Connecting mental disorders to physical ones: an autonomy-centric reform of nonconsensual treatment under S63 of the Mental Health Act 1983

As of March 2016, 25,577 patients were subject to the Mental Health Act 1983 (MHA).[1] S63 MHA subjects the vast majority of these patients to a power allowing clinicians to administer nonconsensual treatment for their mental disorders. Problematically, the courts have repeatedly held that S63 extends to treatment for physical disorders. The tests that have been proposed to determine when treatment for physical disorders falls within S63's scope have generally been either vague or unacceptably broad. In this regard, English law is currently unsatisfactory.

Respect for patient autonomy is a key tenet of medical law. A patient should not be subjected to treatment which she has validly and competently refused. Despite the paternalistic desire to permit administration of a wide range of treatment to mental health patients, their vulnerability should not inappropriately compromise the respect for autonomy. If too broad an approach is taken to S63, unnecessary treatment may be administered despite a patient's competent refusal, violating his or her autonomy. If S63's scope is unclear, NHS Trusts are more likely to seek court declarations that their treatment plans are lawful. This delays appropriate treatment and places additional pressure on the judicial system. The 2013 case of *An NHS Trust v Dr A*[2] represents the correct approach to S63's scope. Problematically, it is not currently reflected in statute. This essay will propose reform by suggesting the addition of a provision to the MHA which sets out when physical disorders may be treated under the Act, in line with *Dr A*.

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[1] National Health Service, *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment - Uses of the Mental Health Act: Annual Statistics, 2015/16* (NHS Digital, 2016).

[2] [2013] EWHC 2442 (COP).

The need for reform

S63 MHA reads: "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...".[3] Since the Mental Health Act 2007 ("the 2007 Act"), S145(4) MHA defines "treatment... for the mental disorder" as "medical treatment the purpose of which is to alleviate, or prevent the worsening of, the disorder or one or more of its symptoms or manifestations".[4] A power to treat patients' mental disorders appears justifiable, considering that mental health patients are at risk of harming themselves or others. However, because mental disorders often cause, or present themselves alongside, physical disorders, it is necessary to clarify whether - and when - the MHA allows treatment of physical disorders. Both S63 and S145(4) have been the subject of several cases, in particular regarding the test determining when physical disorders may be treated under S63.

It was Hoffmann LJ in *B v Croydon Health Authority*[5] who first held that S63 could include "ancillary"[6] treatment for patients' physical disorders (such as force-feeding to treat malnutrition) as long as such treatment was not "entirely unconnected with the mental disorder"[7]. While *Croydon* declares that the mental and physical disorders must be connected for the latter to be treated under S63, it does not define that connection, leaving this test unhelpfully vague. *Tameside & Glossop Acute Services NHS Trust v CH*[8] stretched this test "beyond all expectations"[9]. Wall J held that S63 authorised a Caesarean section for a pregnant patient because "a successful outcome of [the]

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[3] Mental Health Act 1983 (MHA 1983) s 63.

[4] MHA 1983 s 145(4).

[5] [1995] Fam 133 (QB).

[6] ibid 139.

[7] ibid.

[8] [1996] 1 FLR 762 (Fam).

[9] Judith Laing and Nicola Glover-Thomas, 'Mental Health Law' in Andrew Grubb, Judith Laing and Jean McHale (eds), *Principles of Medical Law* (3rd edn, OUP 2010) 627.

pregnancy [was] a necessary part of the overall treatment for her mental disorder".[10] As Dolan and Parker correctly suggest, *Tameside* proposes that "treatment for the physical condition [must be] necessary for the treatment of the mental disorder to take place"[11] to fall within S63's scope. This is a deeply unsatisfactory interpretation; it permits overriding patient autonomy to administer a staggering range of treatment on the basis that patients must be alive, or healthy, to receive treatment for their mental disorders. Such a broad reading of S63 "[fails] to maintain a clear distinction between treatment for mental disorder and treatment for physical disorder", and leads to "misuse of the [MHA]".[12]

