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Case No: 1175458T

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 20/11/2009

Before :

THE HON MR JUSTICE CHARLES

Between :

GJ	**Claimant**
- and -	
(1) THE FOUNDATION TRUST	
(2) THE PCT	
(3) THE SECRETARY OF STATE FOR HEALTH	**Respondents**

Simon Burrows (instructed by **O'Donnells**) for the **Claimant**
Bridget Dolan (instructed by **Ward Hadaway**) for the **First and Second Respondents**
Jonathan Auburn (instructed by **The Department of Health Legal Services**) **for the Third Respondent**

Hearing date: 2 November 2009

Judgment Approved by the court for handing down (subject to editorial corrections)

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Charles J :

Introduction

1. This case is brought under s. 21A of the Mental Capacity Act 2005 (as amended by the Mental Health Act 2007) "the MCA" in respect of a standard authorisation given under Schedule A1 to the MCA which authorises "*the detention of GJ in a hospital - for the purpose of giving him care or treatment - in circumstances that amount to a deprivation of liberty*" (see paragraphs 1(2) and 2 of Schedule A1).

2. The amendments relating to deprivation of liberty introduced into the MCA are complicated and quite lengthy. They need to be read as a whole. They introduce concepts that are defined and it is the definitions of the concepts, rather than the language of the concepts, that is important. They also cross refer to the MHA 1983.

3. I understand that this is the first time that these amendments have been considered in detail by the Court of Protection. It is for this reason, and although cases are likely to be fact specific that:

   (a) I make some general points and have addressed the points of statutory construction that arise generally before turning to the application of the relevant provisions in this case, and

   (b) I have set out a summary of my conclusions by reference to that general approach at the end of this judgment.

Some general background

4. Section 50 of the Mental Health Act 2007 amended the MCA 2005 to add provisions for the lawful deprivation of liberty of a person with a mental disorder who lacks capacity to consent. Section 50(2) inserts two new sections, 4A and 4B, into the MCA. The effect of these is that deprivation of liberty may only take place under the MCA in one of three situations. These are where:

   (a) the deprivation is authorised by an order of the Court of Protection under section 16(2)(a) of the MCA; or

   (b) the deprivation is authorised in accordance with the deprivation of liberty procedures (DOLS) set out in Schedule A1; or

   (c) the deprivation is carried out because it is necessary in order to give life sustaining treatment, or to carry out a vital act to prevent serious deterioration in the person's condition, while a decision as respects any relevant issue is sought from the court.

5. Of particular relevance are ss 4A, 4B, 16A, 21A and Schedules A1 and 1A to the MCA. These provisions for authorisation of the deprivation of liberty apply to people who are over 18 (children are dealt with under section 25 of the Children Act 1989 or the Mental Health Act 1983). The person must lack capacity to consent to the arrangements for his care. Receiving care or treatment in circumstances that amount to a deprivation of liberty must be in his best interests and necessary in order to prevent harm to the relevant person.

6. The underlying purpose of these provisions relating to deprivation of liberty was to address the "*Bournewood Gap*" (see *R* v. *Bournewood Community and Mental Health NHS Trust, ex parte L (Secretary of State for Health and others intervening)* [1998] 3 AER 289). In describing the *Bournewood Gap* I have with gratitude adopted a description used in lectures given by Professor Fennell and Clements. It is:

> "In *Bournewood* a mentally incapacitated man (HL) was admitted to hospital and retained there against the wishes of his carers, without the health care professionals using the powers of compulsory detention in the Mental Health Act 1983. HL was 48 and was suffering from severe autism. He lacked capacity to consent or dissent to being in hospital. For most of his adult life he had been an in-patient in a learning disability hospital, before being placed in the care of Mr and Mrs E under an adult fostering scheme. Whilst at the day centre which he attended on one day each week, he became disturbed and agitated, banging his head with his hands. According to Mr and Mrs E, he had one of these 'tantrums' about every four days, but the Es could cope with them and had never had to call the police or have him admitted to hospital. On this occasion the Es could not be contacted. A local doctor attended and sedated HL. His care worker arranged for him to be taken to the accident and emergency ward of the local hospital. Although initially calm and relaxed, while at the Accident and Emergency Unit he became increasingly disturbed, was again given sedation and was admitted 'informally' to the mental health behavioural unit at the hospital, under the care of the clinical director for learning disabilities, a consultant psychiatrist. Although incapable of consenting to admission, once in hospital he made no attempts to leave. He had no ability to express consent or dissent to treatment (although he could manifest unhappiness as to specific treatment). He was unable to express preference as to residing at one place rather than another. He did not resist admission, nor did he seek to leave. If he had, the doctor would have detained him using the compulsory powers in the Mental Health Act 1983. Because he had not been detained ('sectioned') under the 1983 Act, HL had no right to review of his detention by a Mental Health Review Tribunal. Through his next friends (Mr and Mrs E) he sought legal redress, via judicial review of the decision to detain him, habeas corpus and an action for damages for false imprisonment. To obtain that redress it had to be established (1) that HL had been detained or subject to imprisonment, and (2) that the detention was unlawful.
>
> So there were two central questions: (a) in what circumstances was an incapacitated patient detained in law? and (b) when should a patient who lacks capacity be detained using the powers in the Mental Health Act 1983 and when was it permissible to use common law to admit incapacitated patients?

The House of Lords held that there was a common law power under the doctrine of necessity to detain and restrain patients who lack capacity and where detention was necessary in their own best interests. Five of the nine judges who considered HL's position at English law considered him to have been detained, and did so on the basis of the control assumed by the doctor over HL's treatment, residence, movement and contact with the outside world, a key point being that HL would have been prevented from leaving had he tried to do so. Despite the existence of an extensive case law on detention under the European Convention on Human Rights, the speeches in the House of Lords do not refer to the Convention. Lord Steyn, however, identified the existence of a lacuna, which has come to be known as 'the Bournewood Gap':

> "The common law principle of necessity is a useful concept but it contains none of the safeguards of the 1983 Act. It places effective and unqualified control in the hands of the hospital psychiatrists... [N]either habeas corpus nor judicial review are sufficient safeguards against misjudgements and professional lapses in the case of compliant incapacitated patients."

He also stated that 'the law would be defective if it failed to provide adequate protective remedies to a vulnerable group of incapacitated mental patients.'

HL's carers applied to the European Court of Human Rights, which held that HL had been deprived of his liberty and that there had been a breach of Article 5(4) in that the use by the doctor of the common law doctrine of necessity, instead of statutory powers to detain, did not meet the requirement in Article 5(1)(e) that such a detention must be carried out in accordance with a procedure prescribed by law. They won (*HL v The United Kingdom* (2004) 40 EHRR 761).

In relation to mentally incapacitated adults, the common law doctrine of necessity has largely been superseded in relation to acts of care and treatment by sections 5 and 6 of the MCA. However, it follows from the ECHR's ruling that because sections 5 and 6 of the MCA provide a defence to a battery action, rather than prescribe a procedure, they cannot satisfy the requirements of Article 5(1)(e) in relation to a detention on grounds of unsound mind. For that reason, the Government decided to implement the judgment and bridge '*the Bournewood Gap*' by way of amendments introduced to the Mental Capacity Act 2005 to provide for Deprivation of Liberty Safeguards in relation to adults who lack capacity to decide where they should reside."

7. The amendments enable what are called standard and urgent authorisations to be granted in respect of persons in a hospital or care home. The role of the Court of Protection in respect of these authorisations is conferred by s. 21A.

8. More generally, a part of the relevant background to the construction issues that arise are the points that (a) compliance with Art 5(4) ECHR requires that deprivation of liberty is only implemented in accordance with a procedure prescribed by law, (b) before and after the amendments such procedures for the lawful authorisation of a deprivation of liberty are provided by the MHA 1983, when it applies, and (c) after the amendments such procedures, in defined circumstances, are provided by the MCA.

9. The new provisions in the MCA do not cover taking a person to a care home or a hospital. But they can be given before the relevant person arrives there so that they take effect on arrival (see for example paragraph 52 of Schedule A1 to the MCA).

Preliminary

10. At the heart of the issues before me are questions of statutory construction. The Secretary of State for Health was invited to take part in, and did take part in, the proceedings. Helpfully his Department provided notes of meetings I (and other judges) have had relating to the issues in this case with representatives of the Department and others. I mention this for two reasons. Firstly, because it identifies my part in such discussions and in the light of that no-one asked me to recuse myself. I record, as mentioned in court, that I left the discussions where they lay because it seemed to me that if they went further I might have to recuse myself from hearing cases relating to the issues discussed. Secondly, the notes from the Department refer to the intentions of the Department in proposing (and, it is asserted in the notes, of Parliament in enacting) the amendments. I was not referred to any Parliamentary discussion of the amendments and, in my view, the references in the notes to such intentions are inadmissible and irrelevant to the issues of construction. I have therefore disregarded them save to the limited extent that they identify argument based on material concerning the mischief to which the amendments were addressed (i.e. the *Bournewood Gap*) and thus their underlying purpose.

11. At the heart of the issue of statutory construction that arises in this case is whether the relevant person is "*ineligible to be deprived of liberty by this Act*". This aspect of the test is phrased by posing a negative. In my view it is helpful to remember that the overall question is whether the relevant person is eligible to be, and thus can be, deprived of liberty by the MCA. This aspect of the test limits that jurisdiction. To apply it in a positive sense involves the introduction of a double negative and the question is whether the relevant person is "not ineligible".

Issues of statutory construction

The most relevant provisions of the MCA

12. Sections 4A and 4B provide:

> "4A Restriction on deprivation of liberty

(1) This Act does not authorise any person ("D") to deprive any other person ("P") of his liberty.

(2) But that is subject to -

(a) the following provisions of this section, and

(b) section 4B.

