Case No: C3/2002/1463

Neutral Citation No: [2003] EWCA Civ 547

IN THE SUPREME COURT OF JUDICATURE

COURT OF APPEAL (CIVIL DIVISION)

ON APPEAL FROM ADMINISTRATIVE COURT

(Sir Richard Tucker)

Royal Courts of Justice

Strand, London, WC2A 2LL

Date: 15TH April 2003

**Before :**

LORD JUSTICE SIMON BROWN

LORD JUSTICE DYSON

and

LORD JUSTICE SCOTT BAKER

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**Between :**

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|  | **THE QUEEN ON THE APPLICATION OF “B”** | Appellant |
|  | **- and -** |  |
|  | **ASHWORTH HOSPITAL AUTHORITY** | Respondent |

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**Mr Richard Gordon QC and Mr Hugh Southey** (instructed by **Messrs Roberts, Moore, Nicholas and Jones**) for the Appellant

**Mr Oliver Thorold** (instructed by **Messrs Capsticks**) for the Respondent

Hearing dates : 31st March and 1st April 2003

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JUDGMENT : APPROVED BY THE COURT FOR HANDING DOWN (SUBJECT TO EDITORIAL CORRECTIONS)

**Lord Justice Dyson**:

# **The issue**

# Section 63 of the Mental Health Act 1983 (“the Act”) 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.”

# The sole issue that arises on this appeal is whether this provision sanctions compulsory treatment of a detained patient for any mental disorder which has been diagnosed by the clinicians, or whether it only authorises such treatment (in the case of a patient who has been made the subject of a restriction order under section 41(1)) for the mental disorder specified by the court under section 37(7) or by the Mental Health Tribunal (“the tribunal”) under section 72(5). The judge, Sir Richard Tucker, preferred the first interpretation. He said:

“11. Mr Thorold, on behalf of the defendants, observes that it is common ground that a patient can be dual qualified and submits that the reference in the section to the disorder from which he is suffering must refer to the actual disorder as diagnosed by the clinicians, and need not, and should not, be confined to the disorder or that part of the disorder classified by the Tribunal.

12. I prefer Mr Thorold’s submissions. 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.”

# The mental disorder specified by the court under section 37(7) in this case was a mental illness. At all times, B was classified as suffering from a mental illness. At no time has the tribunal specified the mental disorder from which he is suffering as a psychopathic personality disorder within the meaning of section 1(2) of the Act.

# **The facts**

# Save for certain brief interludes, B has been a patient at Ashworth Hospital (“Ashworth”) since 1987. He is 47 years of age. He is currently detained under sections 37 and 41 of the Act pursuant to an order made by the Crown Court at Birmingham on 25 August 1987. He had been convicted of the manslaughter of his girlfriend. The mental illness specified by the court in making the hospital order was schizophrenia. Most, if not all, of the clinicians who have had B under their care have been of the view that B also suffers from a psychopathic disorder, being a personality disorder (dissocial type). B’s case has been considered by the tribunal from time to time. He has always been classified as suffering from a mental illness, and not a personality disorder.

# B has been transferred on several occasions to the Raeside Clinic, a medium secure unit. But on each occasion, there have been problems, and B has been returned to Ashworth.

# On 17 August 2000, he applied to the tribunal for an order that he be discharged from liability to be detained. At that time, he was on the Shelley Ward at Ashworth, and his responsible medical officer (“RMO”) was Dr Kumurajeewa. He submitted a report to the tribunal for the purposes of the hearing, stating that B most probably had a schizo-affective disorder of the manic type. Keith Scholey, a psychologist, also submitted a report recommending that B should be placed on a “comorbidity” ward suitable for the needs of patients suffering from problems of both mental illness and personality disorder. Reports were obtained from experts instructed on behalf of B. Professor Sashidharan, a psychiatrist, advised that a diagnosis of personality disorder would be “totally inappropriate”. Eric Bromley, a psychologist, questioned whether B should be detained either for mental illness or personality disorder.

# Dr Hughes became B’s RMO on 16 August 2001. In his witness statement dated 27 June 2002, he explains that B is “one of the few patients for whom the traditional classification systems do not provide a straightforward diagnosis. He has been diagnosed as suffering from both a mental illness (schizophrenia) and a psychopathic disorder being a personality disorder (dissocial type), a diagnosis with which I completely agree”.

# B was transferred to the Newman Ward at Ashworth on 15 December 2000, and was there at the time of the hearing before the tribunal on 8 May 2001. This is a personality disorder ward as is the Shelley Ward where he had been previously. At para 5 of his statement, Dr Hughes explains that the reason for the transfer was “to treat the personality disorder traits of the patient”.

# On 8 May 2001, the tribunal refused B’s application for a discharge from liability to be detained, and did not reclassify his mental disorder. He, therefore, remained classified as a patient suffering from a mental illness, and not a personality disorder. They said:

“We heard the witnesses and studied the reports listed.

On that evidence we are satisfied that the patient suffers mental illness (schizo-affective disorder) of a nature or degree that requires his continued treatment in hospital for his welfare and for the safety of others.”

# On 13 August 2001, B’s solicitors wrote to Ashworth expressing concern that he was in a ward for patients diagnosed with a psychopathic disorder. They referred to a number of reports which, they said, suggested that there was no reason to conclude that B was suffering from a psychopathic disorder.

# On 15 January 2002, the Chief Executive of Ashworth wrote to B’s solicitors saying:

“The current clinical team who recognise that, clinically, Mr Brogan has a mental illness and personality disorder consider that his needs are best met, at this time, in the Personality Disorder Service. I am sure you are aware of the difference between a clinical diagnosis of personality disorder and mental health classification of personality disorder.

The fact that there has not been a re-classification or added classification having been obtained or requested from the Tribunal is because the matter has been re-examined at Ashworth. Your client’s mental illness is controlled by medication and it would not be appropriate to transfer him to a mental illness ward given the comorbidity that exists and the outstanding difficulties as regards his personality disorder presentation. These should be addressed, as now, in a PD ward. This is not to say the best placement of your client in the Hospital will not be reviewed on a regular basis.”

