Neutral Citation Number:[2023] EWCOP 33

Case No: COP14053021

IN THE COURT OF PROTECTION

ON APPEAL FROM HHJ BURROWS

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 10/08/2023

Before :

MRS JUSTICE THEIS DBE

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Between :

	MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	**Appellant**
	- and -	
	JS (by her Litigation Friend, the Official Solicitor)	**1st Respondent**
	- and -	
	MANCHESTER CITY COUNCIL	**2nd Respondent**
	- and	
	MIND	**1st Intervener**
	- and	
	SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE	**2nd Intervener**

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Ms Helen Mulholland K.C. and Ms Aisling Campbell (instructed by **Hill Dickinson LLP**) for the **Appellant**
Mr Neil Allen (instructed by the **Simpson Millar LLP** for the **1st Respondent**
Ms Eliza Sharron (instructed by **Weightmans LLP)** for the **2nd Respondent**
Mr Alex Ruck Keene K.C. (Hon) (instructed by **MIND)** for the **1st Intervener**
Ms Arianna Kelly (instructed by **SHSC)** for the **2nd Intervener**

Hearing date: 20 July 2023
Judgment: 10 August 2023

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Approved Judgment

This judgment was handed down remotely at 10.30am on 10 August 2023.

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MRS JUSTICE THEIS DBE

This judgment was delivered in public and the proceedings are subject to the Transparency Order dated 21 June 2023. The anonymity of JS must be strictly preserved and nothing must be published that would identify JS, either directly or indirectly. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Mrs Justice Theis DBE :

Introduction

1. The court is concerned with the appeal by Manchester University Hospitals NHS Foundation Trust ('the Trust') from the decision of HHJ Burrows ('the Judge') on 18 April 2023, when he refused the application by the Trust for orders in the Court of Protection. Permission to appeal was granted on 21 June 2023 on all grounds.

2. The respondents to the appeal are the young person who is the subject of these proceedings, JS, age 17 years, through her litigation friend the Official Solicitor, and Manchester City Council ('the local authority'). The respondents oppose the appeal. In addition, there are two interveners, MIND and the Secretary of State for Health and Social Care ('SHSC'). JS's mother was notified of this appeal but did not take any steps to participate. The proceedings regarding JS are continuing to be heard by the Judge in which the mother takes an active part.

3. In summary, the appeal concerns the interpretation of Schedule 1A to the Mental Capacity Act 2005 (MCA 2005) and the basis upon which the court sitting in that jurisdiction should determine ineligibility. In one sense this appeal is academic as the situation has moved on for JS, she is now detained pursuant to s3 Mental Health Act 1983 (MHA 1983). However, the issues in this appeal may arise again in this case and, in any event, there is a wider interest in the appeal.

4. In accordance with rule 20.14 Court of Protection Rules 2017 (COPR) the appeal will only be allowed if the decision of the judge was wrong or unjust due to a procedural error. The appellant submits the judge was wrong.

5. The court has had the benefit of detailed written and oral submissions from counsel for each of the parties and two interveners, MIND and SHSC. The court is extremely grateful for the depth and eloquence of those submissions.

6. The wider issues that arise in this case are, sadly, not unusual and have been highlighted in a number of judgments, most recently by the President of the Family Division, Sir Andrew McFarlane in *Re X (Secure Accommodation: Lack of Provision)* [2022] EWHC 129 (Fam) a judgment designed, as he set out in paragraph 1, to *'shout as loud as [the court] can'* about the shortfall in provision '*in the hope that those in Parliament, Government and the wider media will take the issue up'.* Although that case concerned an application for secure accommodation under s 25 Children Act 1989 (CA 1989), the shortages of suitable accommodation to meet the needs of young people who are being deprived of their liberty applies in a wider context. It is not a new issue (see former President of the Family Division, Sir James Munby, in *Re X (A Child) (No 3)* [2017] EWHC 2036 (Fam). Much of what was said in that case applies today, nearly six years later with little, if any, evidence of change.

