictionary offers five alternative meanings. Two of them are decidedly archaic and a third is a meaning specific to U.S politics. A fourth is the meaning in law of “valid”, and the remaining meaning is:

> “capable of being employed with advantage or turned to account; hence, capable of being made use of, at one's disposal, within one's reach.”

10.3. When read in the context of the statutory scheme as a whole it is this last meaning which is most apposite: having determined that the treatment relied upon is clinically appropriate the Tribunal must also be satisfied, as a practical matter, that the treatment proposed is one that can be provided should consent be forthcoming. Or, in Judge Jacobs’ words in *SH v Cornwall Partnership NHS Trust,* “it must be both suitable for, and at the disposal of, patients” (at paragraph [15]).

10.4. To consider an example, if the appropriate medical treatment relied upon is not one which the responsible authority has the resources to provide, and there is no plan to source the treatment from another provider, then it could not be said to be “available” because there would be no prospect of the treatment actually being given in practice, even were the responsible clinician to decide that the treatment should be given and should valid consent be obtained.

10.5. What about legal impediments? Do they fall to be considered at the first stage identified by Judge Jacobs in *SH v Cornwall Partnership NHS Trust*, where the treatment is identified and classified, or do they, like consent, come into play only at the later stage when the decision about delivery of treatment is made, and which can only be made once the first stage has been completed and what Judge Jacobs calls the “treatment lock” has been applied?

10.6. It is perhaps helpful to consider examples of possible legal impediments. If a responsible authority were to propose a treatment which, while commonly used in another jurisdiction and accepted to be clinically appropriate, was not approved by the regulator for administration in this jurisdiction, could such treatment properly be said to be “available” here? What if, for the sake of argument, the treatment proposed had regulatory approval in this jurisdiction for administration to animals (and so was physically available) but was not approved for administration to humans? In neither circumstance could the treatment be said to be “capable of being made use of, at one's disposal, within one's reach”, so a legal impediment is at least capable of being relevant at the identification and classification stage to the extent that it can

be said to take the treatment outside the options at the clinician's disposal or within the clinician's reach.

10.7. So, does that mean that it wasn't open to the Tribunal to find that the appropriate medical treatment of Miss M's depot Aripiprazole was "available"?

10.8. The Tribunal's reasons for finding that it was are very brief, and they require the reader to make considerable use of inference, but it is clear that a significant factor in the Tribunal's decision-making was the existence of provisions in the MHA which disapply the procedural safeguards in sections 57 and 58 MHA in respect of certain categories of urgent treatment ("particularly as RC could access emergency powers" (paragraph 12 of the Tribunal's decision with reasons)).

10.9. Section 62 MHA (which does not apply to Part 4A patients) provides that sections 57 and 58 shall not apply to treatment which is immediately necessary to save the patient's life (section 62(1)(a)), or which is not irreversible and is immediately necessary to prevent a serious deterioration of his condition (section 62(1)(b)), or which is neither irreversible nor hazardous and is immediately necessary to alleviate serious suffering by the patient (section 62(1)(c)), or which is neither irreversible nor hazardous and is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or others (section 62(1)(d)).

10.10. Section 64B(3) (which does apply to Part 4A patients) provides that the certificate requirement does not apply if giving the treatment to the patient is authorised in accordance with section 64G (which relates to emergency treatment for patients lacking capacity or competence) (see section 64B(3)(a) MHA) or if the treatment is immediately necessary and the patient consents to it (if capacitous) or a donee or deputy or the Court of Protection consents to the treatment on the patient's behalf (see section 64B(3)(b) MHA).

10.11. In her submissions on behalf of the Respondent in this appeal Ms Pollard argued the case for the availability of the administration of Miss M's depot on the basis that it would be available when it was needed. She relied on three different situations, but two of these assumed that the certificate conditions were met. The third was on the basis that Miss M had been recalled to hospital and one of the "immediate necessity" tests under section 62 was satisfied. She said that the Respondent did not rely on the availability of treatment under section 64G MHA. It was not argued that those tests were satisfied at the date of the Tribunal's decision.