(3) D may deprive P of his liberty if, by doing so, he is giving effect to *a relevant decision of the court.*

(4) A relevant decision of the court is *a decision made by an order under section 16(2)(a) in relation to a matter concerning P's personal welfare.*

(5) D may deprive P of his liberty if the deprivation is authorised by Schedule A1 (hospital and care home residents: deprivation of liberty).

4B Deprivation of liberty necessary for life sustaining treatment etc

----------"

13. Pausing there, as mentioned earlier it can be seen that s. 4A MCA provides two routes by which the deprivation of a person's liberty may be authorised under the MCA, namely by a decision made by an order under section 16(2)(a), or pursuant to Schedule A1.

14. Section 16A provides:

"16A Section 16 powers: Mental Health Act patients etc

(1) If a person *is ineligible to be deprived of his liberty by this Act*, the court may not include in a welfare order provision which authorises the person to be deprived of his liberty

(2) ----------

(3) ----------

(4) For the purposes of this section:

(a) Schedule 1A applies for determining whether or not he is ineligible to be deprived of liberty by this Act;

(b) " welfare order" means an order under section 16(2)(a) (*which I comment provides that the court may by making an order, make the decision or decisions on P's behalf in relation to the matter or matters relating to his welfare, including agreement to a deprivation of P's liberty).*

15. So the court is given power by making such an order to authorise a deprivation of P's liberty if and only if P is not *ineligible to be deprived of his liberty* by the MCA.

16. I pause to note that the statutory power to make such an order is different to the statutory power to make declarations conferred by section 15 of the MCA. It follows that, if and when the Court of Protection (or any other court) is invited to authorise a deprivation of liberty it will need to consider whether it has jurisdiction to do so based on the MCA (or on some other basis) and how it should do so in exercise of that jurisdiction. These jurisdictional issues do not arise in this case and therefore I say no more about them.

17. Schedule A1 (the other route to an authorisation of a deprivation of P's liberty under the MCA) provides as follows:

> " PART 1
>
> AUTHORISATION TO DEPRIVE RESIDENTS OF LIBERTY ETC
>
> *Application of Part*
>
> 1(1) This Part applies if the following conditions are met.
>
> (2) The first condition is that a person ("P") is detained in a hospital or care home - for the purpose of being given care or treatment - in circumstances which amount to a deprivation of the person's liberty.
>
> (3) The second condition is that a standard or urgent authorisation is in force.
>
> (4) The third condition is that the standard or urgent authorisation relates -
>
> (a) to P, and
>
> (b) to the hospital or care home in which P is detained.
>
> *Authorisation to deprive P of liberty*
>
> 2 The managing authority of the hospital or care home may deprive P of his liberty by detaining him as mentioned in paragraph 1(2). "

18. Pausing there, the direct linkage to the *Bournewood Gap* can be seen because the provisions relate to the position when P is at a hospital or care home in circumstances which amount to a deprivation of his liberty.

19. In such circumstances, and if and only if the qualifying requirements set out in paragraph 12(1) of Schedule A1 are met namely (a) the age requirement; (b) the mental health requirement; (c) the mental capacity requirement; (d) the best interests

requirement; (e) the eligibility requirement; and (f) the no refusals requirement, a standard authorisation can be given. Here the most relevant requirements are as follows:

> " *The mental health requirement*
>
> 14(1) The relevant person meets the mental health requirement if he is suffering from mental disorder (within the meaning of the Mental Health Act, but disregarding any exclusion for persons with learning disability) *(and thus incorporating the MHA definition of mental disorder - if he is suffering from any disorder or disability of the mind with that qualification).*
>
> (2) An exclusion for persons with learning disability is any provision of the Mental Health Act which provides for a person with learning disabilities not to be regarded as suffering from mental disorder for one or more purposes of that Act.
>
> *The mental capacity requirement*
>
> 15 The relevant person meets the mental capacity requirement if he lacks capacity in relation to the question whether or not he should be accommodated in the relevant hospital or care home for the purposes of being given the relevant care or treatment.
>
> *The best interests requirement*
>
> 16(1) The relevant person meets the best interests requirement or all of the following conditions are met.
>
> (2) The first condition is that the relevant person is, or is to be, a detained resident (*defined in paragraph 6 as a person detained in a hospital or a care home – for the purpose of being given care or treatment – in circumstances that amount to a deprivation of the person's liberty).*
>
> (3) The second condition is that it is in the best interests of the relevant person for him to be a detained resident.
>
> (4) The third condition is that, in order to prevent harm to the relevant person, it is necessary to him to be a detained resident.
>
> (5) The fourth condition is that it is a proportionate response to -
>
> (a) the likelihood of the relevant person suffering harm, and
>
> (b) the seriousness of that harm,

> for him to be a detained resident.
>
> *The eligibility requirement*
>
> 17(1) The relevant person meets the eligibility requirement unless he is ineligible to be deprived of liberty by this Act.
>
> (2) Schedule 1A applies for the purpose of determining whether or not P is ineligible to be deprived of liberty by this Act."

20. So these requirements provide:

    (a) links with the MHA 1983, but differently worded conditions (e.g. the mental health and best interests requirements),

    (b) a link with the purpose of the accommodation in the hospital or care home and thus the purpose for keeping P there in circumstances that amount to a deprivation of his liberty, and

    (c) the concept of P being "*ineligible to be deprived of liberty by the MCA*".

21. This jurisdictional concept of ineligibility applies equally to a deprivation of liberty based on a welfare order of the court and a standard authorisation under Schedule A1. So, if the authorisation cannot be given on that jurisdictional basis the court has no statutory power to authorise a deprivation of P's liberty.

22. If the relevant person ceases to meet the eligibility requirement provision is made for the suspension of a standard authorisation (see Part 6 of Schedule 1A) and there are provisions for the review of standard authorisations in Part 8.

23. I pause to comment that these provisions for suspension and review are matters that the Court of Protection should take into account in determining whether (a) it should make an order authorising the deprivation of P's liberty, and if so (b) the extent and period of such an authorisation and in particular whether, and/or for how long, it should continue after P is placed in a hospital or care home having regard to, for example, the authorities relating to the need for review of a deprivation of liberty based on the exercise of the inherent jurisdiction (see for example the decisions of Munby J in *Re PS (Incapacitated or Vulnerable Adult)* [2007] EWHC 623 (Fam), [2007] 2 FLR 1083, *DE v JE and Surrey CC* [2006] EWHC 3459 (Fam), [2007] 2 FLR 1150 and *In the matter of GJ NJ and BK (Incapacitated Adult)* [2008] EWHC 1097 (Fam)). One of the jurisdictional issues referred to above is what, if any, inherent jurisdiction the Court of Protection has and whether the High Court retains its inherent jurisdiction in this area or whether it has been suspended by the MCA (see for example *Laker Airways v Dep of Trade* [1977] QB 643 at 719 / 721, *A v Liverpool City Council* [1982] AC 363 and *Harrison v Tew* [1990] 2 AC 525).

24. Schedule 1A to the MCA defines the jurisdictional concept of someone being ineligible to be deprived of liberty by the MCA. It provides:

Part 1

INELIGIBLE PERSONS

Determining ineligibility

2. A person ("P") is ineligible to be deprived of liberty by this Act ("ineligible") if—

(a) P falls within one of the cases set out in the second column of the following table, and

(b) the corresponding entry in the third column of the table—or the provision, or one of the provisions, referred to in that entry—provides that he is ineligible.

	Status of P	*Determination of ineligibility*
Case A	P is— (a) subject to the hospital treatment regime, and (b) detained in a hospital under that regime.	P is ineligible.
Case B	P is— (a) subject to the hospital treatment regime, but (b) not detained in a hospital under that regime.	See paragraphs 3 and 4.
Case C	P is subject to the community treatment regime.	See paragraphs 3 and 4.
Case D	P is subject to the guardianship regime.	See paragraphs 3 and 5.
Case E	P is— (a) within the scope of the Mental Health Act, but (b) not subject to any of the mental health regimes.	See paragraph 5.

25. Cases A to D relate to persons currently subject to an order or regime under the MHA 1983. So they are not applicable in this case. However in my judgment they are parts of the new statutory framework and scheme that are relevant to issues of its construction and application that arise here.

26. Case E applies when the relevant person is not the subject to such an order or regime, and so it applied to GJ when the authorisations under the MCA that relate to him were made.

27. As appears from the introduction to the table to be "*ineligible*" under Case E the relevant person:

    (a) has to be within the scope of the MHA 1983, and then

    (b) paragraph 5 has to be satisfied.

    So there are two gateways or tests that have to be satisfied. The first is described as a status gateway or test, and the second by reference to eligibility. This structure and approach also applies to the other Cases (except Case A).

28. A natural progression is to consider the status test or gateway first and then move on to the other test or gateway in the third column (the paragraph 5 test or gateway, under Case E). But, as will appear later in thus judgment in my view in many cases under Case E it is likely that it will be most convenient for the decision maker to address the paragraph 5(3) test first, or at the same time as the status gateway or test.

29. But I accept the point made on behalf of the Secretary of State that it should be remembered that there are two tests or gateways that have to be satisfied and one should not rule out the possibility that the status test or gateway will be decisive and render consideration of the paragraph 5 test or gateway unnecessary. It seems to me that an example of this might be when P's incapacity is based on a learning disability that is not associated with abnormally aggressive or seriously irresponsible conduct, with the result that he is within the ambit of the MCA but not of the MHA 1983.

Paragraph 12 of Schedule 1A

30. The concept of being "*within the scope of the MHA*" is defined by paragraph 12 of Schedule 1A as follows:

> "12(1) P is within the scope of the Mental Health Act if-
>
> (a) an application in respect of P could be made under s.2 or s.3 of the Mental Health Act, and
>
> (b) P could be detained in a hospital in pursuance of such an application, were one made.
>
> (2) The following provisions of this paragraph apply when determining whether an application in respect of P could be made under section 2 or 3 of the Mental Health Act.
>
> (3) If the grounds in section 2(2) of the Mental Health Act are met in P's case, it is to be assumed that the recommendations referred to in section 2(3) of that Act have been given.