# It was in these circumstances that B sought judicial review of the decision to detain him in a personality disorder ward. The stark issue raised by these proceedings is whether Ashworth could lawfully treat B for a personality disorder despite the fact that he was only classified as suffering from a mental illness. The judge below held that they could do so, and dismissed the application.

# There was no material before the judge as to the nature of the regime and treatment which B has been receiving for the personality disorder which the clinicians have diagnosed. He is now accommodated in Owen Ward, which is another ward within the personality disorder unit at Ashworth. On 15 October 2002, Alan Hazlehurst, B’s solicitor made a witness statement which contained the following:

“2. The Appellant advised me that when he was initially admitted to Ashworth Hospital, he spent a considerable period of time on mental illness wards, and that there is a difference between the present circumstances of his being on a personality disorder ward compared to his being placed on a mental illness ward.

3. The Appellant has described to me that there are broadly the following distinctions between the wards:-

i. That there is 24 hour access to rooms on a mental illness ward. On Owen Ward and on the personality disorder unit, rooms are locked off denying patients access from 8.30am in the morning. They are then re-opened from approximately 12.30pm to 1.30pm but again locked off until 4.30 in the afternoon when they are re-opened. This means that if a patient is unwell or is unable to attend at a workshop and is kept on the ward, he must stay in the day area and is denied access to his room.

ii. The Appellant is not permitted to have parole i.e. access off his ward on to the hospital site. Occasionally the Appellant and other patients are permitted access of the ward if there is sufficient staff, for a short break outside but this occurrence permitting access off the ward occurred much more frequently on the mental illness wards than on the personality disorder unit.

iii. The personality disordered patients are required to attend workshops, and effectively they are compulsory whereas this is not the case on the mental illness unit. When a mental illness patient feels on a particular day he is not up to attending at the workshops he need not attend. In the event of not attending at the workshop from the personality disorder unit, then payments, which are stage payments made to patients to reward them for attending at the workshops are reduced.

iv. There is a major difference in terms of treatment and therapy because of the higher level of security and dependency on the personality disorder unit.

v. The Appellant has explained that there is always a high level of observation, supervision and therefore a greater degree of intrusiveness on the part of staff in relation to their control and supervision of patients on a personality disorder ward. Conversely the Appellant believes that on the personality disorder unit there is less socialisation and interaction with the staff compared to the mental illness ward.

4. The Appellant believes that there are more searches on the personality disorder unit of patients in addition to there being a room search each month, there being random searches of the patient known as rub-down searches when going on and off the ward and when present on the ward.

5. The Appellant has instructed me that there is far less frequent meeting with his RMO and supervising doctor compared to his period on the mental illness unit and wards. He advises me that when on the mental illness wards he would see his doctor weekly whereas when on the personality disorder unit, a doctor in his experience is only normally seen on visits and has an appointment with the patient on average every 3 or 4 months.

6. On the personality disorder unit wards there is very little by way of activities that can be undertaken whilst present on the ward but there is a TV on each ward. The Appellant says that there is more open access on the mental illness wards compared to the wards on the personality disorder unit regarding the TV.

7. The Appellant will say that whilst being detained on a 24 hour day basis in a special hospital, these different conditions on the ward and interactions with the care team and staff make a significant difference to his daily quality of life, and his conditions and treatment whilst remaining at Ashworth Hospital.”

# In his skeleton argument, Mr Thorold submitted that implicit in the challenge to the decision to detain B in a personality ward was the proposition that placement decisions within a hospital are justiciable, and that the designation by a hospital of a particular ward for a particular mental disorder would acquire “binding legal significance”. Given the relief sought by B in his claim form (an order quashing the decision to detain him in a personality ward), this was an understandable response. But in the light of Mr Hazlehurst’s statement and the argument advanced by Mr Gordon QC, it has become clear that the challenge is not to the compulsory placement of B in a personality ward per se. Rather, it is to the compulsory treatment of B for a personality disorder in that ward. In view of the unchallenged evidence of Mr Hazlehurst and, above all, para 5 of the statement of Dr Hughes, it is not surprising that, in his oral submissions, Mr Thorold did not seek to argue that B is not receiving compulsory treatment for a personality disorder. It is for this reason that the only issue for resolution on this appeal is the true construction of section 63 of the Act.

# **The true construction of section 63**

# **The statutory framework**

# Section 63 appears within Part IV (sections 56 to 64), which is entitled “consent to treatment”. Part II (sections 2 to 34) is entitled “compulsory admission to hospital and guardianship”. Part III (sections 35 to 55) is entitled “patients concerned in criminal proceedings or under sentence”. Part V (sections 65 to 79) is entitled “mental health review tribunals”..

# 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. For convenience, I shall refer to this as “the classified disorder”, although it is to be noted that the language of classification is not used in the Act (save only in the heading to section 16 “reclassification of patients”).

# An application for admission to a hospital (“an application for admission for treatment”) may be made in respect of a patient under section 3 on the grounds that:

“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

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

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” (section 3(2)).

# An application for admission for treatment must be founded on the written recommendations of two registered medical practitioners in compliance with section 3(3). Such an application, if duly made in accordance with the provisions of the Act, is sufficient authority for the applicant, or any other person authorised by the applicant, to take the patient and convey him to the hospital within the period specified in section 6(1). Where a patient is admitted within the said period to the hospital specified in the application, “the application shall be sufficient authority for the managers to detain the patient in the hospital in accordance with the provisions of this Act” (section 6(2)).

# These are the material provisions which deal with the admission of a patient for treatment. It will be seen that it is a requirement of an application for admission for treatment that the patient is suffering from one of the specified forms of mental disorder “of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital”. It may be obvious, but it needs to be emphasised, that the basis of the application for admission of the patient is to enable him to receive treatment for the disorder which justifies his detention.

# The position of civil patients who are detained is dealt with in sections 16 to 20. Section 16 provides:

“(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 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.”