Kay J later proposed a different test in *R v Collins and Ashworth Hospital Authority, ex parte Brady*.[13] Ian Brady's hunger strike was held to be "because of [Brady's] personality disorder"[14], and was a "manifestation or symptom of the personality disorder"[15]. It could therefore be treated with artificial nutrition and hydration (ANH) under S63. It was irrelevant that "a person without mental disorder could reach the same decision on a rational basis".[16] *Brady* proposes that if the mental disorder more than "[minimally] or [insubstantially]"[17] contributes to a decision leading to a physical disorder, that disorder can be treated under S63. This test fails to recognise the distinction drawn in *Re C (Adult: Refusal of Medical Treatment)*[18] between irrational decisions and ones which patients lack capacity to make. The *Brady* test would be problematic in scenarios where mental

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[10] *Tameside and Glossop Acute Services Trust v CH* [1996] 4 Med L Rev 193, 195.

[11] Bridget Dolan and Camilla Parker, 'Caesarean section: a treatment for mental disorder?' (1997) 314 BMJ 1183, 1184.

[12] ibid.

[13] [2000] EWHC 639 (Admin).

[14] ibid [44].

[15] ibid.

[16] ibid.

[17] ibid [43].

[18] [1994] 1 W.L.R. 290 (Fam).

health patients retain capacity to refuse treatment (such as *Re C*), and should be considered unduly broad.[19]

Dr A was the first significant case after the 2007 Act, and attempted to resolve S63's "absence of clarity"[20]. Dr A was detained under the MHA for a delusional disorder, and subsequently refused food. Baker J held that ANH for Dr A's malnutrition "[would not make] a difference to [Dr A's] underlying mental state".[21] Thus, even though the malnutrition could be said to be caused by Dr A's mental disorder, ANH could not be considered treatment for the mental disorder under S63. *Dr A* proposes that in order to fall within S63's scope, the treatment of a physical disorder must make a difference to the patient's underlying mental state. This test is not without caveats; defining a "difference in mental state"[22] may be best left to medical opinion.

For its restrictive approach alone, this should be considered the correct approach to S63. Baker J stated that a wider approach would unacceptably permit treatment of physical disorders "only incidentally connected to the mental health disorder".[23] His focus on confining "treatment given under S63... to that which is properly within the definition of section 145 as amended [by the 2007 Act]"[24] desirably enshrines the principle of respect for autonomy. Emphasising effects on a patient's mental state also reflects the plain meaning of the statute. Treating a mental disorder means lessening its severity, which is evidenced by the degree of its mental effects. Therefore, a

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[19] In *Re C*, C suffered from delusions which influenced his irrational decision to refuse an amputation. However, these delusions did not affect his capacity to make the decision to refuse treatment - as a result, his refusal was valid. If the test in *Brady* is adopted, an opposite conclusion to the one in *Re C* would be reached in similar circumstances. This is inconsistent with the fact that *Re C* was explicitly distinguished in *Croydon* because the treatment (the amputation) in that case was "unconnected" to the mental disorder.

[20] *Dr A* (n 2) [76].

[21] ibid [74].

[22] ibid.

[23] ibid [76].

[24] ibid [80].

"treatment... for the mental disorder"[25] is properly one which affects the patient's mental state. Furthermore, a mental disorder's "symptoms or manifestations"[26] are compulsions or other effects on the patient's behaviour; alleviating them or prevent their worsening naturally requires changes in the patient's mental state.

However, in the subsequent case of *Nottinghamshire Healthcare NHS Trust v RC*[27], a Jehovah's Witness with self-harming tendencies refused a blood transfusion after self-lacerating. Mostyn J acknowledged that "if [he] were confined to the literal words of sections 63 and 145(4)"[28] the transfusion could not be treatment for the mental disorder. He nevertheless held that S63 could authorise the transfusion. However, the Trust could (and did) lawfully withhold the transfusion in light of the patient's valid refusal. Mostyn J's resistance of the MHA's "literal words"[29] in *RC* leaves the door open for future expansions of S63's scope, which would further depart from Baker J's restrictive approach and the MHA's plain meaning.