(4) If the grounds in section 3(2) of the Mental Health Act are met in P's case, it is to be assumed that the recommendations referred to in section 3(3) of that Act have been given.

(5) In determining whether the ground in section 3(2)(c) of the Mental Health Act is met in P's case, it is to be assumed that the treatment referred to in section 3(2)(c) cannot be provided under this Act."

31. This again provides a further link to the MHA 1983 and necessitates a consideration of its provisions and application against a background that includes the points that to render P eligible to be deprived of liberty by a standard authorisation under the MCA:

(a) the mental health requirement also has to be satisfied (i.e. P is suffering from a disorder or disability of the mind within the meaning of the MHA 1983 disregarding any exclusion for persons with learning disability – paragraph 14 of Schedule A1), so there may be cases when it is so satisfied and the relevant person does not suffer from a disorder or disability of the mind within the MHA 1983, and

(b) the best interests requirement (defined by paragraph 16 of Schedule A1 in terms that do not mirror the language of ss. 2 or 3 of the MHA 1983) has to be satisfied.

And the Court of Protection when making an order would effectively take account of the same points.

32. The definition in paragraph 12 gives rise to the question what does "*could*" mean in paragraphs 1(a) and (b) thereof.

Paragraph 5 of Schedule 1A

33. The paragraph 5 gateway or test is set by paragraph 5 of Schedule 1A which provides:

"*P objects to being a mental health patient etc*

5(1) This paragraph applies in cases D and E in the table in paragraph 2.

(2) P is ineligible if the following conditions are met.

(3) The first condition is that the relevant instrument *(as defined by paragraph 15 – the standard authorisation or order under s. 16(2)(a))* authorises P to be a mental health patient *(as defined by paragraph 16(1) of Schedule 1A – a person accommodated in a hospital for the purpose of being given medical treatment for a mental disorder).*

(4) The second condition is that P objects—

(a) to being a mental health patient *(as defined by paragraph 16(1) of Schedule 1A - a person accommodated in a hospital for the purpose of being given medical treatment for a mental disorder),* or

> (b) to being given some or all of the mental health treatment *(as defined by paragraph 16(1) of Schedule 1A – the medical treatment referred to in the definition of "mental health patient)."*
>
> (Paragraph 17 of Schedule 1A provides that "medical treatment" has the same meaning as in the MHA 1983, "hospital" has the same meaning as in Part 2 of the MHA 1983 and "mental disorder" has the same meaning as in Schedule A1 paragraph 14 – the mental health requirement and thus includes learning disability that is excluded from the MHA 1983).

34. So the paragraph 5 gateway or test provides that consideration must be given to what is (or is to be) authorised by the court order or standard authorisation. And by the terms of sub-paragraph (3) founds the result that it is only placement in a hospital (as defined) for a defined purpose that is covered (and see *W Primary Care Trust v TB* [2009] EWHC 1737 (Fam)).

35. So, in my view this means that placement in a care home (or the relevant person's (P's) home or other accommodation in the community with a relative and/or a carer) and whilst a person is being taken to a hospital or another placement is not covered.

36. Also, when Case E applies P will only be ineligible to be deprived of his liberty under the MCA if he objects to one of the matters set out in sub-paragraph (4). So if he does not object (like HL in *Bournewood*) he can be (or is eligible to be) deprived of liberty by the MCA.

37. In my judgment, these features of paragraph 5 taken alone, and with the provisions in the column headed "determination of ineligibility", are strong pointers that the MHA 1983 is to have primacy over the MCA in the sense I describe later.

The most relevant provisions of the MHA 1983

38. The relevant criteria for detention for treatment under sections 2 and 3 of the MHA 1983 are as follows:

> " Admission for an assessment
>
> 2(1) A patient may be admitted to a hospital and detained there for the period allowed by subsection (4) below in pursuance of an application (in this Act referred to as "an application for admission for assessment") made in accordance with subsections (2) and (3) below.
>
> (2) An application for admission for assessment may be made in respect of a patient on the grounds that
>
> (a) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and

(b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.

(3) An application for admission for assessment shall be founded on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in subsection (2) above are complied with.

(4) Subject to the provisions of section 29(4) below, a patient admitted to hospital in pursuance of an application for admission for assessment may be detained for a period not exceeding 28 days beginning with the day on which he is admitted, but shall not be detained after the expiration of that period unless before it has expired he has become liable to be detained by virtue of a subsequent application, order or direction under the following provisions of this Act.

Admission for treatment

3(1) A patient may be admitted to a hospital and detained there for the period allowed by the following provisions of this Act in pursuance of an application (in this Act referred to as "an application for admission for treatment") made in accordance with this section.

(2) An application for admission for treatment may be made in respect of a patient on the grounds that—

(a) he is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and

(b) [. . .]

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

(d) appropriate medical treatment is available for him.

(3) An application for admission for assessment shall be founded on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in subsection (2) above are complied with; and each such recommendation shall include

> (a) such particulars as may be prescribed of the grounds for that opinion so far as it relates to the conditions set out in paragraphs (a) and (d) of that subsection; and
>
> (b) a statement of the reasons for that opinion so far as it relates to the conditions set out in paragraph (c) of that subsection, specifying whether other methods of dealing with the patient are available and, if so, why they are not appropriate.
>
> (4) In this Act, references to appropriate medical treatment, in relation to a person suffering from mental disorder, are references to medical treatment which is appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case.

39. As can be seen from those sections they are in permissive terms in that they provide when a person "may" be so admitted to hospital. They confer a power or ability which, if it is exercised, results in a lawful detention in hospital.

40. Also both sections include factors in their trigger provisions on which value judgments have to be made.

41. So, both the ingredients or factors to be taken into account in determining whether (a) the trigger to the power are satisfied, and (b) if they are, whether it should be exercised, include issues in respect of which there can be a range of reasonable opinion.

Paragraph 12 of Schedule 1A

42. As appears earlier in this judgment, when determining whether P is "within the scope of the MHA" for the purpose of ascertaining whether he is ineligible to be deprived of his liberty by the MCA:

    (a) paragraph 12(1)(4) of Schedule 1A to the MCA, provides that the decision maker must assume that the medical recommendations required to found detention under s. 2(3) and/or s.3(3) MHA 1983 would be made, and

    (b) paragraph 12(1)(5) thereof, provides that the decision maker must assume that treatment referred to in s. 3(2)(c) cannot be provided under the MCA.

43. Those deeming provisions operate:

    (a) to provide that the decision maker under the MCA must proceed on the basis or assumption that the relevant medical practitioners will exercise their professional judgment (a) by concluding that the trigger provisions of the sections are met, and (b) by making the relevant recommendations to found the application, and

    (b) to make it clear that in determining whether "*it is necessary for the health and safety of the patient ---------- that he should receive medical treatment in a*

> *hospital and it cannot be provided unless he is detained*" the decision maker under the MCA when considering whether an application in respect of P could be made under s. 2 or 3 MHA 1983, and P could be detained in hospital in pursuance of such an application, must not take into account any possibility of the treatment (and detention) being provided under the MCA.

44. The second deeming provision relates only to s. 3(2)(c) MHA 1983, and thus to treatment rather than assessment, and an assessment can be said to be outside paragraph 5(3) of Schedule 1A to the MCA. But, as the focus of this aspect of the authorisation scheme concerning eligibility is (a) on P being detained in a hospital or in a care home for the purpose of being given care or treatment (see paragraphs 1(2) and 2 of Schedule A1 to the MCA), and (b) arises when an application under s. 2 or s. 3 MHA could be made in respect of P, in my judgment the provisions looked at as a whole have the result that the assessor under the MCA should also proceed on the assumption that assessment and treatment under s. 2 MHA 1983 cannot be provided under the MCA.

45. In my judgment, the deeming provisions alone, and together with that view on assessments, are strong pointers in favour if the conclusions that (a) the MHA 1983 is to have primacy when it applies, and (b) the medical practitioners referred to in ss. 2 and 3 of the MHA 1983 cannot pick and choose between the two statutory regimes as they think fit having regard to general considerations (e.g. the preservation or promotion of a therapeutic relationship with P) that they consider render one regime preferable to the other.

46. This is because they point to the conclusion that <u>when the MHA 1983</u> is being considered by those who could make an application, founded on the relevant recommendations, under s. 2 or s. 3 thereof they, like the decision maker under the MCA, should assume that (a) the treatment referred to in s. 3(2)(c) MHA 1983 cannot be provided under the MCA, and (b) the assessments referred to in s. 2 cannot be provided under the MCA in circumstances that amount to a deprivation of liberty.

47. Also, the assumption that the relevant recommendations will be made by the relevant medical practitioners points to the conclusion that Parliament intended the MHA 1983 to be used when, as provided by paragraphs 12(3) and (4) of Schedule 1A to the MCA, the grounds in s.2(2) or s.3(2) MHA 1983 are met in the relevant case.

48. The term "medical treatment" in s.3 MHA 1983 is further defined under s.145 MHA 1983, as follows:

> "s.145(1)… "medical treatment" includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care (but see also sub section (4) below)…
>
> (4) Any reference in this Act to medical treatment in relation to mental disorder, shall be construed as a reference to medical treatment the purpose of which is to alleviate, or prevent worsening of, the disorder or one or more of its symptoms or manifestations."

Authorities relating to the MHA 1983

49. I was referred to three cases concerning the issue whether treatment for a physical disorder or illness can be considered as treatment for a mental disorder so as to bring it within the definition of "medical treatment" for the purposes of the MHA 1983.