# The appropriate medical officer therefore has the power to reclassify the patient’s mental disorder, by furnishing the managers with a report that the patient is suffering from a form of mental disorder other than the form or forms specified in the application for admission for treatment. Thus, he may produce a report which has the effect of deleting an existing classified disorder (A), and substituting a new disorder (B), or, where appropriate, adding a new disorder (B) to an existing disorder (A). The mechanism adopted by the statute for giving effect to the opinion of the medical officer that the patient is suffering from a mental disorder other than the form or forms specified in the application for admission is to provide for a deemed amendment to the application. The application takes effect as if the “other” disorder were specified in it. 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*.

# Section 20 makes provision for the duration of the authority to detain the patient. So far as material, it provides:

“(3) Within the period of two months ending on the day on which a patient who is liable to be detained in pursuance of an application for admission for treatment would cease under this section to be so liable in default of the renewal of the authority for his detention, it shall be the duty of the responsible medical officer –

(a) to examine the patient; and

(b) if it appears to him that the conditions set out in subsection (4) below are satisfied, to furnish to the managers of the hospital where the patient is detained a report to that effect in the prescribed form;

and where such a report is furnished in respect of a patient the managers shall, unless they discharge the patient, cause him to be informed.

(4) 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 a 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.

……

(8) Where a report is duly furnished under subsection (3) … above, the authority for the detention ….of the patient shall be thereby renewed for the period prescribed in that case by subsection (2) above.

(9) 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.”

# 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*.

# I turn to the relevant provisions of Part III. Section 37 makes provision for hospital orders by the court. Section 37(1) provides that where a person is convicted of certain offences, and the conditions mentioned in subsection (2) are satisfied, the court may authorise his admission to, or detention, in such hospital “as may be specified in the order”. The conditions in subsection (2) are that:

“(a) the court is satisfied, on the written or oral evidence of two registered medical practitioners, that the offender is suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment and that either –

(i) the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and, in the case of psychopathic disorder or mental impairment, that such treatment is likely to alleviate or prevent a deterioration of his condition; or

(ii) ……..

(b) the court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under this section.”

# Section 37(7) provides that the order shall “specify the form or forms of mental disorder referred to in subsection (2)(a) from which…the offender is found to be suffering”. Section 40(4) provides that a patient who is admitted to a hospital in pursuance of a hospital order shall be treated for the purposes of the provisions mentioned in Part 1 of Schedule 1 to the Act as if he had been so admitted in pursuance of an application for admission for treatment, subject to he modifications specified in that Part of the Schedule. Sections 16 and 20 apply, with modifications which are not material to this appeal.

# It will be seen, therefore, that, although there are differences of detail between section 37(1)(2) and (7) to (9) on the one hand, and section 3(1) and (2) on the other hand, 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.

# Section 41(1) provides that where a hospital order is made in respect of an offender by the Crown Court, and the conditions stated in the subsection are satisfied, then the court may further order “that the offender shall be subject to the special restrictions set out in this section” (a “restriction order”). The restrictions include that the provisions of sections 16 and 20 do not apply; and no application may be made to a tribunal in respect of a patient under section 66 or 69(1). Subsection (6) provides:

“(6) While a person is subject to a restriction order the responsible medical officer shall at such intervals (not exceeding one year) as the Secretary of State may direct examine and report to the Secretary of State on that person; and every report shall contain such particulars as the Secretary of State may require.”

# Before I turn to Part IV, I need to refer to Part V. Section 66 provides that application may be made to a tribunal in the circumstances specified in subsection (1). Application may be made where a report is furnished under section 16, and where a report is furnished under section 20 and the patient is not discharged. There is, however, no provision for such an application to be made where treatment is given without the patient’s consent under the direction of the RMO under section 63. Section 72 gives the tribunal the power to discharge a patient. Subsection (1) provides:

“(1) Where application is made to a Mental Health Review Tribunal by or in respect of a patient who is liable to be detained under this Act, the tribunal may in any case direct that the patient be discharged, and –

(a) the tribunal shall direct the discharge of a patient liable to be detained under section 2 above if they are not satisfied -

(i) that he is then suffering from mental disorder or from mental disorder of a nature or degree which warrants his detention in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; or

(ii) that his detention as aforesaid is not justified in the interests of his own health or safety or with a view to the protection of other persons;

(b) the tribunal shall direct the discharge of a patient liable to be detained otherwise than under section 2 above if they are not satisfied –

(i) that he is then suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment or from any of those forms of disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or

(ii) that it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment; or

(iii) in the case of an application by virtue of paragraph (g) of section 66(1) above, that the patient, if released, would be likely to act in a manner dangerous to other persons or himself.”

# Subsection (5) provides:

“(5) Where application is made to a Mental Health Review Tribunal under any provision of this Act by or in respect of a patient and the tribunal do not direct that the patient be discharged or, if he is (or is to be) subject to after-care under supervision, that he cease to be so subject (or not become so subject), the tribunal 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.”

# Section 73 gives the tribunal the power to direct the discharge of restricted patients. Subsection (1) provides:

“(1) Where an application to a Mental Health Review Tribunal is made by a restricted patient who is subject to a restriction order, or where the case of such a patient is referred to such a tribunal, the tribunal shall direct the absolute discharge of the patient if -

(a) the tribunal are not satisfied as to the matters mentioned in paragraph (b)(i) or (ii) of section 72(1) above; and

(b) the tribunal are satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment.”

# It will be seen that in section 72(5) there is a further assertion of the link between the liability to be detained and the mental disorder specified in the application (in the case of civil patients) and in the order or direction relating to the patient (in the case of criminal patients).

# I can now come to Part IV. Section 57 applies to the “following forms of medical treatment for mental disorder”. In the case of these forms of treatment, there is a requirement of consent and a second opinion. Section 58 applies to the “following forms of medical treatment for mental disorder”. These forms of treatment require the consent of the patient or a second opinion. Section 62(1) provides:

“(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 of 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.”

# And then we come to section 63 which I shall repeat:

“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.”

# **Discussion**

# Mr Thorold submits that the judge construed section 63 correctly. It permits any medical treatment not falling within section 57 or 58 to be given by or under the direction of the RMO for any mental disorder from which the patient is suffering, whether or not it is a classified disorder. In support of his contention, he makes a number of points.

