The Significance of Mental Disorder Classification

*Anna Harding**

R (on the application of B) v Ashworth Hospital Authority [2003] EWCA Civ 547
Court of Appeal (15th April 2003) Simon Brown LJ, Dyson LJ, and Scott Baker LJ

"Clearly, following our judgments on this appeal, the question of re-classifying patients to include other disorders will assume a far greater importance than hitherto it has had."[1]

The Facts

B is a restricted patient, having been detained in Ashworth High Security Hospital under sections 37 and 41 of the Mental Health Act 1983 ('The Act') since 1987. The order of the sentencing court specified that the mental disorder for which he was detained was a mental illness, namely schizophrenia. Most of the doctors who had treated B since his admission were of the opinion that B also suffered from a psychopathic disorder, namely a personality disorder (dissocial type). However, his mental disorder had never been reclassified[2] from that of mental illness.

In August 2000, B applied to a tribunal for discharge. His Responsible Medical Officer ('RMO') submitted a report to the tribunal, which stated that B was suffering from a schizo-affective disorder of the manic type. A psychologist's report recommended that B should be transferred to a 'co-morbidity' ward, that is a ward which would be able to provide treatment for both his mental illness and his personality disorder.

In December 2000, B was transferred to a ward that could treat personality disorder, and B was still on this ward at the time of his next tribunal hearing in May 2001. His RMO explained that the reason for the transfer was to treat B's personality disorder traits. At the tribunal hearing B was refused an order for discharge. No reclassification of his mental disorder was made.

In August 2001 B's solicitors wrote to the hospital to express concern that B was on a ward specialising in the treatment of psychopathic disorder. In December 2001 they received a reply from the Chief Executive saying that the clinical team felt that B's needs were best met by the personality disorder service.

B sought Judicial Review of the decision to detain him in a personality disorder ward. The issue was whether Ashworth could lawfully treat B for a personality disorder when he was only classified as suffering from mental illness. Sir Richard Tucker, in the Administrative Court held that they

* *Barrister; Mind Legal Unit (London)*

1 *Simon Brown LJ at paragraph 81.*

2 *It should be noted that the Act does not use the term 'classified disorders'. The expression is used throughout this case review to refer to the disorder specified on the section admission application or hospital order or in a tribunal decision. The heading to section 16 refers to 'reclassification' (see below).*

could do so, and he duly dismissed B's application[3]. B appealed, and in the words of Dyson LJ who gave the lead judgment, the issue for resolution on the appeal was "the true construction of section 63 of the Act".[4]

The Law

The treatment of most detained patients[5] is governed by Part IV of the Act. In particular 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 section 57 or 58 above, if the treatment is given by or under the direction of the responsible medical officer".

Before proceeding further in outlining the statutory framework of the Act, Dyson LJ made clear that the scope of the treatment provisions could only be construed by reference to the statute as a whole, which provides a scheme for the admission, treatment, review and discharge of people suffering mental disorder[6].

Under section 3, the grounds for an application for a person to be admitted and detained for treatment are as follows:

"(a) He is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and

(b) in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition; and

(c) it is necessary for the health or 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

As His Lordship pointed out, the basis for the application for admission is to enable the patient to receive treatment for the disorder which justifies his or her detention[7].

By section 16, the RMO has the power to reclassify the patient's mental disorder by furnishing a report to the hospital managers:

"(1) If in the case of a patient who is for the time being detained in a hospital in pursuance of an application for admission for treatment, or subject to guardianship in pursuance of a guardianship application, it appears to the appropriate medical officer that the patient is suffering from a form of mental disorder other than the form or forms specified in the application, he may furnish to the managers of the hospital, or to the guardian, as the case may be, a report to that effect; and where a report is so furnished, the application shall have effect as if that other form of mental disorder were specified in it.

(2) Where a report under subsection (1) above in respect of a patient detained in a hospital is to the effect that he is suffering from psychopathic disorder or mental impairment but not from mental illness or severe mental impairment the appropriate medical officer shall

3 *[2002] EWHC Admin 1442; 1st July 2002*

4 *Paragraph 14*

5 *Section 56 of the Act specifies the patients to whom Part IV applies.*

6 *Paragraph 16*

7 *Paragraph 19*

include in the report a statement of his opinion whether further medical treatment in hospital is likely to alleviate or prevent a deterioration of the patient's condition; and if he states that in his opinion such treatment is not likely to have that effect the authority of the managers to detain the patient shall cease.