The scope of S63 as written and refined by S145(4) is unclear. The common law is inconsistent, and - *Dr A* excepted - has created unhelpful or unacceptable tests. Considering also that *RC* appears to resist *Dr A*'s properly restrictive view, it is imperative to define S63's scope in a clear and desirable manner. The most practical solution is not to add a new mechanism to the law, but to clarify the existing provisions of the MHA. The *Dr A* position should thus be reflected in statute, both for the sake of clarity, and in order to give a restrictive reading of S63 more weight.

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[25] MHA 1983 s 63.

[26] MHA 1983 s 145(4).

[27] [2014] EWHC 1317 (COP)

[28] ibid [30].

[29] ibid.

The proposed reform

This essay suggests amending the MHA by adding the proposed S145(4A) below:

> "(4A) In relation to subsection (4) above, medical treatment, in relation to mental disorder, can include the treatment of physical disorders only if such treatment is likely to have an effect on the patient's underlying mental state in a manner which is relevant to the disorder for which the patient is detained under this Act."

This reform leaves the power in S63 unchanged. However, it modifies S145(4), which defines medical treatment for the purposes of S63. The proposed reform codifies a test determining when physical disorders may be treated under S63, resolving the uncertainty caused by the wording of the MHA and case law on its interpretation. This test also reflects the *Dr A* approach that treating physical disorders can only be considered treatment "for the mental disorder"[30] if it has an effect on the patient's underlying mental state.

The proposed reform also helps the UK discharge its obligations under the European Convention of Human Rights (ECHR). The positive operational duty under Article 2 ECHR to protect the right to life includes the proper use of statutory powers under the MHA.[31] Accordingly, defining S63's scope allows greater clarity and efficiency in discharging the operational duty. Further, the European Court of Human Rights (ECtHR) in *X v Finland*[32] held that involuntary medical treatment flowing automatically from detention under mental health legislation without substantive and procedural safeguards was incompatible with Article 8 ECHR respect for private life. S63, which automatically allows nonconsensual treatment of detained patients without any apparent safeguards, thus appears inconsistent with Article 8 ECHR. While the proposed reform does not

[30] MHA 1983 s 63.

[31] *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2.

[32] [2012] ECHR 1371.

completely resolve this incompatibility, it narrows S63's applicability, which reduces the severity of the inconsistency.

A defence of the proposed reform

The most immediate counterargument against the proposed reform is that it unduly restricts S63, preventing clinicians from administering necessary treatment. For instance, the proposed reform might counterintuitively exclude ANH in anorexia nervosa cases. However, patients who are detained under the MHA remain subject to the Mental Capacity Act 2005 (MCA). This provides a framework under which mental health patients' physical disorders can properly be treated, even in cases where treatment would be excluded under the proposed subsection 4A. Although deprivation of liberty safeguards (DoLS) at the MCA-MHA interface could present a practical obstacle to the administration of MCA treatment to mental health patients, both commentators and the Law Commission have provided ways to mitigate or remove this obstacle.

S2(1) MCA provides the diagnostic limb of the test for capacity:

> "a person lacks capacity... if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain".[33]

S3(1) MCA provides the second, functional limb of the test:

> "[A] person is unable to make a decision for himself if he is unable—
> (a) to understand the information relevant to the decision,
> (b) to retain that information,

[33] Mental Capacity Act 2005 (MCA 2005) s 2(1).

(c) to use or weigh that information as part of the process of making the decision, or

(d) to communicate his decision (whether by talking, using sign language or any other means)."[34]

Taking Sections 2 and 3 MCA together, if an impairment of mental functioning causes a patient to be unable to understand, retain, or use or weigh information relevant to a decision to accept treatment, or to communicate that decision, then she lacks capacity to consent to or refuse that treatment. Treatment can then be administered in her best interests.

