

# Casenotes

## *The House of Lords and the Unimportance of Classification: A Retrograde Step*

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R (B) v Ashworth Hospital Authority

House of Lords; 17 March 2005

[2005] UKHL 20, [2005] Mental Health Law Reports 47

### **Introduction**

The issue for the House of Lords in this case was whether a patient could be treated on a ward specialising in a form of mental disorder other than the one from which he was classified for the purposes of detention. It held that the law permitted this, and in so doing disagreed with the Court of Appeal. The tensions between the two rulings reflect a fundamental difference of approach to the question of how the Mental Health Act 1983 should be interpreted.

### **The Facts**

The facts are fairly simple. B was convicted of manslaughter in 1987; he had been acutely mentally ill at the time of the offence, showing symptoms of a florid psychotic illness. A hospital order was made together with a restriction order of indefinite duration (ss37 and 41 of the 1983 Act). The required two medical reports showed agreement that B suffered from mental illness (schizophrenia). He was placed in medium secure conditions, but transferred to high secure conditions at Ashworth Hospital in April 1988 after an incident of absconding. By this time, he was still classified as suffering from mental illness (now felt to be a paranoid psychosis), but views were expressed that there were features of personality disorder in a setting of limited intellectual ability. He was returned to medium secure facilities in October 1992 but readmitted to Ashworth in January 1994: he was now felt to be demonstrating features of “hypomanic” illness, also a mental illness, and given anti-psychotic medication. He became more stable.

During 2000, personality tests revealed a “very high” score for psychopathic disorder, a different category of mental disorder. In December 2000, he was transferred to a ward designed to address the traits of personality disorder: B felt that some aspects of the regime on this ward were less

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agreeable<sup>2</sup>, and he also felt that the further therapeutic work which might be expected of him on that ward placed new obstacles in the way of his transfer to a less secure hospital, which had been recommended by his previous Mental Health Review Tribunal.

In May 2001, a Tribunal concluded that he was still suffering from a mental illness (felt to be a “schizo-affective disorder”), but did not exercise its power<sup>3</sup> to reclassify him as detained also on the basis of psychopathic disorder. Evidence in front of the Tribunal had included a report from an independent psychiatrist who felt that B did not suffer from a personality disorder.

In August 2001, B’s solicitors wrote to the hospital to argue that B should not be on a ward for patients with psychopathic disorder. The hospital’s response was that B’s mental illness had been successfully controlled by ongoing medication and so the current ward within the Personality Disorder Unit was appropriate to address the remaining problems of his personality type. A new Responsible Medical Officer expressed his agreement with the view that B suffered from a mental illness and a personality disorder.

B then challenged the decision to place him on a ward within the Personality Disorder Unit and to subject him to the treatment regime within that ward: in judicial review proceedings, he sought an order quashing the decision and a declaration that his detention on a ward for those suffering from a personality disorder was unlawful. Permission was granted but the application was dismissed in a short judgment by Sir Richard Tucker: [2002] Mental Health Law Reports 336; on appeal, B was successful: [2003] Mental Health Law Reports 250; but the House of Lords then reinstated the order of the judge: [2005] Mental Health Law Reports 47.

### **The Legal Background**

To understand the arguments put forward, the following features of the Mental Health Act 1983 should be noted. Section 1 of the 1983 Act defines “mental disorder” as being one of four different categories “and any other disorder or disability of mind”. The four categories are mental illness, mental impairment, severe mental impairment and psychopathic disorder; “mental illness” is not defined further, but the other three categories are. Detention under the Act for treatment has to be on the basis of one of the four categories of mental disorder (and so the phrase “any other disorder or disability of mind” in s1 of the Act is irrelevant): see s3(2)(a) and s37(2)(a). Short-term detention for assessment under s2 requires only “mental disorder”, but it is the only provision of the Act allowing detention in hospital without a formal classification.<sup>4</sup> The medical recommendations must agree on the form of disorder, though they do not need to agree on the precise diagnosis. It is possible to have a dual categorisation, and in this case the medical recommendations must agree on one of the categorisations.

