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'Appropriate' Medical Treatment: What's in a word?

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Introduction

The reforms of mental health law initiated by the Richardson Committee Report in 1999 ended not with a bang, but with a whimper. There was no new mental health act. Instead, yet another set of revisions to existing legislation was passed in 2007, focusing largely on community treatment orders and deprivation of liberty of persons lacking capacity. Little was done to alter the process or substantial standards for civil confinement under the Mental Health Act 1983.

One change that was made was to introduce a requirement that 'appropriate treatment' be 'available' for compulsion to be imposed in a variety of contexts, most notably admission for treatment under section 3. This was greeted with considerable resistance by many stakeholders including medical professionals (see for example, Gostin et al., *Principles of Mental Health Law and Policy* (OUP, 2010) para 2.97-2.104), as it was perceived as reducing the safeguard provided under the 'treatability' requirement of the former section 3(2)(b) of the 1983 Act. This resistance was, perhaps, surprising. The former treatability requirement had affected only those with 'psychopathy' or non severe learning disability [or 'mental impairment', to use the outdated term of the statute]. These accounted for 244 of the 24,832 people detained in 2003-4 (DOH 2004, 16) – a little less than one per cent of detentions. For the other 99 per cent, there were in law no treatment requirements at all prior to mandatory admission. Even for those patients for whom the treatability test did apply, it had been interpreted extraordinarily broadly by the courts. Thus in *R (Home Secretary) v. MHRT* [2004] EWHC 1029 (Admin), it was held that the treatability requirement was satisfied when a patient was not benefitting from the treatment programmes offered in a the hospital, but was able to cope better in the structured environment of the ward than he would have in the general community. It is difficult to see, therefore, that the old requirement created much of a safeguard.

Nonetheless, the meaning and scope of this requirement has caused some concern in professional circles. This article will analyse the requirement.

The Statutory Language and the Code of Practice

The appropriate treatment requirement applies when it is proposed that an individual be admitted for treatment (section 3) or such admission is renewed (section 20); when an individual is to be placed on a community treatment order (section 17A) or where that order is renewed (section 20A); when a person is remanded from Crown Court to hospital (section 36), or where hospital admission is ordered following conviction for an offence in the Crown Court (sections 37, 45A); or where an individual is removed from prison to hospital (sections 47, 48, 51). The statutory definition for all these contexts is provided by section 3(4):

(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.

This definition appears largely circular, and therefore of little assistance: treatment is appropriate when it is appropriate. It does appear to suggest that the focus is on the patient: treatment will be appropriate only if it is appropriate given the actual situation of the patient, taking into account both medical and non-medical factors. This is consistent with the Code of Practice, which suggests that cultural, ethnic and religious considerations must be taken into account in determining appropriateness of treatment (DOH, 2008, para 6.8, 6.10, 6.11). The Code continues:

By definition, it [appropriate treatment] must be treatment which is for the purpose of alleviating or preventing a worsening of the patient's mental disorder or its symptoms or manifestations. (DOH, 2008, para 6.8)

This is virtually identical to the old treatability test, expanding it only with an express acknowledgement that the test applies to the symptoms or manifestations of the disorder, as well as to the disorder itself. This merely reflects the jurisprudence on the pre-2007 test, however: see *Reid v Secretary of State for Scotland* [1999] 1 All ER 481 at 497, 515. The Code's elaboration of the test further reflects the jurisprudence relating to the old treatability test: the mere detention of an individual does not of itself constitute medical treatment (DOH, 2008, para 6.17); the treatment must address the mental disorder for which the individual was detained (DOH, 2008, para 6.9; *B v Croydon HA* [1995] 1 All ER 683 at 687); while one would normally hope for improvements in a patient's condition, in some cases, stabilisation may be all that is possible (DOH, 2008, para 6.15; *South West London and St George's Mental Health Trust v W* [2002] EWHC 1770 (Admin) para 65); a patient's refusal of otherwise appropriate treatment does not necessarily render appropriate treatment unavailable, even when it means that the treatment cannot effectively be given (as for example with psychotherapy) (DOH, 2008, para 6.18-19; *Reid v Secretary of State for Scotland* (above)).

Insofar as the Code is a reliable guide – and on this it surely is – at least on these points, the effect of the appropriate treatment test is to extend the old standard to all patients detained under the sections noted above, rather than to the minority of them covered under the pre-2007 legislation. Critics may complain that the result is not much of a safeguard. Jones for example states in the 12th edition of his *Mental Health Act Manual*:

The 10th edition of this work stated ... that the interpretation in case law of the treatability test was so broad that "it is difficult to imagine the circumstances that would cause a patient to fail it". A similar comment can be made of the appropriate treatment test, without the need for judicial intervention, given that it will almost always be appropriate to provide the patient with either nursing or care.... (Jones, 2009, para 1-056)

This is no doubt true, and it must be acknowledged that the appropriate treatment test at least at this point in the analysis provides no meaningful safeguard, or ground of challenge to detention. On this basis, it really does seem fair to wonder what the fuss was about regarding the introduction of the appropriate treatment test. Two points may, perhaps, modify this assessment somewhat.