(3) Before furnishing a report under subsection (1) above the appropriate medical officer shall consult one or more other persons who have been professionally concerned with the patient's medical treatment."

Section 20 provides for the duration of the authority to detain the patient. Subsection (3) allows for the renewal of the authority if the RMO examines the patient and furnishes a report to the hospital managers stating that it appears that the conditions in subsection (4) are satisfied. These conditions are as follows:

"The conditions referred to in subsection (3) above are that –

(a) the patient is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment, and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in hospital; and

(b) such treatment is likely to alleviate or prevent a deterioration of his condition; and

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

but, in the case of mental illness or severe mental impairment, it shall be an alternative to the condition specified in paragraph (b) above that the patient, if discharged, is unlikely to be able to care for himself, to obtain the care which he needs or to guard himself against serious exploitation."

The wording of section 20(9) should also be noted:

"Where the form of mental disorder specified in a report furnished under subsection (3)… above is a form of disorder other than that specified in the application for admission for treatment…, that application shall have effect as if that other form of mental disorder were specified in it; and where on any occasion a report specifying such a form of mental disorder is furnished…. the appropriate medical officer need not on that occasion furnish a report under section 16 above."

Having similarly outlined these statutory provisions, Dyson LJ paused from his consideration of the statutory framework, and stated as follows[8]:

"It will be seen that the conditions in section 20(4) are substantially the same as the conditions in section 3(2), and that the scheme of section 20 is very similar to that of section 16. In particular, if the form of disorder specified in a report is other than that specified in the application for admission for treatment, the application shall have effect as if that other form of mental disorder were specified in it. So, once again, the important link is maintained between the mental disorder which justifies the patient's detention and his treatment *for that disorder*."

8 *Paragraph 23*

Section 37 makes provision for hospital orders to be made by the courts following criminal proceedings. Where a person is convicted of certain offences and certain conditions are satisfied, the court may authorise his admission his admission to, and detention in, hospital for treatment. Section 37(7) provides that the order shall "specify the form or forms of mental disorder.... from which the offender is found to be suffering"

With some modifications, the provisions of sections16 and 20 apply to patients detained under section 37[9].

The position is different for restricted patients. Section 41 provides that, if certain conditions are met, the court may further order that the offender who is ordered to be detained under section 37, shall also be subject to special restrictions. One consequence of the restrictions is that the provisions of sections 16 and 20 do not apply; another is that no application to a tribunal may be made under section 66.[10] Section 66 enables an application to be made to a tribunal where a report is furnished under sections 16 or 20.

For restricted patients the only way to get the specified mental disorder reclassified is to persuade a tribunal to reclassify in accordance with their apparent power under section 72(5)[11]. The Secretary of State has a number of powers in relation to restricted patients[12], but he does not have the power to reclassify a patient's mental disorder.

Under section 72 (5), where a tribunal does not direct discharge, it "may, if satisfied that the patient is suffering from a form of mental disorder other than the form described in the application, order or direction relating to him, direct that that application, order or direction be amended by substituting for the form of mental disorder specified in it such other form of mental disorder as appears to the tribunal to be appropriate".

Judgment

As already noted, Dyson LJ gave the lead judgment of the Court.

On behalf of the hospital it had been submitted that section 63 allows treatment of any mental disorder from which the patient was suffering regardless of whether or not it was the classified disorder. In support of that contention, counsel made three main submissions:

a) That Part IV makes no reference to classification. Parliament would have been explicit if it was only to apply to classified disorders;

b) That if section 63 does not permit the giving of medical treatment for non-classified mental disorders, there would be no power to treat detained patients in an emergency for non-classified disorders;

c) If the Act only authorised treatment for classified disorders there would be great practical difficulty in cases of co-morbidity.