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2 In a witness statement, it was said that B believed there were more searches on the Personality Disorder Unit, meetings with his RMO were every 3 or 4 months rather than weekly, and matters such as access to the TV were much more controlled.

3 Under s72(5) of the Mental Health Act 1983; in relation to those detained under ss37 and 41, only a Tribunal may reclassify a patient, whereas others may be reclassified by the Responsible Medical Officer under s16 of the Act.

4 A guardianship application requires one of the four classifications (s7(2)(b)); a s35 remand for a report requires one of the four classifications (s35(3)(a)); a s36 remand for treatment requires either mental illness or severe mental impairment (s36(1)); an interim hospital order requires one of the four classifications (s38(1)(a)); the transfer of a prisoner under s47 is predicated on him or her suffering from one of the four classifications (s47(1)(a)) and the transfer of a remand prisoner, civil prisoner or immigration Act detainee requires mental illness or severe mental impairment (s48(1)).

As it features in the reasoning of the House of Lords, it is also worth noting that there is an additional route into hospital detention, namely via the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, following a finding of unfitness to plead under the Criminal Procedure (Insanity) Act 1964 coupled with a finding that the accused committed the actus reus of the matter charged; or a finding of not guilty by reason of insanity. An “admission order” may be made under s5 of the 1964 Act, which allows detention in a psychiatric hospital: under para 2 of Schedule 1 to the 1991 Act, a person so admitted shall be treated “as if admitted in pursuance of a hospital order” under the 1983 Act, and a s41 restriction order may be made<sup>5</sup>. There is no reference to mental disorder (or any of the four categories under the 1983 Act): instead, there are separate tests. Unfitness to plead requires a finding by a jury<sup>6</sup> that the accused is “under a disability”: this is a common law test<sup>7</sup> which includes those who are mute as well as those who are not sane. The special verdict of not guilty by reason of insanity requires insanity<sup>8</sup>, which also rests on the common law test set out in M’Naghten’s Case<sup>9</sup>.

Treatment is a matter separate to detention, governed by different provisions within the Mental Health Act 1983. Section 63 provides: “The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering, not being treatment falling within ss57 or 58 above, if the treatment is given by or under the direction of the responsible medical officer.” (There is also s62, which allows urgent treatment.)

Section 58 provides that certain “forms of medical treatment for mental disorder” (which includes any medication after 3 months from the first administration of medication “for his mental disorder”<sup>10</sup>) shall only be given with capacitated consent of the patient or upon the certification of the Second Opinion Appointed Doctor (in practice from the Mental Health Act Commission) that the patient either has no capacity or does not consent but that the treatment should be given “having regard to the likelihood of its alleviating or preventing a deterioration of his condition”. Section 57 requires both consent and a supporting second opinion and relates to psychosurgery and any other specified form of treatment<sup>11</sup>.

B’s argument was that treatment without consent within s63 for “the mental disorder from which he is suffering” was limited to treatment for the mental disorder under which he was classified for the purposes of detention. The hospital argued that the Act permitted treatment for mental disorder as diagnosed by the treating clinicians and should not be confined to the disorder or that part of the disorder classified by the Tribunal as the basis for detention.

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5 Note that the statutory provisions have now been amended by the Domestic Violence, Crime and Victims Act 2004: s24 of this Act amends s.5 of the 1964 Act to provide that the court may make a hospital order with or without a restriction order when there has been a special verdict or a finding that the accused is unfit to stand trial but committed the actus reus. The article refers to the provisions in force at the time of the judgement of the House of Lords

6 Under s22 of the Domestic Violence, Crime and Victims Act 2004, this is now determined by a judge without a jury

7 *R v Pritchard* (1836) C & P 303.

8 and also a finding that the accused committed the actus reus (s2 of the Trial of Lunatics Act 1883), otherwise a simple not guilty verdict is proper.

9 (1843) 10 Cl and F 200.

10 and also electro-convulsive therapy: see Reg 16 of the Mental Health Regulations 1983.