The first is that appropriateness remains a matter of clinical judgment. The courts have held that they have no jurisdiction to require medical professionals to provide care that the professional does not believe to be in the best interests of the patient or clinically warranted his or her care: see *Re J* [1992] 4 All ER 614, and, in a psychiatric context, *R v. Ealing District Health Authority, ex p. Fox* [1993] 3 All ER 170 at 183. Clinicians who do not think that, in all the circumstances of a case, appropriate medical treatment exists are entitled in law to stand by that position.

The second point is that appropriate treatment must be 'available' for the patient at the time of admission. While this is not contained in the statutory definition quoted above, it is contained in all the individual sections where appropriate treatment is a requirement of admission.

The Code of Practice adds little to the statutory language here. It notes that the requirement of availability refers to 'appropriate' treatment, not necessarily optimal or ideal treatment, but that such appropriate treatment must actually be available when the patient is admitted: the fact that a treatment could theoretically be provided is insufficient (DOH, 2008, para 6.12-13). Quite how immediate the availability needs to be remains to be seen. Certainly, it seems unlikely that treatment would be 'available' if a patient were merely placed on a waiting list to receive it. Equally, however, some treatments have administrative requirements that must occur prior to the treatment commencing. A certain amount of organisation time is presumably permitted. Quite how long this will be remains to be seen, and will no doubt be litigated.

Litigation to Date

To date, there are three reported cases concerning the provision. While it is thus too early to provide a definitive indication of how the courts will interpret the new provision, the early signs indicate a broad approach to the substantive requirements, with some indications that some more specific procedural requirements may be required.

The first case is *R (SP) v Secretary of State for Justice* [2010] EWHC 1124 (Admin). This case concerned a person with personality disorder nearing the end of his prison sentence. There were concerns that he would go on to commit further serious offences if released. The issue was therefore whether there would be a transfer into a psychiatric hospital under section 47 of the Mental Health Act 1983, thus indefinitely postponing the individual's release date. Such a transfer requires the supporting opinions of two approved clinicians, and in this case one of the two had provided his opinion on an old form that referred to the old treatability criteria. No specific mention was made on this form of the treatment that would be provided, nor whether it was available, and SP's lawyer argued that the evidence base for the transfer had thus not been made out, and the Secretary of State could not legally authorise the transfer.

The court disagreed. It held that 'appropriate medical treatment' was a broader question than the previous 'treatability' test, and that, by implication, for anyone who was 'treatable' under the old criteria, there was 'appropriate treatment' under the new. As to the availability of that treatment, while the doctor's report was silent on the point, the Secretary of State was permitted to take into account the fact that a hospital (Rampton in this case) had offered a place for assessment and treatment and confirmed the availability of a bed, and this was held to be sufficient evidence that treatment was available. The transfer direction was therefore lawful.

This is a remarkably generous reading of the law. The Code of Practice requires the certifying physician to turn his or her mind to 'an appropriate package of medical care' (para 6.9). It is not clear why he or she should not be required to articulate in the detention opinion, in at least general terms, what that package of care should be. The availability of 'appropriate treatment' is a requirement of detention, after all, and that means that at least in theory, the person subject to detention ought to be able to challenge the doctor's opinion and make the case that the proposed treatment is not appropriate. Unless the doctor is required to give some indication of what the appropriate treatment is to be, it is difficult to see that the appropriate treatment test means much of a safeguard. Further, section 47 makes it clear that it is for the certifying physician, (and by implication, not the Secretary of State), to attest that the appropriate treatment is available. The offer of a place for 'assessment and treatment' does not necessarily meet this threshold. Insofar as

Rampton's view was that further assessment was required, it may be that it would eventually take the view that appropriate treatment was not available. Certainly, there is nothing in Rampton's offer to suggest that it was in a position promptly to provide the package of care considered by the certifying physician to be necessary. This decision therefore goes a long way to undermining the apparent protections contained in the appropriate treatment criteria.

Although it is from the upper tier tribunal rather than the High Court, *DL-H v Devon Partnership NHS Trust and Secretary of State for Justice* [2010] UKUT 102 (AAC) is considerably more convincing on the substance of the appropriateness of treatment. In this case, the patient was detained under sections 37 and 41 of the Mental Health Act 1983, and was resisting the talking therapies offered to him. He had unsuccessfully challenged that detention before the review tribunal. The appeal to the upper tier tribunal was based in part on the alleged inadequacy of reasons provided by the first-tier tribunal, and on the evidence base of the success of treatments for antisocial personality disorder. The upper tier tribunal provides the following guidance to the first-tier:

[33.] ... The tribunal must investigate behind assertions, generalisations and standard phrases. By focusing on specific questions, it will ensure that it makes an individualised assessment for the particular patient.