9 *Section 40(4); Schedule 1 Part 1 paragraphs (2), (3) and (6) of the Act*

10 *Section 41(3) (a) and (b)*

11 *It should be noted that both Richard Jones in the Mental Health Act Manual (Sweet and Maxwell) (8th edition) (2002) at p.368, and Anselm Eldergill in Mental Health Review Tribunals (Sweet and Maxwell) (1997) at p.555, question whether Parliament intended to confer on tribunals a power to reclassify restricted patients. The Court's judgments contain no reference to this view.*

12 *Section 42 of the Act*

The Judge accepted that, *in isolation*, Part IV could be read as applying to *any* diagnosed mental disorder, whether it was classified or not. But, he went on, "Part IV must be interpreted in its context"[13]. Looking at the whole of the Act, it was clear that it was dealing with the admission and detention of patients suffering from classified mental disorders. The Act contained provisions designed to ensure that patients were only detained as long as they continued to suffer from such disorders. Part IV of the Act was no more concerned with non-classified mental disorders than it was with physical disorders. It was concerned with mental disorders which were treatable and which justified detention for their treatment. The Act had a continuous theme that the liability to detention was linked to the mental disorder from which the patient was classified as suffering, and that the disorder was considered treatable by the person making the classification.

By looking at the Act as a whole, the Judge concluded that it was "not 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."[14] The provisions relating to reclassification within the Act were designed to ensure that the essential link was maintained between the mental disorder which justified the patient's detention and his treatment *for that disorder*. It was therefore not lawful to provide compulsory treatment for a disorder other than the classified disorder.

The Judge held that Sir Richard Tucker in the Administrative Court had misinterpreted section 63, and the appeal was allowed.

The Court went on to look in some detail at the case of *R v Oxfordshire Mental Health Review Tribunal ex p Hagan*[15]. In that case the applicant was detained under sections 37/41 and both mental illness and psychopathic disorder had been specified on the Order. He had applied to a tribunal who found that the psychopathic disorder continued to reach the detention threshold but that the mental illness was in remission. However the tribunal had refused to reclassify him so as to remove the reference to mental illness. The issue raised was whether the tribunal had a *discretion* or a *duty* to reclassify when one of the specified disorders would not on its own justify detention. The court held that the tribunal had a *discretion* and there was no duty to remove from the order a form of mental disorder from which the patient still suffered but which would not justify detention. Waller LJ, giving the principal judgment had said that reclassification related to whether the patient suffered from a mental disorder, not whether he was detainable for that disorder if it stood alone.

In the present case it was submitted that *Hagan* had been wrongly decided and that classification was the touchstone for both detention and for treatment. It was suggested that it was open to the Court not to follow *Hagan* as that case had been decided before the Human Rights Act 1998 came in to force. It was accepted that *Hagan* was not determinative of the present issue but some of the reasoning was relevant.

The Court felt unable to agree with some of the reasoning in *Hagan*. It was agreed that the purpose of classification was to identify the mental disorder for which compulsory treatment was needed. The corollary of that was that it was not the purpose of classification to identify a mental disorder for which compulsory treatment was not needed[16]. It was felt that a better view of sections 16,20 and 72(5) would have been that when a mental disorder ceased to meet the section 3 or section 37 criteria, there should be a reclassification to remove the disorder from the application or order[17].

13 *Paragraph 42*

14 *Paragraph 42*

15 *[2001] LLR Med 119*

16 *Paragraph 64*

17 *Paragraph 65*

It was not felt necessary to say that *Hagan* was wrongly decided because the correct basis for that decision was identified in paragraph 32 of Waller LJ's judgment[18]:

> "… The conclusion of the Tribunal was that the mental illness alone would not render him liable to be detained. That conclusion emphasises that Mr Hagan still suffers from mental illness, and that it may recur unless treatment was available. The conclusion I suggest can be fairly read as being that the mental illness, when taken together with the psychopathic disorder which can be alleviated by treatment in hospital, makes it appropriate for him to be detained in hospital for medical treatment in relation to both types of mental disorder…"

It was therefore not felt necessary to consider whether *Hagan* could continue to be considered good law.

Discussion

The purpose of classification and the scope of compulsory treatment provisions.

This case raises the question in the author's mind about whether the court could reasonably have come to any other conclusion. It is submitted that from a 'rights based' angle it could not. At the same time the judgment does have some significant practical implications, which suggest that the conclusion was not always as obvious as it now appears.