Patients detained under the MHA self-evidently have mental disorders. This means that they satisfy[35] the diagnostic requirement for "an impairment of, or a disturbance in the functioning of, the mind or brain"[36]. Many of the compulsions that mental health patients experience have also been held to affect their ability to use or weigh information relevant to making decisions about their treatment.[37] It is highly likely[38] that mental health patients will lack capacity to make decisions where compromised by their mental disorder. The MCA would then operate to allow treatment in the patient's best interests. Determining patients' best interests usually prioritises medical interests, especially in favour of preserving life. [39] Although in *Re X*[40] ANH was held not to be an anorexic's best interests, if ANH were administered "there [was] a 95-98% chance that she [would] spend a

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[34] MCA 2005 s 3(1).

[35] Department for Constitutional Affairs, *Mental Capacity Act 2005 Code of Practice 2007* (TSO, 2007) para 4.12.

[36] MCA 2005 s 2(1).

[37] In *Re E (Medical Treatment Anorexia)* [2012] EWHC 1639 (COP), the compulsions caused by anorexia nervosa affected the patient's ability to use or weigh the relevant information; she thus lacked capacity to decisions concerning food. More tangentially, in *Dr A*, Dr A was detained for a delusional disorder, and lacked capacity to refuse food. This was not because of a compulsion to refuse food but rather because his delusions rendered him unable to use or weigh relevant information concerning the consequences of refusing food.

[38] *Mental Capacity Act 2005 Code of Practice 2007* (n 35) para 4.22.

[39] *Dr A* (n 2) [53].

[40] [2014] EWCOP 35.

miserable time being forcibly fed before she then [died]"[41]. Considering that medical interests are generally set aside only in exceptional cases, it is highly likely that patients will receive appropriate treatment.

The proposed reform, therefore, does not compromise, but rather reinforces, the ability to properly treat patients. The MCA allows treatment for physical disorders which is excluded under the proposed subsection 4A, but which is required by, and in the best interests of, mental health patients due to their lack of control over certain actions and thoughts, leading to a lack of capacity. These physical disorders are irrelevant to the mental health of the patient, and therefore should not be a matter for the MHA. For instance, in *RC* S63 could have potentially authorised the blood transfusion despite RC's capacitous religious refusal, as well as his advance refusal of blood products. This would have grossly violated RC's autonomy. The Trust correctly decided not to administer the transfusion because it would have been an "abuse of power"[42]. If the MHA were reformed as proposed, on similar facts to *RC*, the transfusion would be outside the scope of S63. Treatment would also not be possible under the MCA because of the patient's capacitous refusal. The same outcome - withholding treatment - would be reached, but without the possibility of abusing the S63 power to cause a violation of patient autonomy.

Where the MCA is used, however, treating mental health patients without consent usually requires restraint. This engages the MCA's DoLS, which are procedural and substantive safeguards preventing arbitrary violations of patients' right to physical liberty under Article 5 ECHR. *Dr A* highlighted a legislative gap which makes restraining MHA-detained patients for MCA treatment impossible without violating their Article 5 ECHR rights. S16A MCA reads: "If a person is ineligible to be deprived of liberty by this Act, the court may not include in a welfare order provision

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[41] ibid [56].

[42] *RC* (n 27) [42].

which authorises the person to be deprived of his liberty."[43] Schedule 1A MCA provides that an MHA patient, P, is "ineligible"[44] for the purposes of S16A if, *inter alia*:

> "P is -
>
> (a) subject to the hospital treatment regime [of the MHA], and
>
> (b) detained in a hospital under that regime."[45]

The effect of this, as shown in *Dr A*, is that it is "impossible for [P] to be treated [under the MCA]... outwith his "treatment" under the MHA if that treatment involves a deprivation of liberty".[46]

Since *Dr A*, where the S16A gap would render a patient unable to be treated, an application for a court order under the inherent jurisdiction is necessary.[47] Because the proposed reform increases the use of the MCA to treat MHA-detained patients, the number of cases where an application is necessary will likely increase. An astute counterargument against the proposed reform is thus that the greater volume of applications to the courts counterproductively increases strain on the judicial system. While this is a valid point, commentators and the Law Commission have suggested ways to deal with the S16A gap.