50. The first point I make from these cases is that they confirm, should it be necessary, that:

(a) the core, or the primary purpose, of the medical treatment referred to in s. 3(2) (and s. 2(2)) MHA 1983 is for the mental disorder referred to in s. 3(2)(a) (and s. 2(2)(a)), namely in s. 3 to mental disorder of a nature or degree that makes it appropriate for the person to receive medical treatment in a hospital, and

(b) under s. 3 it has to be considered whether it is necessary for the health and safety of the patient that he should receive that treatment and whether it can only be provided if he is detained in hospital (there are differences in the wording of the equivalent test in s. 2).

51. The decision of the Court of Appeal in *B v Croydon HA* [1995] WLR 294 related to naso-gastric tube feeding to avert the physical effects of starvation in a woman with borderline personality disorder who starved herself as a form of self-harm. It was found to be permissible under the MHA 1983 because it was aimed at treating a symptom of her mental disorder – the infliction of self-harm. So this treatment of the physical consequence of her impulse to self-harm was ancillary to the treatment of her mental disorder.

52. I agree with the submissions made on behalf of the First and Second Respondents, and the contrary was not argued, that the following general propositions can be taken from that case:

(a) A range of acts ancillary to the core treatment of the mental disorder may be considered to fall within the s.145 definition of medical treatment for mental disorder, see for example:

> "Section 145(1) gives a wide definition to the term "medical treatment." It includes "nursing, and also includes care, habilitation and rehabilitation under medical supervision." So a range of acts ancillary to the core treatment fall within the definition." – *B v Croydon HA* at 298C-D "

(b) Treatment for mental disorder may include treatment for the symptoms of a mental disorder – *B v Croydon HA* at 299C-D,

(c) Treatment for mental disorder may also include treatment for the physical consequences of a mental disorder – see *B v Croydon HA* and the MHA Code of Practice at para 23.4 which states:

> "[Medical Treatment] includes treatment of physical health problems only to the extent that such treatment is part of, or ancillary to,

> treatment for mental disorder (eg treating wounds self-inflicted as a result of mental disorder). Otherwise the Act does not regulate medical treatment for physical disorder."

(d) If there is no proposed treatment for the core mental disorder it will not be lawful to detain a patient to treat the physical consequences of his disorder.

> "If there was no proposed treatment for Ms B's psychopathic disorder, s.63 could not have been invoked to justify feeding her by naso-gastric tube. Indeed it would not be lawful to detain her at all." - *B v Croydon HA* at 298E

(e) Treatment for a physical disorder will not be treatment for mental disorder where the physical disorder is unconnected with the mental disorder - *B v Croydon HA* at 299D:

> "The decision in *In re C. (Adult: Refusal of Treatment)* [1994] 1 W.L.R. 290, in which a schizophrenic was held entitled to refuse treatment for gangrene, is distinguishable. The gangrene was entirely unconnected with the mental disorder."

(f) If the physical disorder is unconnected with the mental disorder then treatment of the physical disorder can only be considered 'treatment for mental disorder' if such treatment is likely to directly affect the mental disorder.

53. As to (f) in *Tameside and Glossop Acute Services Trust v CH* [1996] 1 FLR 762, Wall J considered a caesarean section operation (CS) could be authorised as treatment for mental disorder under s.63 MHA 1983 (which relates to the consent of the patient) and determined it could be because delivering a child safely by CS was likely to directly affect the patient's mental state. Wall J found that:

> "-------- achievement of a successful outcome of her pregnancy is a necessary part of the overall treatment of her mental disorder. Treatment of Mr C's gangrene was not likely to affect his mental condition: the manner of delivery of the defendants child is likely to have a direct effect on her mental state." (at 773H)

54. I agree that from the above propositions it can be concluded that:

(a) whilst treatment for mental disorder can include both medical and surgical treatment for the consequences of mental disorder – such as treatment for self-injury or self-poisoning,

(b) this principle or approach does not extend to the medical or surgical treatment of unrelated physical conditions where giving that treatment will not impact upon the pre-existing mental disorder.

55. To my mind, this view is supported by the approach taken by the Court of Appeal in *St George's Healthcare NHS Trust v S* [1998] 3 WLR 936. There the Court held that when applying the criteria for admission under the MHA 1983 a distinction is to be made between the need for treatment arising from a physical condition (which was

pregnancy in that case) and the separate question whether the patient's mental disorder warrants detention in hospital. The Court of Appeal found that in failing to make this distinction the psychiatric authorities had unlawfully detained S stating (at 962):

> "---------- those involved in the decision to make an application for admission failed to maintain the distinction between the urgent need of S for treatment arising from her pregnancy and the separate question whether her mental disorder (in the form of depression) warranted her detention in hospital. From the reasoning to be found in [the documents] the conclusion that the detention was believed to be warranted in order that adequate provision could be made to deal with S's pregnancy and the safety of her unborn child is unavoidable. ...[the ASW] believed, rightly, that S's condition was threatened by her very severe pre-eclampsia. At the time when she reached her conclusion she did not suggest that detention was required for the purpose of assessing S's mental condition or treating her depression. Put another way, if S had not been suffering from severe pre-eclampsia there is nothing in the contemporaneous documents to suggest that an application for her detention would have been considered, let alone justified.
>
> We are satisfied that, notwithstanding our view that the requirements of section 2(2)(*b*) might well have been fulfilled, the cumulative grounds prescribed in section 2(2)(*a*) were not established. Therefore the application for admission was unlawful. Appropriate declaratory relief will be ordered."

56. In my judgment, these points relating to the scope of medical treatment under the MHA 1983 are relevant to the consideration and application of the two gateways or tests set by paragraph 2 of Schedule 1A MCA for determining whether P is ineligible to be deprived of his liberty under the MCA.

57. In particular this is the case because they recognise and confirm that:

(a) distinctions can and should be drawn between (i) a physical disorder that is and is not connected to or caused by a mental disorder, (ii) treatment for a physical disorder that is likely to directly affect the mental disorder and that which is not, (iii) treatment that is directed specifically to the mental disorder alone, and (iv) more general care and treatment (e.g. nursing, monitoring and providing a safe environment) that is appropriate as part of treatment in hospital for both the mental disorder and the physical disorder or illness, and

(b) the effective reason for the detention, or the giving of treatment without consent, under the MHA 1983 is important.

The relationship between the MHA 1983 and the MCA in the context of deprivation of liberty

58. In my judgment, the MHA 1983 has primacy in the sense that the relevant decision makers under both the MHA 1983 and the MCA should approach the questions they have to answer relating to the application of the MHA 1983 on the basis of an assumption that an alternative solution is not available under the MCA.

59. As appears later, in my view this does not mean that the two regimes are necessarily always mutually exclusive. But it does mean, as mentioned earlier, that it is not lawful for the medical practitioners referred to in ss. 2 and 3 of the MHA 1983, decision makers under the MCA, treating doctors, social workers or anyone else to proceed on the basis that they can pick and choose between the two statutory regimes as they think fit having regard to general considerations (e.g. the preservation or promotion of a therapeutic relationship with P) that they consider render one regime preferable to the other in the circumstances of the given case.

60. My reasons for this conclusion are:

(a) It is in line with the underlying purpose of the amendments to the MCA 2005, to fill a gap namely the "*Bournewood Gap*". This shows that the purpose was not to provide alternative regimes but to leave the existing regime under the MHA 1983 in place with primacy and to fill a gap left by it and the common law.

(b) The regime under the MHA 1983 has been in place for some time and includes a number of checks and balances suitable to its subject matter that are not replicated under the MCA.

(c) The strong pointers referred to above in respect of the provisions of paragraphs 12 and 5 of Schedule 1A to the MCA and thus the two gateways or tests relating to ineligibility taken (a) alone and individually, and (b) together with the approach taken to determine the ineligibility of persons within Cases A to D, identified by the third column in the table set out in paragraph 2 of Schedule 1A.

(d) This accords with s. 28 MCA, as originally enacted, and as it remains to-day.

61. Turning to the provisions in that third column for the other Cases:

(a) In Case A that provision provides that when P is detained in hospital for treatment under a Hospital Treatment Regime (and thus under the MHA 1983 see the definition in paragraph 8 of Schedule 1A) P is ineligible. This favours the conclusion that the MHA 1983 has primacy.

(b) In Cases B and C, which apply when P is subject to the Hospital Treatment Regime or the Community Treatment Regime and is not in a hospital the provisions of paragraphs 3 and 4 apply and provide that P is ineligible:

(i) if the authorised course of action (as defined by paragraph 13 in respect of an order of the Court of Protection and paragraph 14 thereof in respect an authorisation under the MCA) is not in accordance with a requirement that the relevant regime imposes (see paragraph 3), and

(ii) if the relevant care or treatment consists in whole or in part of medical treatment for a mental disorder in a hospital (see paragraph 4),

both of which indicate that the relevant Regime under the MHA 1983 has primacy.

62. In Case D, which applies when P is subject to the Guardianship Regime, paragraphs 3 and 5 of Schedule 1A apply which, as I have said, both indicate that the MHA 1983 has primacy.

63. The points that in applying the MHA 1983:

(a) there are value judgments to be made (a) as to whether the trigger provisions are satisfied, and (b) as to whether an application should be made if they are, and

(b) relevant decision makers could reach different decisions on them that are within a permissible range of reasonable opinion

cause complications. This is because the decision makers under the MCA could reach a different conclusion to the decision makers under the MHA 1983 within that range of reasonable opinion. Additionally, the medical practitioners applying the MHA 1983 may agree with the MCA assessor that an application "could be made" but decide not to make it and this could cause problems or delay in respect of the care of P.

64. But, in my judgment these problems, the close relationship between the value judgments at the two stages under the MHA 1983 and the grey area they create between the two regimes do not lead to a conclusion that, on the true construction of the legislation, there is an overlap between the regimes within such grey area that confers on decision makers an ability to choose between them on the basis that both are equally applicable.