# First, there is no reference to a patient’s classification anywhere in Part IV. If Parliament had intended that the provisions of Part IV should apply only to treatment for classified mental disorders, it would have said so explicitly, and not left the matter to “inference and statutory construction alone” (I quote from Mr Thorold’s skeleton argument).

# Secondly, if section 63 does not permit the giving of medical treatment for non-classified mental disorders, there is an important lacuna in the Act. The inability to administer medical treatment for such mental disorders in urgent cases would be a serious matter, and cannot have been intended by Parliament. It is true that in the case of civil patients, and unrestricted criminal patients who are subject to hospital orders, there is no difficulty, since the appropriate medical officer can reclassify the patient by furnishing a report under section 16. But this speedy solution is not available in the case of restricted criminal patients. In their case, the only route to reclassification is 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). This is a somewhat cumbersome process which takes time, and is not apt to deal with cases where there is an urgent need for reclassification.

# Nor can the problem be overcome by recourse to the common law. Mr Thorold accepts that, but for the Act, it would be open to the hospital at common law to administer essential medical treatment without the patient’s consent in those cases where he or she does not have the capacity to give consent, and in all cases of emergency, regardless of capacity: see the valuable analysis of Lord Goff of Chieveley in *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, 72-78. But he submits that the common law power to administer compulsory medical treatment to mental patients who are liable to be detained in a hospital has been impliedly removed by Part IV of the Act. He relies by analogy on the decision of the House of Lords in *B v Forsey* [1988] SLT 572. In that case, it was held that the powers of detention conferred on hospital authorities by the Mental Health Act (Scotland) Act 1984 are exhaustive, and that any power of detention which they might otherwise have possessed at common law have been impliedly removed by the statute. The provisions of the 1984 Act correspond, so far as material, with those of the 1983 Act. Lord Keith of Kinkel delivered the principal speech. At p 576 he said:

“In my opinion it is impossible to reach any other conclusion than that the powers of detention conferred upon hospital authorities by the scheme were intended to be exhaustive. Procedure is laid down for emergency, short term and long term detention. The period of short term detention might reasonably be expected to be long enough for an application for long term detention to be submitted to and approved by the sheriff under s.18. What happened in this case was that the petitioner’s condition appeared initially to be improving, so that an application under s.18 was not thought appropriate. Dr Mackay was of opinion that an application which turned out to be unnecessary would be upsetting and harmful to the patient. The petitioner’s condition suddenly and unexpectedly deteriorated, and by then it was too late to have an application submitted and approved before the expiry of the short term detention. That would appear to be a situation which was not in the contemplation of the framers of the legislation. However, I am of opinion that the provisions of ss.24(6), 25(5) and 26(7) are absolutely inconsistent with a possible view that the legislature intended that a hospital authority should have a common law power to detain a patient otherwise than in accordance with the statutory scheme. That 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. I would therefore hold that any common law power of detention which a hospital authority might otherwise have possessed has been impliedly removed.”

# By parity of reasoning, Mr Thorold submits that the powers of compulsory treatment conferred on hospital authorities by Part IV were intended to be exhaustive. Section 62(1) addresses the question of urgent treatment in terms. In these circumstances, there is no room for the operation of the common law doctrine of necessity to authorise the compulsory treatment of mental patients who are liable to be detained in hospital.

# The third point made by Mr Thorold is that, if the section 63 power is restricted to classified mental disorders, this will give rise to great practical difficulty in cases of comorbidity. Take a patient who suffers from mental disorder A (which by itself would justify detention in a hospital having regard to the criteria specified by the Act), and from mental disorder B (which by itself would not justify detention on the basis of those criteria). Mr Thorold submits that it would be unfortunate if the patient can only be treated for disorder A without his consent. Even worse if disorder B aggravates disorder A. Such an outcome cannot have been intended by Parliament. It is in my view unfortunate that the respondent has not adduced any evidence to explain how, and to what extent, if the judge’s construction of section 63 is wrong, this will cause real practical difficulty in cases of comorbidity. As it is, the court has had to make do with Mr Thorold’s assertions.

# He further submits that, if the judge’s construction is correct, a patient has considerable protection against the possibility of an abuse of the power conferred by section 63. Decisions under section 63 may be challenged by judicial review, and on such a challenge, the court is entitled to reach its own view as to whether the treatment amounts to an infringement of the patient’s human rights: see *R (Wilkinson) v Broadmoor Special Hospital Authority* [2001] EWCA Civ 1545, [2002] 1 WLR 419*.*

# I cannot accept Mr Thorold’s submissions, and in large measure for the reasons advanced by Mr Gordon QC. I do not think that Mr Thorold’s first (linguistic) point carries any weight. 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 section 63 authorises any forcible medical treatment for a non-classified mental disorder, even if it does not meet the emergency criteria stated in section 62(1). In my judgment, section 63 comes nowhere near to evincing a clear intention by Parliament to permit such treatment for non-classified mental disorder.

# 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.

# It seems to me, therefore, that the natural interpretation of section 63, when construed in its context, is that treatment (other than treatment falling within section 57 and 58) may be given without the patient’s consent, but only for classified mental disorders. It is at this point that it becomes necessary to examine Mr Thorold’s second and third submissions in order to see whether they cast doubt on the correctness of this interpretation.

# In my judgment, *B v Forsey* is distinguishable from the present case. It does not compel the conclusion that, if the section 63 power may only be exercised in relation to classified mental disorder, the hospital authority has no power at common law to treat urgent non-classified mental disorder. In *Forsey*, it was held, as a matter of statutory construction, that the Act of 1984 was exhaustive of the powers of detention in all circumstances, emergency, short term and long term. It followed that there was no room for a power to detain at common law in cases of emergency. Such a power would be truly concurrent with the statutory power, and had been excluded by the Act. But the position with regard to treatment under section 63 is quite different. The hypothesis under consideration is that section 63 may only be invoked in relation to a classified mental disorder. On that hypothesis, section 63 plainly is not exhaustive of the power to treat for mental disorder. It is only exhaustive of the power to treat for classified mental disorder. It simply does not touch non-classified mental disorder, because the Act is not concerned with such mental disorder, any more than it is concerned with physical illness. It follows that, if a non-classified disorder is diagnosed, and the patient needs emergency treatment to which he or she cannot or will not consent, the common law doctrine of necessity allows the hospital authority to give the treatment. There is no basis for saying that the common law doctrine of necessity has been removed by the Act in such circumstances.