7. As the President observed in *Re X (Secure Accommodation: Lack of Provision) (ibid)* at [42] *'Despite the regular flow of judgments of this nature over recent years, it is, at least from the perspective of the experienced senior judges who regularly deal with these cases, a matter of genuine surprise and real dismay that the issue has, seemingly, not been taken up in any meaningful way in Parliament, in Government or in wider public debate.'*

8. In this case no party suggested that JS was in a placement that met her needs, including those who cared for her. There are repeated references in the records of a mixed adult acute mental health ward being wholly unsuitable for her. Those caring for her were ill equipped to manage her extreme behaviours that not only put JS but also others at high risk of serious harm. There was no other placement for her.

9. I agree with the observations made by other judges as set out between [28] – [41] in *Re X (Secure Accommodation: Lack of Provision) (ibid).* The situation remains very difficult and challenging for the young people concerned and their families; for the staff in the hospitals who are having to manage these difficult and dangerous situations, when they are ill equipped and not trained to do so; and for the wider community, as it can often bring whole wards and departments in hospitals to a standstill due to the drain on resources and the disruption these situations cause. In addition, these cases take up scarce judicial court time and resources, with consequent delays for other cases being heard.

10. In *Re X (Secure Accommodation: Lack of Provision) (ibid)* at [59] the court was informed the Secretary of State for Education accepted that cross government action was required. I understand the government has in the past month set up a high-level cross departmental group to look at this, drawn from Departments of Education and Health. It is hoped this step will help improve the situation which is causing so much harm to some of the most vulnerable young people in society.

Relevant background

11. JS has a diagnosis of autistic spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), learning disability and an attachment disorder.

12. JS was admitted to a Tier 4 CAMHS unit on 16 December 2022, age 17 years. The admission was initially an informal admission. JS was assessed as having capacity and became an informal patient under s131 MHA 1983. That admission was changed on that day to be for assessment under s 2 MHA 1983.

13. JS was discharged home on 4 January 2023. Two days later she absconded from home on 6 January 2023 and ran in front of moving traffic. She was taken to A&E, absconded again and was taken to a place of safety under section 136 MHA 1983.

14. Following a review by the relevant assessment centre and a discussion with Dr A she was not considered suitable for inpatient admission and was discharged home.

15. On 7 January 2023 JS stole a large amount of paracetamol and took these in overdose. JS's mother called the police who took her to hospital under s136 MHA 1983 where she was admitted.

16. JS was detained under s 2 MHA 1983 on 8 January 2023 and admitted to a general hospital. That lapsed on 5 February 2023 and JS remained on the ward subject to the same restrictions.

17. An application to the Court of Protection was made by the Trust on 10 February 2023 to seek authorisation for her continued deprivation of liberty.

18. At that time, JS was represented within those proceedings by her mother as litigation friend.

19. The application was listed on 21 February 2023. The Judge heard the oral evidence of Dr K, consultant psychiatrist, who was JS's treating clinician. Declarations were made under s15 MCA 2005 that JS lacked capacity to make decisions as to whether or not to remain in hospital, the restrictions in place, medical treatment including medication and where she should live. The Judge ordered under s16 MCA 2005 that it was in her best interests to remain and be cared for in the hospital and authorised the deprivation of her liberty under s4 MCA 2005.

20. At that hearing the Judge raised the issue of whether JS was ineligible under the MCA 2005 and sought further submissions from the parties. Pending his determination of that issue he accepted the court had jurisdiction.

21. On 24 February 2023 the court re-authorised the deprivation of liberty until 27 February 2023, when JS was discharged from hospital, and directed written submissions by 13 March 2023.

22. On 2 March 2023 JS was taken to the hospital by the police pursuant to s136 MHA 1983, following an attempt to harm herself.

23. On 6 March 2023 the Trust confirmed that JS had been detained under s 2 MHA 1983. JS remained in hospital for two weeks before being transferred to the Tier 4 placement on 16 March 2023.

24. JS's s 2 was due to lapse on 31 March 2023. The Tier 4 placement arrangement was that JS would remain as an informal patient pursuant to s5(2) MHA 1983, which gives the doctors the ability to detain her for up to 72 hours.