65. Rather, in my view in areas of doubt the Court of Protection, other decision makers under the MCA and decision makers under the MHA 1983 must recognise the primacy of the MHA 1983 and take all practical steps to ensure that that primacy is recognised and given effect to.

66. I agree with the Secretary of State that this will often involve discussions between relevant professionals which it is to be hoped will be entered into with co-operation and appropriate urgency. It is also likely that in many cases such problems will arise when P is, or will be, in hospital which should promote that co-operation.

Ineligibility to be deprived of liberty under the MCA - Case E

67. As set out earlier there are two gateways or tests. There is overlap between the matters that have to be taken into account in respect of them because they both require consideration of the MHA 1983.

68. When considering them in my view it should also be remembered that the eligibility requirement is one of 6 requirements for a standard authorisation (and that when

making a welfare order the court will effectively take into account those factors) and, in particular, that:

(a) the mental health requirement leads to a starting point that (save that abnormally aggressive or seriously irresponsible conduct need not be present in the case of a learning disability) the relevant person suffers a mental disorder within the meaning of the MHA 1983, and so generally the relevant person is suffering from the mental disorder referred to in ss. 2 and 3 of the MHA 1983 and the focus of enquiry in the two gateway tests will not be whether or not this is the case. And so it will normally be on

(b) the assessment or treatment in question, and whether, and if so why, P should be detained in hospital to deliver it (applying the different language of ss. 2 and 3 to these questions), and

(c) other reasons why it would be in P's bests interests (applying the MCA which does not precisely mirror the equivalent tests in s. 2 or s. 3 MHA 1983) to be detained in circumstances that amount to a deprivation of his liberty.

69. *Paragraph 12.* Each party advanced a different construction of, or approach to the proper application of, the word "*could*" in paragraph 12(1) of Schedule 1A to the MCA. It is an ordinary English word with a possible range of meaning depending on its context.

70. The primary focus of argument was on its use in paragraph 12(1)(a) and thus on its meaning in the phrase "*an application in respect of P could be made under s. 2 or s.3 MHA 1983*". This is understandable and inevitable because once an application is made it seems to me that whichever of the rival approaches to paragraph 12(1)(a) and (b) is correct if it would carry over to, and be satisfied when, the focus is on paragraph 12(1)(b).

71. The rival contentions cover the possible range of meaning of the word. They were:

(a) On behalf of the Applicant (GJ or P), a "possibility test" was advanced to the effect that the decision maker should ask himself whether it is possible for such an application to be made, or more generally whether detention of P under the MHA 1983 is a possibility or (as put in reply) is it possible that P could be detained under the MHA 1983.

(b) On behalf of the First and Second Respondents, it was argued that "could" should be construed as meaning that no reasonable psychiatrist, or s. 12 approved doctor, could come to the view that the patient did not meet the s. 2 or s. 3 criteria, rather than a wider construction that a reasonable psychiatrist, or s. 12 approved doctor, might find that the patient did meet the relevant grounds. This is a "high probability or effective certainty" test.

(c) The Secretary of State argued that in determining whether an application "could" be made the decision maker should ask himself whether the criteria set by, or the grounds in, s. 2 or s. 3 of the MHA 1983 are met. This is a "what the decision maker thinks" test.

72. The First and Second Respondents argued, and I accept, that their interpretation reflects the approach taken in negligence cases by reference to the range of reasonable views of a reasonably competent professional and that this is a concept that those charged with determining eligibility are familiar with. Their approach is also similar to a test mentioned in the notes produced by the Department namely that the decision maker should ask himself whether "it is clear that the MHA 1983 will apply", which avoids the double negative.

73. The rival approaches of the Applicant and the First and Second Respondents produce results at different ends of the range of decision open to decision makers on the relevant value judgments. This is because the Applicant takes an approach that the test is at one end of a range from possibility to effective certainty and the First and Second Respondents' approach is at the other end (if not just outside it).

74. The First and Second Respondents' approach has the potential advantage that it reduces the risk that problems such as those that arose in *Surrey CC v MB* [2007] EWHC 3085 (Fam) will occur because it makes it unlikely that (a) the relevant decision makers under the MHA 1983 would decide not to make an application under the MHA 1983, and (b) the treating doctors would not support such an application and would prefer the court to deal with deprivation of liberty to promote their therapeutic relationship with P and their important relationship with P's family. This is what occurred in that case. In that case the expert evidence before the court was to the effect that P should be detained under the MHA 1983 and there was a risk that did not materialise that P would be evicted from his home and then arrested and kept in police custody. In the events that happened MB went to the hospital without objection and the need to rely on my declaration that it would be lawful to deprive him of his liberty to transport him to, and during his assessment at, the hospital did not arise.

75. However, in my view:

    (a) it does not rule out problems arising from such a disagreement, and the primacy of the MHA 1983 reduces them,

    (b) as a matter of the ordinary use of language it is the most strained of the interpretations,

    (c) the gap which Parliament deliberately left by not providing that authorisations under the MCA covered taking a person to a hospital or care home can be filled by the Court of Protection because, in my view, an order that covered that transportation would not be within paragraph 5(3), and also

    (d) an authorisation that provided for P to be in a care home (or anywhere other than a hospital) would not be within paragraph 5(3), so if in a care home P could be deprived of liberty by an authorisation (or an order) and if elsewhere P could be deprived of liberty by an order.

76. Further, this approach would lead to a situation in which a number of cases, that many practitioners would regard as ones that should be dealt with under s. 2 or s. 3 MHA 1983, might be dealt with under the MCA which would undermine the primacy of the MHA 1983.

77. I therefore reject the First and Second Respondents' argument on the construction of "could" namely, the high probability or near certainty test.

78. The more natural meaning of the word "could" favours the "possibility" test or the "what the decision maker thinks" test.

79. I reject the "possibility" test for the following reasons:

(a) it introduces into the test an exercise with involves an assessment of what others may think or conclude, on the question whether the criteria or grounds set by s. 2 or s. 3 MHA 1983 are met,

(b) it is more likely that Parliament intended that the decision makers under the MCA were to apply their own expertise to assess and decide whether those criteria or grounds are met in a given case,

(c) point (b) is supported by the opening words of paragraphs 12(3) and (4), namely - if the grounds in s. 2(2) / s. 3(2) MHA 1983 are met in P's case, and

(d) point (b) is supported by the deeming provisions in paragraphs 12(3) and (4) because it is likely to reduce the number of cases in which the assumption does not occur.

80. So, in my judgment the construction urged by the Secretary of State is the correct one, namely that the decision maker should approach paragraph 12(1) (a) and (b) by asking himself whether in his view the criteria set by, or the grounds in, s. 2 or s.3 MHA 1983 are met (and if an application was made under them a hospital would detain P).

The paragraph 5 gateway or test

81. The first and second conditions in paragraphs 5(3) and (4) are linked in that the objection required by the second condition is to being a mental health patient or to some or all of the treatment for a mental disorder (as defined by the MCA) and thus the treatment given to such a patient.

82. In my view, that links the two conditions to the reasons why a deprivation of liberty is thought to be necessary.

83. In my judgment, the second condition (in paragraph 5(4)) has to be looked at in this way and without taking any fine distinctions between the potential reasons for the objection to treatment of different types, or to simply being in a hospital. As is recognised and provided for by paragraph 5(6), this is because it is often going to be the case that the relevant person (P) does not have the capacity to make a properly informed and balanced decision. So what matters, applying the approach set out in paragraph 5(6), is whether P will or does object to what is proposed.

84. This puts the focus on what is proposed, and thus what is authorised by the order or authorisation (see paragraph 5(3)). In turn that test, when the definitions are written into it, namely:

> "---------- the standard authorisation or order authorises P to be a person accommodated in a hospital for the purpose of being given treatment for a mental disorder (as defined by the MCA)"

focuses on:

(a) the purpose of the treatment that is authorised, and thus:

(b) the purpose of, or reason for, accommodating that person in a hospital in circumstances that amount to a deprivation of his liberty, because the effect and purpose of a standard authorisation is to make such a deprivation of liberty lawful (see paragraphs 1(2) and (3) of Schedule A1).

85. I pause to repeat (see paragraphs 34 and 35 above) that the test in paragraph 5(3) of Case E therefore does not cover an authorisation that results in P being deprived of his liberty in any place other than a hospital. So, in my view, Case E:

(a) does not impact on placement in a care home, and

(b) does not preclude the Court of Protection from making an order that authorises a deprivation of P's liberty to take him to a hospital or care home. But in that context the Court will have to consider whether it is appropriate to make any such order having particular regard to the likely position when P gets to a hospital.

86. Correctly in my view, it was common ground that what has to be looked at is the reality of the purpose and result of a standard authorisation rather than its wording.

87. I have concluded that the correct approach for the decision maker to take when applying paragraph 5(3) is to focus on the reason why P should be deprived of his liberty by applying a "but for" approach or test. And to do that he should ask himself the following questions, namely:

(a) what care and treatment should P (who will usually have a mental disorder within the MHA 1983 definition) have if, and so long as, he remains in a hospital:

(i) for his physical disorders or illnesses that are unconnected to, and are unlikely to directly affect, his mental disorders (the package of physical treatment), and

(ii) for (i) his mental disorders, and (ii) his physical disorders or illnesses that are connected to them and/or which are likely to directly affect his mental disorders (the package of treatment for mental disorder).

And then:

(b) if the need for the package of physical treatment did not exist, would he conclude that P should be detained in a hospital, in circumstances that amount to a deprivation of his liberty. And then, on that basis

(c) whether the only effective reason why he considers that P should be detained in hospital, in circumstances that amount to a deprivation of liberty, is his need for the package of physical treatment.

88. If he answers part (b) in the negative and part (c) in the affirmative then the relevant instrument does not authorise P to be a mental health patient and the condition in paragraph 5(3) is not satisfied.