# I should add for completeness that, in his skeleton argument, Mr Gordon also suggested that section 3 of the Act provides a further alternative solution to the problem where there is a need for emergency treatment of a non-classified mental disorder: the patient can simply be admitted under section 3. But section 5(1) specifies the circumstances in which a patient may be admitted under section 3 if he or she is already in hospital. These are where the patient is an informal in-patient, or is already detained under an application for assessment under section 2. They do not include the situation where the patient has already been detained under section 3 or 37. In these circumstances, I think that Mr Gordon was right not to pursue this point in oral argument.

# I turn to comorbidity (of which the present case is an example). The problem presented by comorbidity is inherent in the scheme of the Act. At the very outset, the doctors who recommend the patient’s admission for treatment have to decide which mental disorder(s) are of a nature or degree which “make it appropriate for the patient to receive medical treatment in a hospital” (section 3(2)(a)). Similar judgments have to be made by the doctor furnishing a report under sections 16 or 20, and by the tribunal when considering whether to direct a discharge under sections 72 or 73. If a separately identifiable mental disorder does not satisfy the statutory criteria for compulsory detention, the patient cannot be detained or treated against his or her will for that disorder. That applies at all stages of the process. Thus, the patient cannot be admitted by compulsion for such a disorder, and may not continue to be detained for treatment for that disorder if it ceases to satisfy those criteria. As for Mr Thorold’s example of disorder B (which alone does not justify detention) aggravating disorder A (which alone does justify detention), if treatment for disorder B is required to treat disorder A, it is difficult to see why treatment for disorder B is not ancillary to, and therefore a necessary part of, the treatment for disorder A. In *B v Croydon Health Authority* [1995] Fam 133, 138H Hoffmann LJ said:

“Nursing and care concurrent with the core treatment or as a necessary prerequisite to such treatment or to prevent the patient from causing harm to himself or to alleviate the consequences of the disorder are, in my view, all capable of being ancillary to a treatment calculated to alleviate or prevent a deterioration of the psychopathic disorder.”

# In the example just given, the classified disorder is disorder A, but this classification authorises treatment for condition B as part of the treatment for condition A. I accept that patients who suffer from more than one mental disorder present particular problems for those who are charged with the sensitive and difficult task of caring for and treating mental patients. But I am not persuaded that these problems compel a meaning of section 63 which is different from what I conceive to be its natural meaning.

# For these reasons, I consider that the judge misinterpreted section 63, and that the appeal should be allowed. But I should not stop here, since we heard considerable argument as to the purpose of classification, and as to the relevance of the decision of this court in *R v Anglia and Oxfordshire Mental Health Review Tribunal ex p Hagan* [2001] LLR Med 119.

# **The purpose of classification**

# This is directly relevant to the true construction of section 63, since, if that section permits compulsory treatment for any mental disorder which is diagnosed by the clinicians, whether it is classified or not, it is difficult to see what purpose is served by reclassification in sections 16, 20 or 72(5). It is true that sections 16 and 20 do not apply to the present case, since they have no application to restricted patients, but section 72(5) does apply to all patients liable to detention, and anyway section 63 applies indifferently as between restricted and unrestricted patients. If Mr Thorold is right, the purpose of reclassification is not to identify those mental disorders which justify a patient’s continued detention and for which compulsory treatment may be given. He is, it seems, unable to attribute any significant purpose to reclassification.

# In my view, it is clear that the elaborate provisions in the Act for classification and reclassification are intended to serve a real purpose. In *R v Pathfinder NHS Trust ex p Wey* 3 CCLR 271, the applicant was detained in hospital under section 3. His classified mental disorder was “mental illness”. His disorder was reclassified as “mental illness and psychopathic disorder” under section 16. The applicant appealed to the tribunal. The tribunal made an order under section 72(5) reclassifying his mental disorder back to “mental illness”. The appropriate medical officer then purported to exercise his section 16 power to reclassify his disorder yet again as “mental illness and psychopathic disorder”. The applicant sought judicial review of this last decision. The application succeeded before Kay J. The issue was whether, without a significant change of circumstances, the medical officer could make a classification decision which was in conflict with that of the tribunal. Kay J said that he could not do so. He said:

“If the effect of the Act is that, immediately afterwards and with no material change of circumstances, the doctor can re-exercise his powers under section 16, then the protection given for the patient is totally toothless and in no way affords any protection at all.”

# If Mr Thorold is right, the exercise of classification is not intended to provide the patient with any protection. Classification is irrelevant to treatment, since a patient may be treated for any mental disorder under section 63. It is at this point that I need to consider *Hagan*.

# In that case, the applicant was a restricted patient. The hospital order specified that he was suffering from mental illness and psychopathic order which were of a nature or degree which made it appropriate for him to be detained in a hospital for medical treatment. In other words, it was a comorbidity case where, at the admission stage, both mental disorders were classified. The applicant applied to the tribunal to be discharged under section 73. The tribunal refused to discharge him. It found that he continued to suffer from the psychopathic disorder, which continued to be of a nature and degree that required his detention in hospital for his own health and safety, and for the protection of others. It also found that the applicant continued to suffer from the mental illness, which was at that time in remission, but that the mental illness taken alone would not justify his being detained. Nevertheless, the tribunal decided not to exercise its power under section 72(5) to reclassify so as to remove from the hospital order the reference to the mental illness. The applicant argued that, in view of its findings, the tribunal was bound under section 72(5) to delete the reference to mental illness in the hospital order. This argument prevailed before Collins J. The tribunal succeeded on appeal before Lord Woolf MR, Waller and Chadwick LJJ.