25. On 18 April 2023 JS was further detained following her causing damage to the ward. JS was placed in holds and taken to the intensive nursing suite and later returned to the ward. As JS was expressing her wish to leave a decision was made for JS to be placed on s5(2) MHA 1983.

26. In his judgment dated 18 April 2023 the Judge determined JS was ineligible to be deprived of her liberty under the MCA 2005.

27. On 19 April 2023 JS was reviewed and detained under s 2 MHA 1983.

28. On 5 May 2023 JS was placed on s 3 MHA 1983 and moved placement. The case has continued to be considered by the Judge, with the next review due on 4 September 2023.

Relevant legal framework

The context

29. The purpose of introducing Schedule 1A MCA 2005 was, in part, to promote a consistent framework for detention of people in hospital for medical treatment of mental disorders who were objecting to that treatment. The policy behind Schedule 1A is such patients, with or without capacity, who were considered to require detention for the purposes of medical treatment for mental disorders should be treated in the same manner.

30. As regards the interface between the MHA 1983 and MCA 2005 neither Act is to have primacy over the other. The choice as to which Act is used will turn on the relevant decision-maker's consideration of the options that are available.

31. There are different frameworks to prevent the arbitrary deprivation of someone's liberty including:
    (1) MHA 1983, which can authorise a person's confinement in a hospital for the purpose of assessing and treating mental disorder.
    (2) The MCA 2005, which can take place in two ways, namely (i) the administrative process of the deprivation of liberty safeguards whereby a supervisory body can authorise the confinement of an adult in a hospital or care home; (ii) the judicial process of the Court of Protection whereby a judge can authorise the confinement of someone age 16 years and over in any care setting.
    (3) The inherent jurisdiction of the High Court, including for those who are under 18 years and some adults in certain circumstances, such as those who do not lack capacity, but are in some respect considered vulnerable.

32. In the SHSC's written submission he provided a very helpful overview of the scope of s 2 and 3 MHA 1983 which is set out below:
    a. *The vast majority of people with mental disorders are treated in the community, without any form of detention being used in their care or treatment. Many individuals who require treatment in hospitals for mental disorders and are not objecting to that treatment are treated on an 'informal' or 'voluntary' basis,*

residing in hospital, but not being detained. This is in keeping with the 'least restrictive' principle under the MHA. (See s.13(2) MHA, MHA Code of Practice at 1.1-1.6) Any decision to detain a person for the purposes of assessment or treatment of a mental disorder under ss.2 and 3 MHA should only be taken where it is necessary to do so and in accordance with the MHA.

b. *If a patient is not objecting to inpatient treatment but lacks the capacity to consent to it and is deprived of their liberty, it may be appropriate to authorise this detention under the MCA. (See MHA Code of Practice at 13.49-13.70; the SHSC would note in particular paragraph 13.60).*
c. *An application for admission to hospital under ss.2 or 3 MHA must be made to a named hospital. An application for admission to hospital under the MHA should only be made where it has been confirmed that the hospital has the capacity to admit the person. A person may be transferred to a different hospital while remaining under a ss.2 or 3 MHA detention.*
d. *The 'least restrictive' principle exists under both the MCA and MHA. Detentions under both the MCA and MHA should be tailored to eliminate unnecessary restrictions on the person, and in particular, avoid 'blanket' restrictions which are not related to the person's particular needs where possible. (Paras 8.9-8.14 MHA Code of Practice)*
e. *The MCA and MHA both have frameworks to facilitate a person's right to challenge a deprivation of liberty pursuant to Article 5(4) ECHR, though the frameworks operate differently.*
f. *Inpatient treatment may occur in a variety of settings, and hospitals and wards may have different specialisms or patient populations. Individual hospitals or categories of hospitals may have their own criteria for admission, which exist alongside the MHA framework.*
g. *'Gatekeeping' assessments are notably a feature of admission to inpatient settings which serve children and adolescents, known as Children and Adolescent Mental Health Services (CAMHS) Tier 4 units. Acceptance to a Tier 4 CAMHS service takes place through the National Referral and Access Process; this process was recently described in the judgement of MacDonald J in Blackpool Borough Council v HT (A Minor), CT, LT and Lancashire and South Cumbria NHS Foundation Trust [2022] EWHC 1480 (Fam). A child or young person will not be admitted to a Tier 4 CAMHS service unless <u>both</u> the requirements of the MHA are met, and the child's admission is recommended by the Gatekeeping service.*
h. *An individual who is considered to require admission to hospital for medical treatment for a mental disorder may not be able to immediately access the full range of inpatient options, as they may not be available at the time the person is considered to require detention. A person may be admitted to a hospital under ss.2 or 3 MHA which is not necessarily seen as a long-term option for the person's care and treatment because the person is considered to need care immediately, a bed is immediately available to the person at the hospital and the hospital provides the most appropriate treatment for the person's mental disorder which is available <u>at the time.</u>*
i. *Detentions under ss.2 or 3 MHA may be of long or short duration, and any s.2 detention can last a maximum of 28 days. Per the MHA Code of Practice at 1.4, '[i]f the [MHA] is used, detention should be for the shortest time necessary in the least restrictive hospital setting available.'*