89. At part (a) of the question the decision maker must identify P's package of care for mental disorder (and thus the treatment for, or which will be likely to directly affect P's mental disorders as defined by the MHA 1983 and any physical disorders or illnesses that in his view are connected to them). It seems to me that if, having done so, the decision maker is of the view that the criteria set by, or the grounds in, s.2 or s.3 MHA 1983 are satisfied then on that "but for" approach he would have to answer part (b) and (c) differently. This is because he could not then conclude that the package of physical treatment was, on that "but for" approach, the only effective reason why he considers that P should be detained in hospital, in circumstances that amount to a deprivation of his liberty.

90. So, generally the application of this "but for" approach or test will effectively incorporate an application of the status test or gateway set by paragraph 12(1)(a) and (b) of Schedule 1A, applying the approach to it that I have concluded is the correct one (namely, that the decision maker should determine whether in his view the criteria set by, or the grounds in, s. 2 or s.3 MHA 1983 are met - and if an application was made under them a hospital would detain P).

91. To my mind this "but for" approach or test also recognises, and caters for the points, that:

(a) it falls to be applied against a background that the Mental Health Requirement and the Best Interests Requirement will also have to be satisfied,

(b) it will not be uncommon that when P is in hospital (say for an operation) he will continue to receive the treatment for his mental disorder that he has been having in the community (e.g. medication),

(c) it will not be uncommon that there will be cases in which some care (e.g. nursing, monitoring and providing a safe environment) is the appropriate background for, or part of the treatment for, both P's mental disorders and his unconnected physical disorders or illness, and would therefore be included in both packages of treatment if and so long as, or to the extent that, they were to be given in a hospital, and

(d) the existence of such an overlap may not be decisive in determining whether the only effective reason why the decision maker concludes that P should be detained in a hospital, in circumstances that amount to a deprivation of liberty, is his need for care and treatment for his physical disorders or illnesses that are (i) unconnected to, and (ii) are unlikely to directly affect, his mental disorders.

92. The point that the paragraph 5 test applies when the status test or gateway is satisfied (and thus when the decision maker has concluded that P could be, although he has not

been, detained under s. 2 or s. 3 of the MHA) might be said to favour a wider approach to paragraph 5(3), based on say a consideration of the predominant, primary or significant purpose of the reason for deprivation of liberty because my approach effectively elides the status test or gateway with the paragraph 5 test.

93. But, in my view the primacy of the MHA 1983 supports my "but for" test albeit that I acknowledge that its application does not exclude the possibility of there being an overlap between the two statutory regimes because, as the authorities relating to whether treatment for physical disorder for illness can be considered as treatment for a mental disorder indicate, in some cases when the "but for" test is applied other decision makers might properly and lawfully reach different conclusions.

94. But those authorities also confirm that value judgments inevitably arise in borderline cases and I have concluded that a "but for" approach recognises the primacy of the MHA 1983 but also provide a practical approach that should help to minimise gaps and the potential for persons who lack capacity suffering harm by falling between the two statutory regimes, particularly in cases of emergency.

95. The application of Cases A to D was not investigated or argued before me. So the following views are preliminary ones.

96. Case A is a clear indication of the primacy of the MHA 1983 when a person is detained in hospital under the hospital treatment regime and it would seem that when it applies P cannot be deprived of liberty under the MCA in a hospital for any purpose. But by definition P is not so detained when Case E applies, and although such detention could occur because P is "within the scope of the MHA 1983" as defined, in my judgment this does not mean that Case E should be equated to Case A.

97. The test in paragraph 4(2) applies to Cases B and C and thus when P is subject to the Hospital Treatment Regime but not detained in hospital under it or the Community Treatment Regime (both under the MHA 1983 and defined by paragraphs 8 and 9 of Schedule 1A). The test in paragraph 4(2) is differently worded to paragraph 5(2) in that it provides that P is ineligible if the relevant care or treatment consists in whole or in part of treatment for a mental disorder in hospital. Paragraph 3 also applies and provides that P is ineligible if the authorised course of action (as defined) is not in accordance with a requirement of the relevant regime (i.e. the mental health regime to which P is subject) imposes.

98. It seems to me that in contrast to Case A the eligibility tests under Cases B and C permit P to be deprived of his liberty under the MCA for relevant care or treatment that is not in whole or in part treatment for a mental disorder (e.g. if it is for a heart operation). To my mind the use of the word "relevant" enables the physical treatment to be isolated on a "but for" approach so as to enable detention in hospital in circumstances that amount to a deprivation of liberty to be authorised or ordered under the MCA in respect of treatment for a physical disorder or illness.

99. In my view, these preliminary views on Cases A to C provide support for the conclusions I have reached in the application of the tests or gateways under Case E.

Application in this case

Approach in law

100. I did not hear argument on the approach to be taken by the Court of Protection under s. 21A, but all parties proceeded on the basis that the Court should reach its own conclusions on the evidence before it rather than take an approach equivalent to either that taken on an appeal from a discretionary decision, or on a review of a decision at public law.

101. I have taken that approach and my preliminary view is that it is correct. That is the approach the Court would have to take if it was making a welfare order that has the effect of depriving P of his liberty. Further, in my view the court should focus on the position when the case is before it rather than the position when the standard authorisation was granted.

102. The approach to be adopted to assessing the lawfulness of a deprivation of liberty under a standard authorisation (whilst it is in force) that the Court varies or terminates because, without a change of relevant circumstances, the Court reaches a different view to the persons who granted the standard authorisation was not argued, and does not arise on the approach I have taken based on the evidence before me when this case was argued on 2 November 2009.

103. Naturally I heard no argument on the impact of the change which occurred because of, or in respect of the changes which founded, the detention of GJ pursuant to s.2 MHA 1983 on 6 November 2009.

The facts

104. Professor McWilliam, a consultant psychiatrist, instructed for the purpose of these proceedings by the Official Solicitor, has reported:

> **"Diagnosis and prognosis**
>
> GJ has a diagnosis of Vascular Dementia. He also has a diagnosis Korsakoff's Syndrome and Amnestic Disease due to Alcohol. Both these conditions are Psychiatric Illnesses, as per the Mental Health Act 1983. Both these conditions are chronic, irreversible and not susceptible to direct medical treatment. His prognosis, is, therefore, one of continued mental deterioration.
>
> His physical health is also likely to deteriorate and close monitoring of his diabetes and its treatment with Insulin will form a key part of his care plan. ---
> ---
>
> **Capacity**
>
> I believe that GJ does not have capacity to litigate. I believe that GJ does not have capacity to make directions as to management of his property and affairs. I believe that GJ does not have capacity to make decisions about his current and future care needs including place of residence.

He has no concept of risk associated with his chronic mental and physical disorders. I relation to all the above he cannot –

- understand information about the decision to be made;
- retain that information;
- use or weigh the information as part of the decision-making process: or
- communicate the decision (by any means).

I believe this lack of capacity to be permanent and not susceptible to treatment."

105. Save as to his capacity to litigate (which was not addressed by them) this accords with the views of a number of doctors who have been involved in GJ's care, and/or assessment under the MHA 1983, for a Mental Health Review Tribunal hearing and in considering the application of the MCA.

106. All of this medical evidence is compelling and well reasoned. It founds the common ground, and my conclusion, that GJ does not have the capacity to litigate or to make the relevant decisions relating to his care, treatment and residence.

107. So the Court of Protection has jurisdiction and GJ is now represented by the Official Solicitor who helpfully and appropriately has instructed his previous counsel.

108. GJ is a man of 65. In October 2008 his partner died. She had previously assisted him in managing his diabetes in the community. Since then GJ's glycaemic control has been described by his previous treating consultant as "*appalling*". He is prone to hypoglycaemic attacks, and at high risk of brain injury and death if his diet and insulin intake is not adequately managed.

109. On at least two occasions just prior to his admission to hospital in December 2008 he had suffered a hypoglycaemic attack as a result of him neglecting his insulin injections, and his memory problems are such that on at least one occasion he has administered insulin to himself twice within a 10 minute period. The immediate background and trigger to his admission were these attacks.

110. A chronology of events is as follows:

11 Dec 2008	GJ detained under s.2 MHA at the C Clinic.
6 Jan 2009	GJ detained under s.3 MHA at the C Clinic.
20 Feb 2009	MHRT hearing – finding that the criteria for continued s.3 detention are met.
10 June 2009	GJ discharged to the K Care Centre, a residential care home, initially on trial leave under s.17 MHA (and subsequently pursuant to a DOLS authorisation).
5 July 2009	Authority for detention under s.3 (and hence s.17 leave) expires and is not renewed.

31 July 2009	Breakdown of the placement at K Care Centre and readmission to the H Unit at the C Clinic.
6 Aug 2009	Urgent authorisation for DOLS detention at the H Unit issued.
8-9 Aug 2009	First DOLS assessments conducted.
13 Aug 2009	Standard authorisation for DOLS detention at the H Unit issued (lasting until 10 Sept 09).
4 Sept 2009	Application to Court of Protection made by GJ.
9 Sept 2009	Further DOLS assessments conducted.
12 Sept 2009	Further Standard authorisation for DOLS detention at the H Unit issued (lasting until 16 Nov 09).
14 Oct 2009	First Court hearing: Directions for final hearing made.
2 Nov 2009	Hearing.
6 Nov 2009	GJ detained under s. 2 MHA 1983 for a period of assessment.

111. Expanding on the chronology:

(a) GJ was initially detained at the H Unit, C Clinic under s. 2 MHA 1983 on 11 December 2008. He was subsequently detained for treatment under s.3 MHA 1983 on 6 January 2009. The treatment plan of his treating consultant psychiatrist at that time was recorded in his two reports to the Mental Health Review Tribunal (MHRT) as *"to assess his problems further with a CT brain scan and get some OT assessments of his activities of daily living skills and functional cognitive skills. With time off alcohol in a sheltered environment and better nutrition his memory function may improve to a degree"* and *"to have further assessment and treatment of his amnesic syndrome"*. In addition to the above assessments, GJ's in-patient management when detained under MHA 1983 consisted of a detoxification programme, nursing care and medication. That medication consisted in vitamins, insulin and Acamprosate (which is intended to treat the symptoms of withdrawal from alcohol).