# The principal judgment was given by Waller LJ. The central question for the court was whether on the facts of that case the tribunal had a discretion or was under a duty to reclassify pursuant to section 72(5), by deleting mental illness on the grounds that it was a mental disorder which would not by itself justify detention. The court held that the tribunal had a discretion. It is necessary to examine the reasoning of Waller LJ’s judgment in a little detail. At para 19, he recorded the submission of Mr Gordon (who appeared for the applicant in that case) that it is not lawful to treat a patient compulsorily for any form of mental disorder other than one that is classified: the very submission that he makes on the present appeal. Waller LJ said that it was unnecessary to decide whether this submission was correct, and that it was “probably better to leave final resolution to a case where it is directly in issue”.

# He then turned to the question of reclassification and its purpose. At para 22 he said:

“There is force in Mr Gordon’s submissions that there should be some touchstone for the use of compulsory powers both of detention and treatment. Nor do I dissent from the view that reclassification is a means whereby that touchstone can be kept under review. Furthermore, I have no doubt that the requirement that there must be at least one common mental disorder as between two medical practitioners before an application is effective, is the touchstone for detention under section 3, but it clearly is not in one sense the touchstone for treatment in that instance because under section 16 one report from the appropriate medical officer stating that the patient is suffering from a different form of mental disorder will lead to the application being deemed to contain that different form.”

# He then considered (still in para 22) what the position would be if the appropriate medical officer were of the opinion that the applicant (a) continued to suffer from a mental illness which did not alone justify detention, but (b) also suffered from a psychopathic disorder which did justify detention. Waller LJ said that in such circumstances the medical officer would not be able to reclassify under section 16 because “it would not be appearing to the appropriate medical officer that the patient was suffering from a form of mental disorder other than the form or forms specified in the application”. He added that he did not see any warrant for implying a duty on the medical officer “to delete a mental disorder from which the patient suffers and may need treatment, albeit that mental disorder *alone* might not justify detention”. He then considered the position of restricted patients, and said that he derived assistance in construing section 72(5) from the civil context ie the position under section 16.

# At para 24, he said:

“That leads me to the conclusion that reclassification is not simply about defining those mental illnesses in the sense of making sure that the document authorising detention only contains references to the forms of mental disorder when taken on their own would justify detention. I accept that the document authorising detention, whether it be an application or an order of the court, is the starting point for authorising the powers under the Mental Health Act. But reclassification in my view does not involve an obligation to remove from that order a form of mental disorder from which a patient still suffers.”

# He summarised his overall conclusions as follows:

“25. First, the primary purpose of section 72(5) is to enable a Tribunal which has concluded that the form of mental disorder which requires the patient to continue to be detained is different from the form of mental disorder specified in an order (or an application or direction), to substitute that mental disorder so as to in effect correct the order to accord with the position as it is now known to be.

26. Second, reclassification in the civil context under section 16, would not have taken place if the conclusion of the medical officer was that Mr Hagan still suffered from mental illness albeit it was in remission, and in the result in the civil context (a) the application would still have specified mental illness, and (b) whatever section 63 means, treatment for mental illness could continue to be compulsorily administered. Section 72(5) ought to be construed as providing the Mental Health Tribunal with a discretion so that they are not obliged to reclassify Mr Hagan in a way different from that which he would have been classified as a civil patient.

27. In addition, in the context of section 37 and section 41, section 72(5) ought to be construed as giving the Mental Health Tribunal a discretion not to delete a mental disorder from which a patient still suffers where deletion might frustrate their powers in relation to conditional discharge in the future.

28. Reclassification relates to whether the patient suffers from a particular mental disorder, not to whether he is detainable for that mental disorder if it stood alone.

29. It is possible that if the conclusion was that a patient no longer suffered from a form of mental disorder previously specified in the order at all, that deletion in circumstances where substitution was not required would be permissible, but that is not this case.

30. The judge put Mr Gordon’s submissions in this way:

In short, what Mr Gordon’s submissions boil down to is this. The purpose of classification, whether it be in an application or in an Order, or indeed any other formal document, is to show the basis for the detention of the relevant person. It is, as it were, akin to a warrant or a Court Order justifying detention in, for example, a prison, because detention in a mental hospital is as much a deprivation of liberty as detention in any other sort of institution. Such a detention must be justified. The document shows third parties why a person is being detained and, therefore, should contain, and contain only, the reference to the form of mental disorder which justifies any current detention.

It will be noted that he commences with the words “purpose of classification”. I do not dissent from the view that at least part of the purpose of classification in the original form of application, and the court order under section 37 is to show the basis for the detention and at least part of the purpose is to identify the mental disorder for which compulsory treatment is needed (albeit the treatment aspect was not much pursued before the judge). It also seems to me that the reason why under section 16 a report may generate some other form of mental disorder being specified in the application has to do with the lawfulness or otherwise of continued detention pursuant to an application, and the purpose of substitution under section 72(5) has to do with ensuring that the order correctly reflects a basis for detention. But it does not follow in either case that the purpose of reclassification is to ensure that there is not described in the application or order a form of mental disorder from which the patient suffers and may need treatment if he continues to be detained on the basis of another form of mental disorder. Indeed the ordinary application of section 16 leads to that conclusion, and there is no reason why the Tribunal, under section 72(5), should be obliged to reach a different conclusion.

31. Thus the judge was wrong to accept the submission that the purpose of reclassification wherever it appeared in the Mental Health Act was to ensure that there was not described in the application or the order a mental disorder from which the patient suffered but which would not on its own justify detention. In particular it seems to me the judge was wrong to accept the submission that the purpose of reclassification under section 72(5) was to describe accurately the basis on which the patient was lawfully detained. The patient was lawfully detained under an order of the court, and there was nothing inaccurate in describing him as being lawfully detained on the bases specified in the order. Furthermore, there is no warrant in my view for reading into the section that it is “incumbent upon [the Tribunal] to reclassify if it decides that one of the current forms of mental disorders, from which the patient is suffering which is contained in the order or application or direction which has led to his detention, is no longer appropriate … because the relevant mental illness is not of a nature or degree which makes it appropriate for him to receive medical treatment” where the conclusion of the Tribunal is that for another reason the patient is to be detained. Of course if the conclusion relating to the mental illness related to the only basis for detention, reclassification would not be appropriate but discharge either absolutely or conditionally would follow.