11 Extended to the surgical implanting of hormones to reduce the male sex-drive: see Reg 16 of the 1983 Regulations.

### **The Administrative Court decision**

Sir Richard Tucker preferred the hospital's construction. He noted that the treatment regime in place was designed to assist his transfer back to medium secure conditions and so would be to his advantage (and that of the community). It is to be noted that in the judgment, the judge first reached the conclusion that the treatment regime was to the benefit of B before he considered the question of whether it was lawful. In relation to that question, the judge concluded:

“12. ... If Parliament had intended the mental disorder to be that classified by the Tribunal it would have said so. It is clearly a matter for the professional judgment and expertise of the clinicians in charge of B's case to decide upon the best therapeutic regime for the disorder from which they assess him to be suffering. To conclude otherwise would be to put an artificial and strange interpretation upon the words of the section.”

He also dismissed any suggestion that part of the European Convention was engaged.

### **The Court of Appeal decision<sup>12</sup>**

The Court of Appeal, however, took a very different view. Their conclusion was that as the context of the treatment provisions was the detention provisions, there was no need for any express limitation in the treatment provisions to the form or forms of mental disorder under which the patient was detained because that was dealt with in the detention provisions. The key to understanding the intention of Parliament as expressed in s63 of the Act was the fact that compulsory medical treatment was a serious intrusion of personal autonomy: as such Parliament could not have intended to permit compulsory treatment in the absence of clear and unambiguous language.

The Court noted two caveats which meant that their interpretation retained the necessary flexibility: first, the common law doctrine of necessity was not excluded and so emergency treatment for a non-classified disorder was possible without consent; and it would be possible to treat for a non-classified form of disorder if this was a necessary precursor to treatment for the form of disorder which justified detention.

Lord Justice Dyson, who has given a number of important judgments on mental health law<sup>13</sup>, gave the leading judgment. He noted:

“16. Section 63 must be construed in its statutory context. The Act provides a detailed and carefully worked out scheme for the admission of mentally disordered patients to hospital for treatment, the review of their condition from time to time, and their discharge when they are no longer liable to be detained. As I shall seek to show, a theme that runs through the Act is that the liability to detention is linked to the mental disorder from which the patient is classified as suffering, and that this disorder is considered to be treatable by the person or body making the classification. ...”

He then reviewed section 3 of the Act and the need for a classification of the disorder in order to detain, and noted that section 16 of the Act<sup>14</sup> provides a power for the Responsible Medical

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12 See ‘The Significance of Mental Disorder Classification’ Anna Harding, *JMHL* July 2003 pp 106–114

13 For example, *R (Wirral Health Authority) v MHRT* [2002] *Mental Health Law Reports* 34, *R (Ashworth Hospital Authority) v MHRT* [2002] *Mental Health*

*Law Reports* 314, *R (N) v Dr M* [2003] *Mental Health Law Reports* 157; he was also in the Court which gave a joint opinion in *R (IH) v Secretary of State* [2002] *Mental Health Law Reports* 87.

14 Which also applies to a s37 patient: see Schedule 1, Part 1, paras 2 and 3.

Officer to reclassify the patient as suffering from a different form of disorder, which has the result that the application for admission then takes effect as if the new form or forms of disorder were specified: “21. ... The reason for doing it this way is that the crucial link is maintained between the mental disorder which justifies the patient’s detention and his treatment in hospital *for that disorder.*”

In addition, he noted that when a s3 detention is renewed under s20, s20(9) allows reclassification:

“23. ... So, once again, the important link is maintained between the mental disorder which justifies the patient’s detention and his treatment *for that disorder.*”

In relation to those detained under the criminal provisions of the Act, Dyson LJ noted that there is a mirror scheme in that the court order specifies the form of disorder: so “26. ... the essential link between a patient’s mental disorder which justifies his detention in hospital and his treatment *for that disorder* is common to both.” However, in relation to restricted patients, the RMO’s power to reclassify under s16 or s20 do not apply, but a Tribunal may reclassify under s72(5).