j. A detention under ss. 2 or 3 MHA can be ended at any time by the person's responsible clinician if they consider that detention is no longer required to achieve the person's treatment. The appropriateness of continuing a detention under the MHA should be kept under continuous review by treating clinicians.

k. The question of whether it is necessary to detain a person under the MHA for treatment is not determined by absolute descriptions or metrics, but will depend on whether there is a less restrictive means available to deliver the person's treatment. If treatment for the person's mental disorder is actually available without the person being detained in hospital, this is likely to be highly relevant in any consideration as to the use (or continuation) of ss.2 or 3 MHA.

l. Appropriate care and treatment in the community may take time to arrange, and may not be immediately available to the person outside of hospital. If no appropriate care and treatment for the person's mental disorder is yet available in the community because care planning is ongoing, this is also likely to be relevant to the consideration of the use of ss.2 and 3 MHA, and the appropriate duration of the person's detention under the MHA.

Schedules 1A and A1 MCA 2005

33. These were introduced into the MCA 2005 through the Mental Health Act 2007. This was in order to close the gap in the law where incapacitated compliant mental health patients were being unlawfully deprived of liberty in hospital because they did not meet the MHA 1983 criteria but were not free to leave.

34. Schedule A1 provides the administrative procedure to authorise such confinement in hospitals and CQC registered care homes. In circumstances that do not fall within that procedure, the Court of Protection's powers to deal with deprivation of liberty in other circumstances are under s 4A, 16, 16A MCA 2005.

35. Both the judicial and administrative procedures are subject to the provisions under Schedule 1A MCA 2005 which provides the framework for the interface between detention under the MCA 2005 and MHA 1983.

36. Schedule 1A MCA 2005 establishes that certain categories of people cannot be deprived of their liberty under the MCA 2005, or places restrictions on what deprivations of liberty may be authorised under the MCA 2005. These provisions determine whether that person is eligible or not.

37. Schedule 1A sets out five situations, referred to as 'cases', where arrangements which deprive a person of their liberty may be considered between the MCA 2005 and MHA 1983. Cases A-D concern those already detained under the MHA 1983, which did not apply in this case. This case concerns Case E.

    Part 1

    INELIGIBLE PERSONS

    Determining ineligibility

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

(b) 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.

For someone to be "*ineligible*" under Case E the relevant person:

(a) has to be within the scope of the MHA 1983, and
(b) paragraph 5 has to be satisfied. [i.e., the patient must object to some or all of the mental health treatment].

"Within the scope of the Mental Health Act" is defined by paragraph 12 of Schedule 1A as (emphasis added):

"(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.

Paragraphs 5, 12, 16 and 17 Schedule 1A provide:

Objects to being a mental health patient etc (paragraph 5)

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 authorises P to be a mental health patient.

(4)The second condition is that P objects—

(a)to being a mental health patient, or

(b)to being given some or all of the mental health treatment.