32. I would finally add that there is in my judgment possibly a short answer to this case even accepting much of Mr Gordon’s submissions. 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. Clearly there could be no criticism of the Tribunal’s refusal to reclassify so as to delete the mental illness if that was their view.”

# Mr Gordon submits that *Hagan* was wrongly decided. He contends that the court should have held that classification is the touchstone for both detention and treatability, and that the decision of Collins J was correct. He submits that it is open to this court not to follow *Hagan* since that decision was made before the Human Rights Act 1998 came into force, and without reference to the European Convention on Human Rights. He nevertheless submits that the decision in *Hagan* is no bar to his appeal in the present case, since the court expressly refused to decide the point that arises here, namely whether it is lawful to treat a patient compulsorily for any form of mental disorder that is not classified (see para 19 of the judgment). .

# Mr Thorold submits that *Hagan* was correctly decided, but he does not contend that the answer to the question that arises in the present case is provided by *Hagen*. Counsel are, therefore, agreed that *Hagan* is not determinative of the section 63 question. Nevertheless, it seems to me that at least some of Waller LJ’s reasoning is relevant to that question.

# I confess, with the greatest of respect, that I am unable to agree with some of that reasoning. The court in *Hagan* seems to have been of the opinion that classification is the touchstone for detention, but not necessarily for treatability. Waller LJ states in various places that it is the touchstone for detention. Thus at para 25, he says that the primary purpose of section 72(5) is to enable a tribunal which has concluded that the form of disorder which requires a patient to continue to be detained is different from the classified disorder to make a substitution “so as in effect to correct the order to accord with the position as it is now known to be”. And at para 30, he says that (a) “at least part of the purpose” of an original classification is to show the basis for detention; (b) the reason why a section 16 report may reclassify a mental disorder “has to do with the lawfulness or otherwise of continued detention pursuant to an application”; and (c) the purpose of substitution under section 72(5) “has to do with ensuring that the order correctly reflects a basis for detention”. In these passages, Waller LJ is clearly saying that the reason for a reclassification under sections 16 or 72(5) is to provide a touchstone for lawful detention: to ensure that the application or hospital order (as the case may be) accurately describes the mental disorder which justifies the patient’s lawful detention in hospital.

# As to whether classification provides the touchstone for treatability, Waller LJ sees force in the submission that it does (para 22); and at least part of the purpose of the original classification is “to identify the mental disorder for which compulsory treatment is needed” (para 30). But this did not require the removal from the order of a form of mental disorder from which a patient still suffers, even though that would not by itself justify detention (para 24).

# It seems to me that two factors played a considerable, and perhaps decisive, part in the conclusion expressed in para 24 to which I have just referred. First he was of the opinion that an appropriate medical officer cannot reclassify under section 16 if he considers that one of two classified disorders no longer satisfies the section 3(2) criteria (para 22). This led to his point (also in para 22) that there was no warrant for adding by implication some duty on the medical officer to delete a mental disorder from which the patient suffers and may need treatment, albeit that this mental disorder alone might not justify detention. But I do not see why the medical officer cannot reclassify in such a case (see para 21 above). At the outset, there are two classified disorders A and B. The medical officer now considers that there is only one, A. It appears to him that the disorder from which the patient is suffering (A) is “other” than the disorders which were specified in the application form (A and B). The importance of Waller LJ’s opinion as to the scope of section 16 in the reasoning that led to his conclusion about the meaning of section 72(5) is evident from para 26 and the last sentence of para 30 of his judgment.

# The second important factor in Waller LJ’s reasoning is the concern expressed at para 19 about the implications of accepting Mr Gordon’s submissions as to the meaning of section 63. Waller LJ speaks of an “unsatisfactory state of affairs” if the tribunal were bound to delete mental illness from the order since (1) the hospital could not treat the patient compulsorily so as to keep his mental illness in remission, and (2) even more worryingly, “could not treat him compulsorily if the mental illness came out of remission until they had gone through the Secretary of State route to get the order re-amended”. No reference is made to the possible recourse to the power to treat under the common law doctrine of necessity. It would seem that the relevance of this power was not brought to the attention of the court.

# Waller LJ acknowledges that part of the purpose of classification is to identify the mental disorder for which compulsory treatment is needed. I respectfully agree. But in my view the corollary is that it is not the purpose of classification to identify a mental disorder for which compulsory treatment is not needed.

# In my judgment, the better view of sections 16, 20 and 72(5) is that, where a classified mental disorder ceases to meet the section 3(2) or 37(2) criteria, then there should be a re-classification to delete the disorder from the application for admission or hospital order as the case may be. For the reasons that I have given, neither of the factors which seem to have led the court in *Hagan* to its conclusion as to the meaning of section 72(5) justifies that conclusion.

# It follows that I do not feel able to agree with the reasoning that led the court to allow the appeal in *Hagan*. I do not, however, find it necessary to say that it was wrongly decided. In my view, the correct basis for allowing the appeal in *Hagan* was identified by Waller LJ in para 32 of his judgment. It is not, therefore, necessary to consider Mr Gordon’s submission that *Hagan* can no longer be regarded as good law since the Human Rights Act 1998 came into force.

**Conclusion**

# For the reasons given earlier, the natural and correct interpretation of section 63 is that it permits compulsory medical treatment only for classified mental disorders. Were it otherwise, the carefully drafted provisions for reclassification in section 16, 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.

# In my opinion, this appeal should be allowed.

# **Lord Justice Scott Baker:**

# I have had the advantage of reading in draft the judgments of my Lords and I agree with them. Detention in a mental hospital is something that the law permits only if the specified conditions are satisfied. I can see no reason why a patient should ordinarily be subjected to treatment without his consent for a condition that does not justify his detention. That this is the position under the Mental Health Act 1983 is in my view clear from the careful analysis of the Act by Dyson L.J.