The scheme of the Act clearly aims to provide a balance between the two issues of protection and autonomy. Finding the right balance is not always easy and views change about what is the best way to achieve it. Doctors traditionally have a great deal of discretion in their clinical judgement but in the field of mental health there is a visible overlap between what may be said to be a clinical approach and a more legalistic approach. The legal approach recognises the infringements on civil rights and is more concerned to provide an effective check on the use of power. There may be some cases where the position is not clear-cut and where a decision needs to be made by balancing up the competing arguments, which may be strongly made in either direction. It is likely that reasonable and fair people could legitimately disagree about decisions made in this 'grey area'. However, the courts have been quite willing in recent times, particularly since the introduction of the Human Rights Act 1998, to show that any use of power must not be arbitrary, that it must be in accordance with the law, and that the courts will provide an effective check on its exercise.

Ashworth had argued in this case that the correct interpretation of section 63 meant that once a person was lawfully detained under the Act they could be treated for any mental disorder from which they were suffering. This argument does not stand up to a rights based critique. As Simon Brown LJ stated[19]:

> "Two important considerations should be borne in mind when construing section 63: first, that on no view does it extend to treatment for any physical condition, however serious, and however mentally incapacitated the patient may be. Secondly, that 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?"

18 *Paragraph 66*

19 *Paragraph 78*

Urgent Treatment and Capacity

Although the court gave section 63 a restrictive interpretation, and so gave greater weight to patients' right to self-determination, the way that Ashworth's supporting submissions were dealt with may mean that the rights are more illusory than real.

Ashworth's second submission was that if section 63 did not permit treatment of non-classified mental disorders there would be an important lacuna in the Act. It would mean that there was no authority to administer treatment to detained patients in urgent cases for the non-classified disorder. Although this would be less of a problem for unrestricted patients, where the RMO could quickly furnish a report to the managers[20], in the case of restricted patients, according to both Dyson LJ and counsel for Ashworth, "the only route to reclassification was by a reference to the tribunal by the Secretary of State under section 71, with a view to the exercise by the tribunal of its power to reclassify under section 72(5)"[21].

Further, the submission was that the common law would not help solve this problem because common law powers, in relation to detained patients, were impliedly removed by Part IV of the Act. Counsel relied on the House of Lords decision in *B v Forsey*[22], in which it was held that the hospital's powers of detention conferred by the Scottish mental health legislation were exhaustive and there was no residual common law power to detain. In that case Lord Keith of Kinkel said that "the scheme contains a number of safeguards designed to protect the liberty of the individual. It is not conceivable that the legislature, in prohibiting any successive period of detention under provisions containing such safeguards, should have intended to leave open the possibility of successive periods of detention not subject to such safeguards".

The judge dealt with this submission quite shortly by distinguishing *Forsey*. He said that section 63 of the Act was clearly not exhaustive of the power to treat for mental disorder because it was only concerned with treatment for classified disorders. It followed that, in relation to a non-classified mental disorder, the common law applied in the same way as it did to physical disorders.

What was not clearly expressed was the significance of this finding. This may mean that the court missed an important opportunity for asserting the value of the rights of detained patients. Alternatively, it may bring the validity of their decision into question at some future time.

The Scope of Common Law Treatment

Counsel for Ashworth accepted that, outside the Act, the common law allowed medical treatment without consent where the patient did not have capacity. It seems also to have been accepted that such treatment could be administered to people with capacity in "an emergency". The judge referred to *In re F (Mental Patient: Sterilisation)*[23], and the judgment of Lord Goff at 72–78, to support this contention[24]. However, it would appear that the situations envisaged by Lord Goff when talking about emergency actions, particularly in relation to medical treatment, should more properly be categorised as short-term periods of incapacity (e.g. unconsciousness etc). That leaves

20 Under section 16 of the Act

21 Paragraph 36. A restricted patient's case might also come to the attention of the tribunal by the patient exercising his/her right to apply under section 70.

22 [1988] SLT 572

23 [1990] 2 AC 1

24 This proposition also finds favour in paragraph 15.25 of the Code of Practice (Department of Health and the Welsh Office) (1999). The author agrees with Richard Jones (op. cit. at page 307) that paragraph 15.25 "cannot be correct".

very few (if any) situations where treatment can be given to a person with capacity when they do not consent. There are significant implications flowing from the Court's failure to analyse the common law position properly.