(5)The third condition is that a donee or deputy has not made a valid decision to consent to each matter to which P objects.

(6)In determining whether or not P objects to something, regard must be had to all the circumstances (so far as they are reasonably ascertainable), including the following—

(a)P's behaviour;

(b)P's wishes and feelings;

(c)P's views, beliefs and values.

(7)But regard is to be had to circumstances from the past only so far as it is still appropriate to have regard to them.

P within scope of Mental Health Act (paragraph 12)

12(1)P is within the scope of the Mental Health Act if—

(a)an application in respect of P could be made under section 2 or 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.

Expressions used in paragraph 5 (paragraphs 16 and 17)

16(1)These expressions have the meanings given—

- "donee" means a donee of a lasting power of attorney granted by P;
- "mental health patient" means a person accommodated in a hospital for the purpose of being given medical treatment for mental disorder;
- "mental health treatment" means the medical treatment for mental disorder referred to in the definition of "mental health patient".

(2)A decision of a donee or deputy is valid if it is made—

(a)within the scope of his authority as donee or deputy, and

(b)in accordance with Part 1 of this Act.

Expressions with same meaning as in Mental Health Act

17(1)"Hospital" has the same meaning as in Part 2 of the Mental Health Act.

(2)"Medical treatment" has the same meaning as in the Mental Health Act.

(3)"Mental disorder" has the same meaning as in Schedule A1 (see paragraph 14).".

38. As Schedule 1A governs both the judicial and the administrative authorisation procedures it applies to
    (1) Young people (16+) and adults subject to welfare orders (ss4A, 16-16A MCA 2005);
    (2) Adults subject to deprivation of liberty safeguards framework (MCA 2005 Schedule A1).

39. Schedule 1A does not govern s4B MCA 2005 which, if the conditions in that section are satisfied, authorise a person to deprive P of their liberty while a decision is *'being sought from the court'* (s4B(7) MCA 2005).

40. The MHA Code of Practice, which is a statutory guidance issued under s.118 MHA, discusses the definition of 'medical treatment for mental disorder' and 'appropriate medical treatment' as follows:

    23.3 In the Act, medical treatment for mental disorder means medical treatment which is for the purpose of alleviating, or preventing a worsening of, a mental disorder or one or more of its symptoms or manifestations.
    23.4 Purpose is not the same as likelihood. Medical treatment must be for the purpose of alleviating or preventing a worsening of mental disorder even if it cannot be shown, in advance, that a particular effect is likely to be achieved…

    23.6 Even if particular mental disorders are likely to persist or get worse despite treatment, there may well be a range of interventions which would represent appropriate medical treatment. It should never be assumed that any disorders, or any patients, are inherently or inevitably untreatable. Nor should it be assumed that likely difficulties in achieving long-term and sustainable change in a person's underlying disorder make medical treatment to help manage their condition and the behaviours arising from it either inappropriate or unnecessary…

    23.13 Medical treatment must always be an appropriate response to the patient's condition and situation and indeed wherever possible should be the most appropriate treatment available. It may be that a single medical treatment does not address every aspect of a patient's mental disorder.
    23.14 Medical treatment must actually be available to the patient. It is not sufficient that appropriate treatment could theoretically be provided.
    23.15 What is appropriate will vary greatly between patients. It will depend, in part, on what might reasonably be expected to be achieved given the nature and degree of the patient's disorder.

23.16 Medical treatment which aims merely to prevent a disorder worsening is unlikely, in general, to be appropriate in cases where normal treatment approaches would aim (and be expected) to alleviate the patient's condition significantly. However, for some patients with persistent and severe mental disorders, management of the undesirable effects of their disorder may be the most that can realistically be hoped for.
23.17 Appropriate medical treatment does not have to involve medication or psychological therapy – although it very often will. There may be patients whose particular circumstances mean that treatment may be appropriate even though it consists only of nursing and specialist day-to-day care under the clinical supervision of an approved clinician in a safe and secure therapeutic environment with a structured regime.

Section 3 MHA 1983

41. Section 3 MHA 1983 provides:

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.