10.12. Would the Tribunal have been entitled to find that appropriate medical treatment was available because, even though it could not be given as at the date of the Tribunal, it would be available should Miss M be recalled to hospital and should the administration of her depot become "immediately necessary"?

10.13. When discharging its responsibilities under section 72 MHA the Tribunal had to decide whether the criteria set out in section 72(1)(c) were satisfied as at the date and time of the Tribunal's decision.

10.14. However, that determination cannot be based on a snapshot. When considering the definition of medical treatment under MHA before its amendment by the Mental Health Act 2007 Sullivan J. said in *R. (on the*

application of Epsom and St Helier NHS Trust) v Mental Health Review Tribunal [2001] EWHC 101; [2001] M.H.L.R. 8 at [47]:

> "[O]ne has to look at the whole course of treatment. To do so, one has to look at the past, present and future. It is not enough to say that a patient is not receiving treatment at a particular time."

10.15. That approach must still be right under MHA as amended, and it must apply not only to the assessment of whether what is proposed amounts to "medical treatment" but also whether it is "appropriate" and "available".

10.16. While the requirement in section 72(1)(c)(iii) MHA that the tribunal be satisfied that the power of recall is necessary requires the tribunal to consider changes that might occur after the date of the tribunal's decision, paragraphs (i), (ii) and (iv) require the tribunal to focus on the circumstances that obtain when the tribunal decides whether it is under a duty to discharge the patient.

10.17. Looking at the "whole course of treatment" means that the tribunal doesn't need to be satisfied that someone is standing by ready to administer the medication relied upon as soon as the tribunal hearing comes to an end if it is to find the requirements of paragraph (iv) to be met. If, for example, a patient had just received a long-acting depot injection, and it wouldn't be clinically indicated to administer another injection (or indeed any other medical treatment) for another month, the Tribunal wouldn't be obliged to discharge the patient on the basis either that treatment was not then necessary or that it was not appropriate or available. It would be sufficient that the medication should and could be given when it became due (subject to consent). But what Ms Pollard argues for goes much further than that because the availability of the treatment relied upon is dependent on Miss M experiencing a deterioration in her condition after the date of the Tribunal Decision. If Miss M's treatment is necessary only at the point at which she has deteriorated sufficiently for the conditions in section 62 MHA to be satisfied then it cannot be said that section 72(1)(c)(ii) was satisfied. If it was necessary as at the date of the Tribunal's decision but the section 62 MHA conditions were not met then the treatment was not then available.

11. Policy arguments

11.1. In her written submissions Ms Pollard highlighted the existence of a national back log in obtaining SOAD reviews. She said:

> "If CTOs had to be struck down on the basis that there was no available and/or appropriate treatment because a SOAD certificate had not yet been obtained, then in a great many cases the CTO scheme could not be commenced because such a back log exists. There is a risk that this would render the system unworkable for a large number of patients."

11.2. This is a policy argument, not a legal argument. The MHA established a finely calibrated framework of compulsory powers and associated protections that has been decided upon by parliament following extensive debate and consultation with stakeholders. The limitations on the power to restrict the liberty of patents must be respected even if that means that treatment which is in a patient's best interests is not capable of being administered.

11.3.

12. Conclusion and disposal

12.1. I consider that the Tribunal erred in law because it was not open to it on the evidence before it to find itself satisfied that appropriate medical treatment was available, and further it failed adequately to explain its reasons for making the decision that it did. While the lawfulness of the administration of treatment is not, per se, relevant to the "appropriateness" of medical treatment it is relevant to its "availability".

12.2. However, while the Tribunal erred in law, and its errors were material, I have a discretion under section 12(2)(a) of the Tribunals, Courts and Enforcement Act 2007 whether to set aside the Tribunal's Decision.

12.3. I have decided not to exercise my discretion in favour of setting aside the Tribunal's Decision because to do so would serve no purpose given that Miss M is no longer subject to the CTO to which these proceedings relate, and has not been subject to it for some time.

Signed

Thomas Church
Judge of the Upper Tribunal

Dated **05 March 2020**