The Law Commission's recent report on Mental Capacity and Deprivation of Liberty[48] and draft Mental Capacity (Amendment) Bill specifically addresses the S16A gap. As Ruck Keene

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[43] MCA 2005 s 16A.

[44] ibid.

[45] MCA 2005 sch 1A.

[46] *Dr A* (n 2) [67].

[47] ibid [96].

[48] Law Commission, *Mental Capacity and Deprivation of Liberty* (Law Com No 372, 2017).

explains, the draft Bill suggests eliminating the gap by repealing S16A.[49] If the draft Bill were passed, authorising treatment for an MHA-detained patient under the MCA regime would not require navigating a legislative gap. This is the simplest and most effective solution, and would allow the proposed subsection 4A to operate without any practical difficulty. In the interim, or should the Bill not be accepted by Parliament, commentary from 39 Essex Street suggests that the 'residual liberty' jurisprudence of the ECtHR provides a better solution to the legislative gap than the inherent jurisdiction.[50] Under this approach, patients detained under the MHA retain a measure of residual liberty. If the restraint required to administer MCA treatment deprives a patient of that residual liberty, then S16A renders her ineligible to be restrained. However, if it does not deprive the patient of residual liberty, the restraint would amount to a variation in the conditions of her MHA detention, and would not engage S16A ineligibility. While applications might still have to be made in complex cases, adopting the concept of residual liberty would be an improvement over the use of the inherent jurisdiction, which essentially makes applications mandatory.

The proposed reform would require the use of the MCA to treat MHA-detained patients' physical disorders. This could exacerbate the practical difficulties in restraining and treating patients caused by the S16A gap. However, either adopting the draft Bill or following ECtHR residual liberty jurisprudence would mitigate, or remove, this problematic area of the MCA-MHA interface, allowing the proposed reform to restrict the scope of S63 MHA without compromising the ability to administer treatment which is in patients' best interests.

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[49] Alexander Ruck Keene, 'Mental Capacity and Deprivation of Liberty: the Law Commission report and draft Mental Capacity (Amendment) Bill 2017' (Presentation at the 39 Essex Street Breakfast Briefing: Law Commission Mental Capacity and Deprivation of Liberty Report and draft Bill, 14 March 2017) <https://app.box.com/s/fcevig19t9ryzknfppwovbkga5dkguw4> last accessed 19 September 2017.

[50] 39 Essex Chambers, 'A NHS Trust v Dr A' (*39 Essex Chambers*, March 2013) <http://www.39essex.com/cop_cases/a-nhs-trust-v-dr-a/> last accessed 18 September 2017.

Conclusions

There is no doubt that mental health patients sometimes require treatment for physical disorders, occasionally without their consent. However, not all such procedures can be properly considered treatment for their mental disorders. This essay has posited that a restrictive approach to S63 MHA is correct. The proposed reform codifies such an approach. It decreases the possibility of clinicians forcibly administering, under the guise of mental health treatment, procedures which are irrelevant to a patient's mental disorder. By clearly delineating the scope of S63, the proposed reform also reduces confusion in discharging the Article 2 ECHR operational duty, and lessens the severity of the MHA's incompatibility with Article 8 ECHR. It has further been advanced that the MCA, the Law Commission's draft Bill, and ECtHR jurisprudence can counter objections that such an approach is too harsh, or that the MCA-MHA interface results in practical obstacles to administering treatment. The proposed reform would thus be a practical step towards ensuring that the respect for mental health patients' autonomy is not compromised by the presence of a vague or arbitrary power to treat without consent.

(2995 words, excluding footnotes and references)