(b) GJ appealed against his detention to a MHRT. On 20 February 2009, having considered oral evidence and the above reports, the MHRT determined that GJ remained detainable under MHA.

(c) On 10 June 2009, GJ was transferred under s.3 MHA (on s.17 leave) from the C Clinic to the K Care Home. His liability for detention under s.3 expired on 5 July 2009. However, GJ "escaped" from the K Care Home on four occasions. This culminated in his being taken into custody by the Police and returned to the H Unit at the C Clinic on 31 July 2009.

(d) Following his return to the H Unit GJ was made the subject of an Urgent Authorisation under DOLS at the H Unit on 6 August 2009. It was due to expire on 12 August 2009.

(e) On 12 August 2009, a standard authorisation under DOLS was issued, expressed as lasting until 10 September 2009. In the Mental Health Assessment, GJ's mental disorder was stated as being "Korsakoff's psychosis and vascular dementia" and mention is made of insulin diabetes mellitus. The

clinical picture refers to a history of heavy alcohol abuse, very poor short-term memory, an inability to manage his diabetes because of these symptoms and the concomitant risk of self neglect and a consequent worsening of his mental and physical health. This largely echoes the submissions made to, and accepted by, the Mental Health Review Tribunal. GJ would say quite accurately, in the Eligibility Assessment by Dr N under E5 it is recorded that GJ objects to being in the hospital to be given medical treatment for his mental disorder, that there is no donee or deputy that has given valid consent and that he meets the criteria for being detained under sections 2 or 3 of the MHA. In the standard authorisation itself it is stated that: "*GJ needs to receive nursing care in hospital for both his physical health (diabetes) and for his mental health (alcohol related mental disorder)*". It is accepted by the Respondents that DOLS authorisation should not have been granted on 12 August 2009 on the basis of this document as, on its face, GJ did not meet eligibility criteria.

(f) A further standard authorisation lasting until 16 November 2009 was provided on 17 September 2009. The Eligibility Assessment supporting this authorization was on this occasion by Dr T. On the Eligibility Assessment form under E5 the "*no*" box is ticked, indicating Dr T's opinion that GJ was not detainable under s.2 or s.3 MHA and was hence eligible for a DOLS detention.

112. It is this standard authorisation that is the subject of these proceedings.

113. On behalf of GJ, it had been asserted that when he was at K Care Home GJ was unimpressed with an authorisation of his detention under the MCA (DOLS) whereas he recognised the force of the MHA 1983. But, whatever (a) his position and understanding then, and (b) the impact that such an understanding and objection might have on the application of paragraph 5 of Schedule 1A, in my judgment the present and undisputed evidence as to his capacity means that it cannot be said with any confidence what the reasons for his objection to remaining in hospital now are.

114. What can be said, and I find, is that he does so object and that if, and so far as, he is being detained for treatment for his mental disorder he objects to that.

115. Dr T, a Specialty Doctor specialising in old age psychiatry and who was the eligibility assessor under the MCA in September 2009 has provided two witness statements. In summary he states that:

(a) GJ is not suffering with a functional mental disorder like a psychotic illness or major depression which would need treatment against his will,

(b) GJ has not received any specific psychotherapy such as cognitive therapy or other definitive treatment of his mental disorder subsequent to his admission to the C Clinic in August 2009,

(c) no active treatment is being provided to improve his cognitive brain function at the current time since no curative treatment exists,

(d) the care and support that GJ has received since he has been at the clinic from August 2009 is care and treatment that could be provided by any health

professional or support worker and is not treatment that requires its provision by anyone qualified or specializing in psychiatric treatment. The care and treatment provided is general and not psychiatric in nature,

(e) GJ has been prescribed oral aspirin, thiamine, Acamprosate (a drug to maintain abstinence in alcohol dependence) and Vitamin B and Quetiapine (to assist sleep) however when he refuses to take these medications (as he very frequently does) they are not enforced upon him. He is not being detained in order to give him these medications, they are prescribed because taking them would be desirable but they are not considered sufficiently necessary to justify detention under s.3 MHA,

(f) when he was compulsorily detained under s.3 in January 2009 GJ was placed on detoxification treatment and therapies which were aimed at improving his mental health. There was no improvement in his mental condition with these interventions and these therapies are no longer being provided, and

(g) the treatment GJ requires (for his diabetes) does not need to be provided in a mental hospital setting or by hospital staff.

116. This description of the treatment that GJ was receiving was not challenged. I accept it.

117. However the correct application of the statutory regimes to that treatment was in issue given, in particular:

(a) the wide definition of "medical treatment" in s. 145 MHA 1983. It being submitted that "all the circumstances of the case" must be intended to include medical considerations and so the immediate and catastrophic consequences of self neglect is an appropriate consideration for the clinician considering the imposition of a section under the MHA 1983,

(b) an assertion by Dr T in his witness statement dated 12 October that the purpose of GJ's detention in the unit "is to provide a safe environment as well as to minimize the risk of sudden death of further brain damage as a result of fluctuations in his serum glucose level. It being submitted that the use of the phrase "as well as" shows that part of the treatment (largely nursing care and monitoring within a safe environment) was needed because of GJ's mental disorder,

(c) the reasoning of Dr W before the Mental Health Review Tribunal on 20 February 2009, that was accepted by the Tribunal and formed the basis of GJ's continued detention under s. 3 MHA 1983,

(d) the point that nothing significant had changed since then, and

(e) GJ's self neglect was a symptom or manifestation of his mental disorder that was being treated by the provision of nursing care, monitoring and a safe environment and that his failure to properly manage his insulin is only one aspect of his self neglect (albeit one that will cause very severe consequences if it is not ameliorated).

118. Without being asked to do so Professor McWilliam volunteered views as to the future management of GJ, he said:

> " I agree with the care plan as outlined in the clinical notes and by the named nurse, i.e. that GJ will require long-term care in an appropriate care home.
>
> This will require a period of assessment in which gives clear GJ can play now active part.
>
> I believe his current care plan as delivered in a psychiatric assessment unit amounts to psychiatric care as provided for in the Mental Health Act 1983.
>
> This would also apply to future care home placement, which I believe will require specialist input from psychiatrically trained care staff.
>
> I believe that this indicates his needs would be most appropriately met by use of the Mental Health Act (section 3 Treatment Order) rather than the Mental Capacity Act or DoL Legislation.
>
> This would enable supervision of any leave while assessment in a care home was taking place using Section 17 leave.
>
> Long-term placement may well require the provisions of Section 7 Guardianship Order that this would be subject to ongoing assessment and review. "

119. In my view correctly, counsel for GJ did not seek to place great weight on this opinion. However I mention it because it is an example of doctors with appropriate medical expertise reaching different conclusions as to which of the two statutory regimes should be applied.

120. Following the hearing I was notified that on 6 November 2009, Dr N and a different Dr W made an application that GJ be detained under s. 2 MHA 1983 for a period of assessment the reasons in the relevant form are as follows:

> " Patient has a pre-existing Korsakov's dementia. He has recently shown signs of depression with presenting ideas/delusion resulting in significant attempt to end his life. He has limited insight. Because of his very poor memory he is incapable of managing his diabetes with insulin. He needs a period of assessment regarding his recent drop in his mood and presenting ideation."

121. I was told that the significant attempt to end his life took place over the weekend 31st October / 1st November. None of the parties present in court was aware of this on 2 November.

122. So some 3 to 4 days after the significant attempt on his life the statutory regime pursuant to which GJ is detained in hospital was changed back to the MHA 1983 (this time s. 2).

Headline findings on the evidence

123. I find that:

(a) GJ suffers with a mental disorder (Vascular dementia and Korsakoff's syndrome),

(b) a feature or consequence and thus a symptom or manifestation of that mental disorder is self neglect (see Code of practice to the MHA 1983 paragraph 6.5 and the quote from the speech of Baroness Royall cited in Jones, Mental Health Manual (11th edition) at 1-1306),

(c) GJ suffers from diabetes which is unconnected with, not caused by and is not a symptom or manifestation of his mental disorder (although no doubt his drinking, diet and lack of personal care which can, at least, in part be attributed to his mental disorder have not helped his diabetes),

(d) GJ's direct treatment for his mental disorder and for his diabetes are different, and separate, although both are promoted by the provision of nursing care, monitoring and a safe environment,

(e) GJ's treatment for his diabetes is affected by his inability because of his mental disorder to manage it appropriately,

(f) GJ's treatment for his diabetes is unlikely to directly affect his mental disorder,

(g) the underlying reality of the position relating to GJ's care and treatment was not effectively different during the periods of the two standard authorisations albeit that on the wording of the first it should not have been granted,

(h) there is a relevant difference between the position when GJ was subject to a section under s.2 and s.3 MHA 1983 before August and the periods covered by the standard authorisation (up to and on the evidence before the court when this case was heard) because in the former period there was active assessment and treatment of his mental disorder, whereas during the latter this was not the case, and the medications he was being given that related to his mental disorder were thought to be desirable rather than of such importance that it warranted his detention in hospital, and

(i) the position has changed again as a result of the recent section under s.2 MHA 1983

The rival arguments

124. GJ's case is that he should not have been subject to detention under the MCA because he objects to being in the hospital in order to be given treatment, for his mental

disorder, or to being given some or all of the mental health treatment and he meets the criteria for detention under ss. 2 or 3 of the MHA. His case was argued:

(a) primarily on the "possibility test" to the application of paragraph 12 of Schedule 1A that I have rejected. But in the alternative by reference to the other tests, and

(b) on the basis that whilst the standard authorisations were effective (and thus up to the recent detention under s. 2 MHA 1983) GJ was receiving treatment for his mental disorder.