Having set the statutory context, Dyson LJ dealt with the submissions which had persuaded Sir Richard Tucker to rule against B. First, there was no reference to a patient’s classification anywhere in Part IV, the provisions relating to treatment, which one would expect Parliament to have made express if it were important. This was the key argument and the response of Dyson LJ was in these terms:

“41. ... There is nothing which clearly indicates that Parliament intended Part IV to apply to *any* mental disorder from which the patient is suffering while liable to be detained in hospital, whether classified or not. Compulsory medical treatment is a serious intrusion of a person’s autonomy. I would not impute to Parliament an intention to permit compulsory treatment unless this was expressed in clear and unambiguous language. It is important to underline the full reach of Mr Thorold’s submission: it is that s63 authorises any forcible medical treatment for a non-classified mental disorder, even if it does not meet the emergency criteria stated in s62(1). In my judgment, s63 comes nowhere near to evincing a clear intention by Parliament to permit such treatment for non-classified mental disorder.

42. It is true that, if Part IV is considered in isolation from the rest of the Act, it might appear to apply to any mental disorder from which the patient is diagnosed as suffering, whether classified or not. But Part IV must be interpreted in its context. The Act contains detailed provisions for the admission to and detention in hospital of patients who suffer from classified mental disorders. It also contains provisions which are designed to ensure that they remain liable to be detained only so long as they continue to suffer from classified mental disorders. I have earlier set out the relevant provisions. Part IV apart, Mr Thorold was unable to draw our attention to any provision in the Act which deals with non-classified mental disorders. Part IV apart, the Act is no more concerned with non-classified mental disorders than it is with physical disorders. The Act is concerned with mental disorders which are treatable and which justify detention for their treatment. In these circumstances, I do not find it at all surprising that Part IV does not define the mental disorder for which medical treatment may be given without the patient’s consent as the classified mental disorder. That is assumed. Part IV is not dealing with the definition of the mental disorder: that is determined elsewhere in the Act. Part IV is dealing with the very important ancillary question of defining the circumstances in which forcible treatment for the mental disorder may be given.

43. It seems to me, therefore, that the natural interpretation of s63, when construed in its context, is that treatment (other than treatment falling within s57 and 58) may be given without the patient's consent, but only for classified mental disorders. ..."

Subsidiary arguments were then put forward and it was concluded that they did not cast any doubt on this central conclusion as to the statutory meaning.

The second argument was that, in contrast to the power of administrative reclassification allowed under s16, restricted patients can only be reclassified by a Tribunal: whilst the Home Secretary can refer a case to the Tribunal at any time (under s71), this will take time, is cumbersome and so is not apt to deal with any urgent situation. This argument was predicated on the view that treatment was only possible under the Act, whereas Dyson LJ's view, which meant that this argument was not sound, was that the statutory scheme allowed treatment under the common law for the non-classified form of disorder. In short, whilst s63 governs treatment for the classified disorder, it does not deal with the non-classified disorder and so the common law doctrine of necessity has not been excluded.

The third argument was that limiting s63 would cause practical difficulties in cases of comorbidity, because it would be unfortunate to deny the patient treatment for a form of disorder which did not justify detention and it would cause major problems if this disorder aggravated that form of disorder which did justify treatment. This was also felt to be an imagined rather than real problem because, in the first place, if the disorder did not justify detention then treatment without consent could not be justified; and in the second place, if treatment was necessary in order to deal with the form of disorder which did justify detention, then it was justified as ancillary treatment for the latter form of disorder (which is authorised: see *B v Croydon Health Authority* [1995] Fam 133).

Having dealt with the hospital's arguments, Dyson LJ then considered the purpose of classification. There was, he felt, an important point in that if treatment could be given for any disorder, then there was no purpose to reclassification. The better view, he felt, was that the purpose is to identify the mental disorder for which compulsory treatment is needed: "67. ... Were it otherwise, the carefully drafted provisions for reclassification in s16, 20 and 72(5) would serve no real purpose. Those provisions are designed to ensure that the essential link is maintained between the mental disorder which justifies the patient's detention and his treatment for that disorder, and no other."

Scott Baker LJ gave a brief concurring judgment, as did Simon Brown LJ, who noted:

"74. ... If the patient can only lawfully be detained for a classified treatable mental disorder, there ought properly to be a correlation between the disorder(s) classified and the treatable disorder(s) from which the patient is suffering."