- What precisely is the treatment that can be provided?
- What discernible benefit may it have on this patient?
- Is that benefit related to the patient's mental disorder or to some unrelated problem?
- Is the patient truly resistant to engagement?

The expectation from the upper tier tribunal is that the first-tier tribunal will engage with arguments presented to it on these points:

34. In this case, the tribunal merely recorded: 'We accept the opinion of Dr Parker that continued treatment in hospital provides alleviation or prevention of a deterioration in his [DL-H's] condition. Appropriate medical treatment is available on C Ward with the hope that he will begin to engage in treatment.' This is too general to deal with the issue and it ignores evidence to the contrary. It begged the question of whether the patient could be persuaded to engage. It is correct that Dr Parker set out in two reports details of the treatment that was available for the patient. Their effectiveness would depend on the patient's co-operation. On this, the patient's staff nurse gave evidence that the patient was hostile to the nurses and that there was no nursing input unless he asked for it. The nurse doubted whether the patient was getting any benefit from being on his ward. The tribunal did not refer to that evidence.

The tribunal makes no findings as to the evidence for the efficacy of treatments for antisocial personality disorder (although its view, supported by NICE guidance, that care should proceed as a partnership is perhaps evident in the above approach). It does appear to require a considerably more detailed assessment of the evidence than is apparent in the SP case, apparently expecting, consistent with the statute, that the availability of appropriate treatment will be a significant criterion in compulsory admission, and that as such it should be supported by suitable evidence. This is a much more convincing approach than SP.

The third case is *MD v Nottinghamshire Healthcare NHS Trust* [2010] UKUT 59 (AAC), another decision of the upper tier tribunal actually decided before *DL-H*. In this case, the first-tier tribunal

found that the patient's psychological defence mechanisms prevented him from engaging with therapy. Therapy was not, therefore, appropriate in his circumstances, at least in the short- to mid-term. The patient had, however, the potential to benefit from 'the milieu of the ward both for its short term effects and for the possibility that it would break through the defence mechanisms and allow him later to engage in therapy.' [para 39]

At its core, therefore, the case turns on distinguishing between treatment and mere confinement. This is a distinction also identified by the Code of Practice, which allows that treatment consisting 'only of nursing and specialist day-to-day care under the clinical supervision of an approved clinician, in a safe and secure therapeutic environment with a structured regime' may constitute appropriate medical treatment [para 6.16], but 'simply detaining someone – even in a hospital', does not [para 6.17].

The tribunal in this case holds that there is no requirement that appropriate treatment reduce the risk posed by an individual [para 34]. It is sufficient if the treatment prevents a deterioration of the symptoms or manifestations of the disorder. It further acknowledges that if there is no prospect that the patient will move beyond the 'milieu therapy' provided on the ward, there may come a point where continuation may be inappropriate. That was held not to be the case here, where the first-tier tribunal had identified short and long-term advantages of the therapy, although it did not rule out the possibility that this might arise, if the optimism of the medical staff and the first-tier tribunal proved unfounded.

While these findings have their merits, they do not really address the core of the problem: how does one distinguish 'milieu therapy' from mere detention? What is the therapeutic intervention that differentiates the two? How does it differ from treatment in any other structured environment (such as a prison environment)? If it is different from mere psychiatric detention, in deciding availability, how is it determined which wards offer 'milieu therapy' and which do not? What particular expertise or benefit is actually being provided by the approved clinician, particularly in cases such as that of MD, who was unable to engage with therapy? And how would the lower tier tribunal actually answer the four questions framed by *DL-H*, above? In *MD*, it does not seem that the same level of detailed assessment is required as in the later case of *DL-H*. If the availability of appropriate medical treatment is to be a real criterion of compulsory detention, the distinction between mere detention and appropriate treatment is too important to be left to lie. It is difficult to see that *MD* will be the last word on the subject.

Inevitably, appropriateness of medical treatment will depend on the individual circumstances of the patient in question. The approach in *DL-H* suggests a refreshing move from the abstract to the concrete, with the expectation that practitioners will consider the matter in the context of a series of specific and bite-sized questions. While the specific questions will vary according to the patient, the following, based on the cases and the Code of Practice, may provide a helpful starting point:

- What precisely is the treatment that can be provided and what is its purpose?
- Is the treatment actually available?
- What discernable benefit will it have for the patient? (This does not mean a cure is certain; it does mean that there is a reasonable likelihood that treatment will result in significantly better outcomes than non-treatment.)
- Are there adverse effects of the treatment that outweigh the benefits?
- Are the benefits related to the patient's mental disorder (either its symptoms or manifestations), or to some unrelated problem?

Is the patient resistant to engagement, so that meaningful treatment really is unlikely to be practicable in the reasonably near future?

References

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Declaration of Interest

None.