125. The First and Second Respondents' case is that when the authorisations were granted GJ was not ineligible under Schedule 1A MCA because:

(a) the purpose of his detention was to provide him with physical treatment for his insulin dependent diabetes;

(b) he was not being provided with treatment for his mental disorder; and

(c) he did not meet the criteria for detention under s. 2 or s.3 MHA. (This was argued on the basis that this was the result whether the approach to the meaning of "could" I have found to be correct was taken, or the "high probability or effective certainty" test was applied).

Conclusions

126. This is a borderline case and it provides an excellent example of the point that experienced doctors can take different views on relevant issues and that the position of someone like GJ when in hospital evolves and changes from time to time.

127. Also as he is in hospital and the nature of his treatment for diabetes means that he can be treated for it in that hospital, or in a care home, this case raises some different problems to one where the relevant treatment for a physical disorder or illness (e.g. an operation) is to be carried out in a different hospital.

128. Applying the approach to the construction and application of the MCA set out above I have concluded that although the provision of nursing care, monitoring and a safe environment are aspects of the care and treatment of GJ's self neglect that is a manifestation of his mental disorder, and thus within the package of medical treatment for that disorder, the First and Second Respondents are correct because in my judgment, on an application of the "but for" approach set out earlier, when both standard authorisations were given:

(a) His package of physical treatment so long as he remained in hospital was, and should have been, to ensure that he had his medication for his diabetes and the provision of nursing, monitoring and a safe environment.

(b) His package of treatment for mental disorder so long as he remained in hospital was, and should have been, the provision nursing, monitoring and a safe environment and medication for his mental disorder if, and importantly if, he did not object to taking it.

(c) So if the need for his package of physical treatment had not existed:

(i) he should not have been detained in hospital, in circumstances that amounted to a deprivation of his liberty, so that he would receive his package of treatment for mental disorder, and so on that basis

(ii) the only effective reason for his detention in hospital, and thus for the authorisations, was the need for him to be treated for diabetes by the receipt of his package of physical treatment.

(d) The reality is therefore that the standard authorisations do not authorise GJ to be a person accommodated in a hospital for the purpose of receiving his package of treatment for his mental disorders, in circumstances that amount to a deprivation of his liberty.

(e) Rather the reality is that the standard authorisations only authorised GJ to be a person accommodated in hospital, in circumstances that amount to a deprivation of his liberty, for the purpose of him being given treatment for his diabetes.

129. The same approach founds the conclusion that GJ is not within the scope of the MHA 1983.

130. This renders a consideration of the second condition in paragraph 5(4) of Schedule 1A, and thus his objections to treatment, academic. But in my view if the first condition had been satisfied then the second would also have been satisfied even if he was not physically resisting being medicated for his mental disorders (see paragraph 114 above).

Postscript

131. I would like to thank counsel and those who instructed them for their help in this case.

Summary of conclusions on the construction and application of the relevant provisions

132. As appears earlier in this judgment:

(1) The MHA 1983 has primacy in the sense that the relevant decision makers under both the MHA 1983 and the MCA should approach the questions they have to answer relating to the application of the MHA 1983 on the basis of an assumption that an alternative solution is not available under the MCA.

(2) A person can only be deprived of liberty by the MCA where:

(a) the deprivation is authorised by an order of the Court of Protection under section 16(2)(a) of the MCA; or

(b) the deprivation is authorised in accordance with the deprivation of liberty procedures (DOLS) set out in Schedule A1; or

(c) the deprivation is carried out because it is necessary in order to give life sustaining treatment, or to carry out a vital act to prevent serious

deterioration in the person's condition, while a decision as respects any relevant issue is sought from the court.

(3) Such an authorisation and order under s. 16(2)(a) can only be given or made if P is not ineligible to be deprived of his liberty by the MCA. This jurisdictional concept of ineligibility applies equally to a deprivation of liberty based on a welfare order of the court and a standard authorisation under Schedule A1. So, if the authorisation cannot be given on that jurisdictional basis the court has no statutory power to authorise a deprivation of P's liberty.

(4) That jurisdictional basis is to be considered by reference to the reality of its purpose and result rather than the wording of an authorisation.

(5) The decision maker should approach the status test or gateway concerning eligibility in paragraph 12(1) (a) and (b) of Schedule 1A by asking himself whether in his view the criteria set by or the grounds in s. 2 or s.3 MHA 1983 are met (and if an application was made under them a hospital would detain P).

(6) I have concluded that the correct approach for the decision maker to take when applying paragraph 5(3) is to focus on the reason why P should be deprived of his liberty by applying a "but for" approach or test. And to do that he should ask himself the following questions, namely:

(a) what care and treatment should P (who will usually have a mental disorder within the MHA 1983 definition) have if, and so long as, he remains in a hospital:

(i) for his physical disorders or illnesses that are unconnected to, and are unlikely to directly affect, his mental disorders (the package of physical treatment), and

(ii) for (i) his mental disorders, and (ii) his physical disorders or illnesses that are connected to them and/or which are likely to directly affect his mental disorders (the package of treatment for mental disorder).

And then:

(b) if the need for the package of physical treatment did not exist, would he conclude that P should be detained in a hospital, in circumstances that amount to a deprivation of his liberty. And then, on that basis

(c) whether the only effective reason why he considers that P should be detained in hospital, in circumstances that amount to a deprivation of liberty, is his need for the package of physical treatment.

If he answers part (b) in the negative and part (c) in the affirmative then the relevant instrument does not authorise P to be a mental health patient and the condition in paragraph 5(3) is not satisfied.

(7) At part (a) of the question to be applied in respect of paragraph 5(3) of schedule 1A, the decision maker must identify P's package of care for mental disorder (and thus the treatment for, or which will be likely to directly affect P's mental disorders as defined by the MHA 1983 and any physical disorders or illnesses that in his view are connected to them). If, having done so, the decision maker is of the view that the criteria set by, or the grounds in, s.2 or s.3 MHA 1983 are satisfied then on that "but for" approach he would have to answer part (b) and (c) differently. This is because he could not then conclude that the package of physical treatment was, on that "but for" approach, the only effective reason why he considers that P should be detained in hospital, in circumstances that amount to a deprivation of his liberty.

(8) So, generally the application of this "but for" approach or test will effectively incorporate an application of the status test or gateway set by Paragraph 12(1)(a) and (b) of Schedule 1A applying the approach to it set out in (5) above.

(9) To my mind this "but for" approach or test also recognises, and caters for the points, that:

i) it falls to be applied against a background that the Mental Health Requirement and the Best Interests Requirement will also have to be satisfied,

ii) it will not be uncommon that when P is in hospital (say for an operation) he will continue to receive the treatment for his mental disorder that he has been having in the community (e.g. medication),

iii) it will not be uncommon that there will be cases in which some care (e.g. nursing, monitoring and providing a safe environment) is the appropriate background for, or part of the treatment for, both P's mental disorders and his unconnected physical disorders or illness, and would therefore be included in both packages of treatment if and so long as, and to the extent that, they were to be given in a hospital, and

iv) the existence of such an overlap may not be decisive in determining whether the only effective reason why the decision maker concludes that P should be detained in a hospital in circumstances that amount to a deprivation of liberty, is his need for care and treatment for his physical disorders or illnesses that are (a) unconnected to, and (b) are unlikely to directly affect, his mental disorders.

(10) The decision maker should approach the test in paragraph 5(4) of Schedule 1A concerning eligibility without taking any fine distinctions between the potential reasons for P's objection to treatment of different types, or to simply being in a hospital. As is recognised and provided for by paragraph 5(6), this is because it is often going to be the case that the relevant person (P) does not have the capacity to make a properly informed and balanced decision. So what matters, applying the approach set out in paragraph 5(6), is whether P will or does object to what is proposed.

(11) The new provisions in the MCA do not cover taking a person to a care home or a hospital. But they can be given before the relevant person arrives there so that they take effect on arrival (see for example paragraph 52 of Schedule A1 to the MCA).

(12) Case E in paragraph 2 of Schedule 1A does not cover an authorisation that results in P being deprived of his liberty in any place other than a hospital (see *W Primary Care Trust v TB* [2009] EWHC 1737 (Fam)). So, Case E does not impact on placement in a care home (or the relevant person's (P's) home or other accommodation in the community with a relative and/or a carer), and does not preclude the Court of Protection making an order that authorises a deprivation of P's liberty to take him to a hospital (or elsewhere). But the Court will have to consider whether it is appropriate to make any such "transportation order" having particular regard to the likely position when P gets to a hospital.

(13) More generally, a part of the relevant background to the construction issues that arise are the points that (a) compliance with Art 5(4) ECHR requires that deprivation of liberty is only implemented in accordance with a procedure prescribed by law, (b) before and after the amendments such procedures for the lawful authorisation of a deprivation of liberty are provided by the MHA 1983, when it applies, and (c) after the amendments such procedures, in defined circumstances, are provided by the MCA. So the statutory provisions for suspension and review of standard authorisations are matters that the Court of Protection should take into account in determining whether (a) it should make an order authorising the deprivation of P's liberty, and if so (b) the extent and period of such an authorisation and in particular whether, and/or for how long, it should continue after P is placed in a hospital or a care home having regard to, for example, the authorities relating to the need for review of a deprivation of liberty based on the exercise of the inherent jurisdiction.

(14) The statutory power to make a welfare order that deprives P of his liberty is different to the statutory power to make declarations conferred by section 15 of the MCA. It follows that, if and when the Court of Protection (or any other court) is invited to authorise a deprivation of liberty it will need to consider whether it has jurisdiction to do so based on the MCA (or on some other basis) and how it should do so in exercise of that jurisdiction.