Simon Brown LJ then referred to his own judgment in *R (Wilkinson) v Broadmoor Hospital Authority* [2001] Mental Health Law Reports 224, [2002] 1 WLR 419, at para 9, to the effect that detention was not itself sufficient to justify treatment, which was a separate matter. Since s58 of the Act authorises treatment without consent, the hospital's submissions would mean that "77. ... patients classified as suffering only from mental disorder A could be compulsorily subjected to the sorts of severe treatment provided for by s58 with regard to mental disorder B. That is not a conclusion that I would reach except upon the clearest language and s63 does not provide it." For Simon Brown LJ, the key was that

“78. ... a person suffering from a treatable mental disorder, but not one of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital, cannot be detained and treated under the Act. If the patient cannot be forcibly treated in either of those circumstances, why should he be amenable to such treatment for a non-specified mental disorder merely because he is already lawfully detained for the treatment of some other mental disorder?”

### **The House of Lords decision... and Comment**

The House of Lords took a different view: the only reasoned judgment was given by Baroness Hale, with whom the other Lords agreed. Before describing the reasoning of her Ladyship, it is worth noting that the Court of Appeal's judgment had been distinguished in two situations. First, in *R (AL) v Home Secretary* [2005] MHLR 12, a patient was recalled on the basis of a form of disorder other than the one under which he was classified when released: the Court of Appeal held that this was acceptable. In the first place, the power of recall was not expressed to be limited; further, a restricted patient might have been reclassified several times, and while in the community might suffer a recurrence not of the form most recently diagnosed but of an earlier classified form of mental disorder, so it would be contrary to the purpose of recall to place an unnecessary restriction on the power of recall.

There is another important point to this case. The patient had been detained following a finding of not guilty by reason of insanity of a homicide. He had been discharged by a Tribunal which felt that his ongoing personality problems did not amount to psychopathic disorder. He was recalled, concern being expressed that he had a mental illness: however, by the time of his Tribunal hearing<sup>15</sup>, the RMO was of the view that AL could not be detained on the basis of mental illness but could be detained on the basis of psychopathic disorder. The argument for him had been that once it became clear that the basis for his recall was a different form of disorder which no longer justified detention, he should have been released. The Court of Appeal noted that a patient detained as a result of the 1964 Act was admitted and detained without any reference to any form of disorder.

With respect to the Court of Appeal, this part of its reasoning is simply not so in relation to ongoing detention. It is true that there is no classification on admission: but such a patient may make an immediate application to a Tribunal<sup>16</sup>, which will apply the criteria of s72 of the Act, which requires release unless the Tribunal is satisfied that there is one of the four classifications of disorder present so as to justify detention. Accordingly, the ongoing detention of the patient is dependent on a finding that at least one of the forms of disorder (rather than “any other disorder”) is applicable. This criticism does not undermine the other part of the court's reasoning.

The second case which had distinguished the Court of Appeal's ruling in *B* was *R (SC) v MHRT* [2005] Mental Health Law Reports 31, in which Munby J held that there was no required link between the mental disorder from which the patient was classified as suffering and the grounds for believing that it was “appropriate for the patient to remain liable to be recalled to hospital for further treatment” (ie the test for any discharge being conditional as opposed to absolute under

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15 Which has to be arranged speedily after a recall: see s75 of the 1983 Act together with r29(cc) of the Mental Health Tribunal Rules 1983.

16 See s69(2) of the 1983 Act: the restriction applied to a s37 patient that they cannot apply until 6 months has passed does not apply.

s73) and no reason to import such a link when a Tribunal was considering a decision under s75 as to whether to make a discharge absolute rather than conditional. As with the AL case, the valid reasoning for this is that in a case of comorbidity, it is possible that the need for ongoing supervision will be the form of disorder which had not justified detention prior to the conditional discharge.

Returning then to the reasoning of the House of Lords in *B*, the view taken by Baroness Hale was that the absence of any reference to the classified form of disorder in the statutory language relating to treatment meant that Parliament did not feel that it was important. She noted that, although patients are vulnerable, they are protected by the law of negligence and the provisions of the Human Rights Act 1998 or judicial review if treatment is in breach of a Convention right. The question in front of the House was defined as whether “21. ... the only treatment which they may be given without their consent under s63 is treatment for the particular form or forms of mental disorder from which they are recorded as suffering in the application, order or direction under which they are detained.”