# I cannot see that our conclusion should present an insuperable problem for the treating doctors. Where a patient is suffering from more than one form of mental disorder justifying detention it will be important for him to be classified accordingly and tribunals will need to keep this in mind. I also see the force of Dyson LJ’s point at para 46 that there will be circumstances where treatment for disorder B is required to treat disorder A, and it is difficult in such a case to see why treatment for disorder B is not ancillary to, and therefore a necessary part of, the treatment for disorder A.

# I too would allow the appeal.

# **Lord Justice Simon Brown:**

# I too would allow this appeal for the reasons given by Dyson LJ but because of the obvious importance of the case and because our decision may be thought to sit somewhat uneasily alongside that in *R -v- Anglia & Oxfordshire Mental Health Review Tribunal ex parte Hagan* [2001] LLR Med 119, I want to add a few words of my own.

# Dyson LJ at paragraph 16 above set out to show, and later in his judgment plainly does 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.”

# That theme of itself to my mind calls into question the correctness of parts at least of the reasoning in *Hagan* if not the actual result there arrived at. 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. That, however, is not directly the question raised on this appeal. Rather the question here is whether, assuming the patient to be lawfully detained, he can thereafter be compulsorily treated for any mental disorder diagnosed by his RMO or only for such disorder(s) as he is at that time classified to be suffering from.

# It is the respondent’s submission (and here I quote Mr Thorold’s skeleton argument) that:

“The primary purpose of classification under the 1983 Act is to establish a legal basis for detention, and to indicate which diagnoses are in issue at a Mental Health Review Tribunal, not to limit the permissible limit of treatments which can be given to the specified disorders.”

# In common with my Lords, that is not a submission I feel able to accept. I explained in *R (Wilkinson) -v- Broadmoor Hospital Authority* [2002] 1 WLR 419, 426, at paragraph 9, the scheme for compulsory treatment under the 1983 Act:

“9. … Detention under the Act does not of itself authorise treatment without consent. It is not sufficient merely that the patient was admitted (and indeed remains detained) because his condition was regarded as treatable. Compulsory treatment must be authorised if at all under part IV of the Act. As s.63 makes plain, it is a pre-requisite of such treatment that it shall be given "for the mental disorder from which [the patient] is suffering". Without that it will be unlawful in any event. Ss.57 and 58 then provide a range of safeguards graded to reflect the severity of the various treatments which may be contemplated. S.57 (not here directly in point) is concerned with surgery for destroying brain tissue or other forms of severe and perhaps irreversible treatment prescribed by the Secretary of State and it precludes any such treatment being given compulsorily. Rather it requires both the patient's capacitated consent, which must be certified to be valid by a panel of three persons including a SOAD, and also the SOAD's certified approval for such treatment having regard to the likelihood of it assisting the patient's condition. S.58 applies to two defined forms of treatment for mental disorder: ECT and long-term medication. These are forbidden save - and thereby, taken in conjunction with s.63, permitted only - upon the stipulated conditions. These are that the patient has either (a) given a capacitated consent, so certified by the RMO or a SOAD, or (b) not given such a consent (or, indeed, indicated a capacitated refusal) but the SOAD, having consulted with two others as required, has nevertheless certified that the treatment should be given.”

# We are not here concerned with s57 (which, in any event, as provided by s56(2), applies “also to any patient who is not liable to be detained under this Act”) because, subject only to the requirement for urgent treatment as defined in s62, it requires in every case the patient’s capacitated consent. Section 58 (also subject to s62), however, does not always require the patient’s consent so that, were Mr Thorold’s submission correct, 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.

# Two important considerations should be borne in mind when construing s63: 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?

# I add only this. The Tribunal’s decision here was made on 8 May 2001, well after this court’s judgment in *Hagan* and presumably with that case in mind. It may be doubted whether in those circumstances, given that the Tribunal found the appellant still liable to be detained on the ground of mental illness, they thought it necessary to give serious consideration to the exercise of their s72(5) power to re-classify him as suffering also, assuming they thought he was, from a psychopathic disorder. To my mind, indeed, if one looks at the totality of the reasoning for their decision, it seems tolerably clear that they did not. Dyson LJ in paragraph 9 above has set out the first part of the Tribunal’s reasoning. It continued as follows:

“The RMO gave evidence in accordance with his report and its addendum. He was emphatic that the patient had improved over the last 18 months. That had allowed greater engagement with the care team. The patient was still ill, and without medication and the structured care of the hospital, would relapse. The RMO outlined a pattern of treatment which he considered should be put in hand before a transfer could be considered. The risk factor was difficult to assess but was real.

Dr Scholey and Mrs White gave evidence emphasising that of the RMO.

Professor Sashidharan considered that the mental illness was controlled by the medication and that the patient’s outbursts in past years were due to the culture from which he came reacting against the regime of the hospital, rather than mental illness. However, the Professor was specific that the patient wherever he was, must continue medication for fear of a relapse.

Mr Bromley echoed the Professor’s view that some of the patient’s behaviour was due to growing up in a criminal subculture, but agreed that the patient presented some risk, not readily quantifiable.

The patient was courteous and articulate. He was anxious to say that the suffered no mental illness and had not for many years. Questioned, he said that although mad at the time of the offence, he had already recovered by the time he came before the Crown Court for sentence. He would take medication if it was enforceable but not otherwise.

We note that the patient has made progress over the past year or two, but much work remains before a transfer would be appropriate.”

# Had the Tribunal appreciated that it would be unlawful to treat the appellant compulsorily in a personality disorder ward without re-classifying him as suffering from that disorder - indeed, that he was already being unlawfully treated in such a ward - it may be supposed that they would have addressed the issue of re-classification altogether more directly, rather than merely appearing to approve the RMO’s proposed pattern of future treatment.

# 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.

# These observations, however, cannot affect the outcome of the present appeal. Clearly it succeeds so that unless and until the appellant is hereafter re-classified by a Tribunal as suffering also from a psychopathic disorder it will not be lawful to continue his treatment for that condition.