The expression of the common law doctrine of necessity is frequently shortened but in *Re F* it was expressed in two stages:

> 1) There must be a necessity to act when it is not practicable to communicate with the assisted person; 2) the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person.

'Not practicable to communicate' can either mean that the person does not have capacity to communicate, or may mean that the situation is so urgent as to demand immediate action to the extent that there is not time to ascertain the other person's wishes. Neither of these situations applies to a patient who may need urgent treatment but is mentally capable and refuses it (or who does not have capacity but has made an advance decision to refuse certain treatment).

The Court gave the impression that there was force in Ashworth's submission but that it was mistaken because treatment could be given under common law. However, the Court misstated the common law position. People with capacity are entitled to refuse any medical treatment unless it is authorised by the Act. If the Act only allows medical treatment for the classified mental disorder then treatment for a different mental disorder, where the patient retains capacity, may not be given – even in an urgent situation.

The case is undoubtedly extremely important and it should have a significant impact. Perhaps, in practice, most situations where urgent psychiatric treatment is needed will be assessed as resulting in a loss of capacity, so that treatment can be given under the common law. However, there will at least be an extra step in the process where the doctor has to address his mind to the question of capacity. The Court's failure to recognise the impact of the decision means that any force in Ashworth's submission has not been adequately dealt with. That leaves a good decision vulnerable to future challenge.

Cases of Co-morbidity

Following this judgment there may well be more cases of dual classification as doctors become cautious to ensure that they can administer treatment where necessary. The doubts cast on the *Hagan* judgment will become more significant as patients have the right to be reclassified so as to remove disorders that do not meet the detention criteria.

Counsel for Ashworth had submitted that if treatment under section 63 could only be given for the classified disorder there would be a real difficulty in cases of co-morbidity. The argument was based on the theoretical situation of a patient having been diagnosed as suffering a mental illness, which reached the threshold criteria for detention and treatment, and another disorder e.g. personality disorder that did not reach that threshold. The judgment was to the effect that if the personality disorder was 'free-standing' the patient could not be detained and treated for it, but if it aggravated the mental illness treatment may be administered for it under the guise of it amounting to ancillary treatment for the mental illness.

Unfortunately, the way this issue was dealt with undermines the significance of the rest of the judgment. Treatment for one disorder should never be described as ancillary treatment for another. The passage from *Hagan*, set out above[25], that was expressly said to be correct suggests that there may be situations where a combination of disorders means that the threshold is reached when it might not be if there was just one disorder. Even if that is right, it is not the same as saying that treatment for one is ancillary to treatment for the other. The doctors must decide what disorder they are treating and formulate a treatment plan for that disorder. To say that treatment can be compulsorily given for a non-classified disorder, on the basis that it is ancillary to treatment for another disorder, entirely negates the protection that the Court agreed was afforded by the Act.

What if there is no classification?

Perhaps more significant is the effect of the judgment on cases where there is no classification, for example, under section 2. Patients detained under section 2 are subject to the compulsory treatment provisions as set out in Part IV, but it is not necessary to 'classify' the mental disorder from which they are suffering. In fact, in many cases it would be impossible to do so, and if possible, may be admission under section 3 would be more appropriate.

The Court does not seem to have looked at section 2 in reaching its decision. However, the implication of the judgment is clear. A person detained under section 2 can be given compulsory treatment for any disorder from which they may be suffering even if that disorder does not reach the threshold for detention. This means that people being assessed are more vulnerable under the treatment powers than those who are detained specifically for treatment. This may well affect the perceived attraction of using section 2 before a section 3.

Conclusion

This case may provide a practical example of the fact that compulsory treatment is such a severe infringement of autonomy that any power to exercise it must be expressly provided for by Parliament. The Mental Health Act 1983 clearly does express that power. This case clarifies the limits of that power, and by doing so reinforces the underlying value of autonomy by making it clear that apart from what is expressly removed by the Act, a patient retains the all the same rights as a non-detained person in relation to treatment. However, the Court did not take the opportunity to make a clear statement of principle and may have undermined the significance of their decision by failing to do so.

25 *Paragraph 32 of Waller LJ's judgment in Hagan. See footnote 18 above.*