Baroness Hale felt that there were a “great many reasons” for concluding that s63 was not so limited. Her starting point was the language used in s63, which makes reference to the wide definition of mental disorder rather than any of the categorised mental disorders. Accordingly, “the natural and ordinary meaning of the words is that the patient may be treated without consent for any mental disorder from which he is suffering” (para 22). This, however, should be merely a starting point for the discussion because, as the Court of Appeal noted, the question is the meaning of the language in its context. Their conclusion was that as a patient was only detained on the basis of one or more of the categories of mental disorder, this meant that the question of the relevance of the category of disorder was dealt with at that stage and so did not need to be dealt with separately at the stage of treatment without consent.

Her Ladyship’s second point was that the Act made plain with express language when one of the specific forms of disorder was important (using as examples the provisions relating to reclassification and the medical recommendations for a s3 or s37 order), and so the absence of such language was important. This again is a point which is valid but hardly conclusive: if it is self-evident that Parliament could not have intended to allow compulsory treatment for something which does not justify detention (which was the very point in issue), then there would be no reason for express language to state the obvious. Even if the language of the statute does not make Parliamentary intention obvious, the same point applies if the true intention of Parliament was that compulsory treatment could only follow for the classification of disorder justifying detention for treatment.

The third point noted by Baroness Hale was that s63 applies to all patients covered by Part IV of the 1983 Act and some of them are not detained on the basis of a category of disorder: rather, they merely have to be shown to be disordered. The groups covered by this are those admitted for assessment under s2 and those detained by virtue of the Criminal Procedure (Insanity) Act 1964<sup>17</sup>; there is also a group of military detainees under s46 of the 1983 Act. In all these cases, so the argument accepted goes, s63 must refer to any mental disorder from which the patient is suffering. Baroness Hale noted, at para 24 of her the judgment: “It would be surprising if the same words had a different meaning when the patient is detained under these provisions from the meaning it has when he is detained under the others.”

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<sup>17</sup> See footnote 5 above



This can be looked at from two angles. First, assuming that s63 does allow treatment for any form of disorder for these groups of patients, it does not mean that it should apply to all other groups of patients. If it is right to conclude, as did the Court of Appeal, that those detained under treatment provisions should only be subject to forced treatment for the category of disorder which justifies their detention, it is hardly a compelling argument to suggest that because this cannot apply to all detainees, it should apply to none.

Secondly, this part of her Ladyship's argument carries little weight in reality. In relation to s2 patients, the lack of any categorisation is obviously required because the whole purpose of the section is to allow the clinical team to assess the condition of the patient and determine whether there is any need for a s3 detention to be put in place: accordingly, once it has been determined what category of disorder is suffered and that the patient needs detention under s3 of the Act, the reasoning of the Court of Appeal will apply. In short, there is a good reason why s2 patients are treated differently and it makes no difference to the validity of the reasoning of the Court of Appeal in relation to other patients.

Further, in relation to the other groups mentioned (ie those detained under the unfitness to stand trial or insanity provisions, and the military group), they are treated as if detained under s37 of the 1983 Act: accordingly, as soon as their case has been considered by a Tribunal, they will only be detained on account of one of the four specific categories of mental disorder because s72(b)(i) – which applies to both non-restricted and restricted patients – provides that a Tribunal must discharge unless the patient is suffering from one of the four categories of disorder. In other words, a patient who is suffering from “any other disorder or disability of mind” within s1 of the Act cannot be detained beyond their first Tribunal hearing. It is only if they suffer from one (or more) of the four categories of disorder that their detention can continue. In relation to the most significant number in this category, ie those detained following decisions under the Criminal Procedure (Insanity) Act 1964<sup>18</sup>, there is an immediate right of application to a Tribunal following their admission: see s69(2). So Parliament has provided a mechanism whereby their detention continues on the basis of a categorisation imposed by a Tribunal.

A point could be made against this latter argument that it still does not ensure that there is a specified category of disorder, because s72(1)(b) simply lists all the forms of disorder. But all these patients are treated as if detained under s37 of the Act (which imports a categorisation) and s72(5), the power of the Tribunal to reclassify a patient, applies to every patient who applies to a Tribunal<sup>19</sup> and only makes sense if there is a categorisation of all patients other than those under s2.

The fourth point put forward by Baroness Hale was that the statutory history of the relevant provisions indicates that classification and reclassification relate to the criteria for admission and continued liability to detention rather than to the treatment which may be given while in hospital. In essence, her point here was that the different categorisations of disorder go back to the Mental Health Act 1959 (albeit expressed differently), which had no regulation as to treatment and hence no limitation of whether a patient could be treated only for the form of disorder for which they were detained. But the question in issue in the case was what was the meaning of the amendments introduced to regulate treatment and contained in s63 of the 1983 Act: it is difficult to see how this can be answered by examining an earlier statute which had no such provision in it. Parliament

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<sup>18</sup> See footnote 5 above

<sup>19</sup> The statutory language is “Where application is made ... under any provision of this Act by or in respect of a patient ...”

grafted onto an existing system whereby detention was regulated according to categorisation some much-needed regulation of the circumstances in which treatment could be compelled: the fact that the pre-existing system dealt only with admission and detention (necessarily so as there was no regulation at all of treatment) cannot mean that categorisation issues remained limited to admission and detention rather than treatment. It is the new statutory structure which has to be considered to determine the intention of Parliament.

The fifth and final statutory construction point relied on by Baroness Hale was that the RMO cannot reclassify a restricted patient, and a Tribunal can only do so if they decide not to discharge. If treatment was restricted to the classified form of disorder, the cumbersome and time-consuming process of arranging a Tribunal hearing would have to be pursued before a patient could be treated for this new form of disorder. Her Ladyship noted (at para 28) “It is unlikely that Parliament intended that the patient could not be treated without his consent in the meantime, particularly as the patient may find ways of delaying the Tribunal hearing.” Again, this is a valid point but it does not prove much because, as the Court of Appeal pointed out, any urgent treatment – which should be a rare occurrence in any event – could be provided under the doctrine of necessity and this would deal with any concerns during the delay before a Tribunal hearing.

Accordingly, none of the arguments put forward by Baroness Hale as points of construction carry sufficient weight to overturn the view of the Court of Appeal. What is noticeable as well is that she did not take any account of European Convention arguments which, pursuant to s3 of the Human Rights Act 1998, must be at the forefront of any arguments as to statutory interpretation when fundamental rights are at stake. This was relegated to the final part of her judgment and dealt with in extremely brief fashion. Given that the issue was the conditions of detention rather than the fact of detention, the relevant Convention provisions are Articles 3 and 8. On the facts, it was noted that there were no arguable breaches, and in relation to the wider principle her Ladyship simply noted that patients were offered better protection by the law of negligence and by a claim for breach of the Human Rights Act 1998 than by the construction put forward.

This part of her reasoning was clearly flavoured by her view as to whether there were any policy reasons in support of the Court of Appeal’s preferred construction. Whilst noting that compulsory patients are a vulnerable group who deserve protection from being forced to accept inappropriate treatment, Baroness Hale noted that the tool of categorisation does not really provide protection because, for example, it would not prevent the wrong type of medication being given to a patient detained under the category of mental illness. But, again, this does not actually prove anything: the fact that a blunt tool cannot achieve everything that would be worthwhile does not mean that it should be rejected entirely.

The second policy matter to which Baroness Hale referred was that psychiatry is not an exact science: she noted that, as had been the case with B, a number of different diagnoses had been reached over the years. Further, given that there is often present a mental illness and a personality disorder (“comorbidity” being the medical term), it may be difficult to determine which features of the patient’s presentation stem from a disease of the mind and which stem from his underlying personality traits. From this reality, Baroness Hale produced the following conclusion: “31. ... The psychiatrist’s aim should be to treat the whole patient. ... Once the state has taken away a person’s liberty and detained him in a hospital with a view to medical treatment, the state should be able (some would say obliged) to provide him with the treatment which he needs. It would be absurd if a patient could be detained in hospital but had to be denied the treatment which his doctor thought

he needed for an indefinite period while some largely irrelevant classification was rectified.”

This is disquieting. There are two elements to compulsory treatment under the Mental Health Act 1983: one is detention and the other is treatment. Accordingly, there are two fundamental rights in play: liberty and self-determination. Psychiatric treatment – particularly medication – often involves unpleasant side-effects; our concept of self-determination is that people should make the decision about what treatment to accept even if a medical professional believes that only one decision can be sensible.

The loss of liberty does not carry with it a loss of self-determination: that was the clear principle underlying the conclusion of the Court of Appeal. That was also the basis for the decision in *Wilkinson*: the fact that treatment is separately regulated reflects an acceptance that it involves a different fundamental right, which is not subsumed in the loss of liberty. But the reasoning of the House comes close to saying that if the state takes away liberty on account of mental disorder, then any self-determination is lost: instead, the medical professionals have to do what they can to treat and put the patient back into the community.

Why is this disquieting? Admittedly, it sounds sensible in principle, but when one starts with the premise that psychiatry is an inexact science, the truth is that safeguards are required for the personal autonomy rights of the patient because the inexact nature of the science means that mistakes are a greater rather than lesser possibility. That favours not the wide licence given to psychiatrists by Baroness Hale but the restrictive interpretation favoured by the Court of Appeal. The inexact nature of the science should mean that treatment is impossible only if clear statutory language is in place. In other words, whereas section 63 of the Mental Health Act 1983 allows treatment without consent for “the mental disorder from which he is suffering”, if Parliament is to be taken to have meant to allow treatment without consent for any mental disorder, including one which did not justify detention, clearer language would achieve that: for example, it could have referred to “any mental disorder from which he is suffering”. The same applies to section 58: this allows treatment for “his mental disorder” but in the context of a patient being “liable to be detained”; had Parliament meant to refer to treatment for any form of mental disorder, not just the one relevant to detention, it could have said “any mental disorder”.

Baroness Hale was perfectly right to say that in some instances, where the dispute is about the particular diagnosis within a given category (eg different forms of mental illness), since different specific disorders may involve different treatments, the Court of Appeal’s decision offers little protection against the imposition of treatment which turns out to be wrong: but neither would the law of negligence, particularly as psychiatry is such an inexact science and accordingly a breach of the duty of care imposed is more difficult to demonstrate. And, as a matter of principle, the risk apparent from mistaken diagnoses within a category is hardly reason to take away such protection as was given by the approach of the Court of Appeal. The position now is that a person can be detained for treatment in relation to one form of disorder but also treated for a form of disorder which would not have justified his or her detention in the first place. So take two patients with capacity: patient A suffers from mental illness alone, but not sufficient to justify detention; he retains both liberty and the right to self-determination. Patient B suffers from both mental illness which does not justify detention but also mental impairment which does justify detention; he loses both liberty and all rights to self-determination, even in relation to a form of mental disorder which had it stood alone would not have justified detention.

It is true that in *B*, the additional form of disorder was a personality disorder in relation to which most treatment is psychologically based rather than chemical and so not necessarily invasive: but this is not universal and it may not be the same in the future. And the fact is that the House of Lords sets a principle applicable to different circumstances. So, a person suffering from mental impairment which justifies detention and also suffering from a psychotic illness which does not justify detention can now be treated forcibly for the latter without clear authorisation in the Mental Health Act.

It is not too much to insist that the statute be clear about this (so that at least Parliament would have had to confront the issue and reach a conclusion as to what was justified). This is consistent with the Human Rights Act 1998 and the requirement for sufficient precision in the law to meet the requirements of legal certainty. This should now be the approach to statutory interpretation: section 3 of the 1998 Act so requires when, as here, fundamental rights are at stake.

Baroness Hale was clearly concerned that by taking away from the professionals the power to treat the patient's entire range of problems, it was the patient who would suffer the indignity of longer detention. But the concept of autonomy means that it is for the patient to make the decision as to whether to accept treatment, weighing in the balance a judgment as to the consequences of non-acceptance (including that liberty may be lost for longer). For this reason, the approach of the Court of Appeal was better: but it is not the law.