GJ v The Foundation Trust [2009] EWHC 2974 (Fam) Charles J

42. The provisions in Schedule 1A were the subject of careful scrutiny by Charles J in *GJ v The Foundation Trust* [2009] EWHC 2972 (Fam).

43. In that case GJ was the subject of a Standard Authorisation, and detained in a hospital against his will under the authorisation. Whilst there, he was treated for diabetes and for his mental disorder. The treatment for his mental disorder took the form primarily of care and support. He was also prescribed various medications for his mental disorder but was never forced to take them against his will whilst subject to the Standard Authorisation.

44. The question was whether he was ineligible to be dealt with via the MCA 2005 on the ground that his circumstances fell more properly within the scope of the MHA 1983 and that he objected. Charles J made it clear at paragraph 59 that *'it is not lawful for medical practitioners referred to in [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 one regime preferable to the other in the circumstances of a given case'*.

45. In *GJ* the primary focus of argument was on the court's approach to the proper application of the word *'could'* in paragraph 12 (1) of Schedule 1A MCA 2005 and its meaning in the phrase *'an application in respect of P could be made under s3 or s3 MHA 1983'*. He set out the rival contentions and his conclusions as follows:

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 <u>not</u> 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 the 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).

46. Charles J continues, when considering paragraph 5(3) Schedule 1A, as follows:

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.

47. This was the test followed by the Judge and which is the subject of this appeal.

The key questions

48. In this appeal the parties have agreed the sequence of questions advanced by the Official Solicitor that distil the issues in Schedule 1A Case E, namely:

    (1) Is P a 'mental health patient'?
    (2) Is P an 'objecting' mental health patient?
    (3) Could P be detained under s 3 MHA 1983?

49. I agree these key questions provide a useful structure to aid practitioners and judges who have to navigate these choppy waters within a legal framework that could have been expressed with more clarity.

Submissions

The Trust

50. Ms Mulholland K.C. seeks to challenge the Judge's decision on two grounds (1) the judge wrongly concluded that P was ineligible within the meaning of Schedule 1A MCA 2005 on the basis that she was within the scope of the MHA 1983 and (2) the Judge wrongly concluded that there was a relevant instrument that authorised P to be a mental health patient.

51. In relation to the first ground her submissions can be summarised as follows:

    (a) The decision in *GJ* is different and distinct from the case of JS and that in so far as the Judge followed it he was wrong to do so. Her submissions suggested that the different facts in *GJ* and Charles J describing it as a ' *finely balanced case'* enable the court to distinguish it as to the facts. For example, in JS's case she only suffered from mental health conditions, not

concurrent mental health and physical conditions as in *GJ*. In *GJ* they had expert evidence, in JS's case they didn't.

(b) The Judge fell into error when asking himself the question whether the treatment P was receiving in hospital (which included chemical and physical restraint) was, or could be said to be, treatment for her mental disorder. That focus by the Judge on the treatment meant he failed to consider properly section 3 MCA 1983.

(c) The Judge failed to give any weight to the opinion of the clinicians where, the evidence was that the psychiatric team did not consider JS was appropriate for detention under s3. The Judge should have been slow to depart from those views and if he did he ought to have given cogent reasons.

(d) In reaching his decision the Judge failed to consider and apply a number of aspects of s3(2) MHA 1983 namely that the patient (a) is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; (b) it is necessary for the health and 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 detailed under this section; and (c) appropriate medical treatment is available for him.

52. The test contended for in *GJ* by the First and Second Respondents in that case is the more appropriate test where, Ms Mulholland submits, '*the Court is to pitch itself against the views of experienced clinicians',* it would have more certainty and could properly be referred to as the *'responsible clinician'* test.

53. Ms Mulholland submits the adoption of the decision maker test in accordance with *GJ* leads to a *'...counter-intuitive outcome. It cannot be right that a vulnerable young person who seeks the protection of the Court emerges with a decision which is contrary to her best interests and is, potentially, damaging to her'.*

54. Turning to the second ground of appeal; that the Judge wrongly concluded there was a relevant instrument that authorised P to be a mental health patient. Ms Mulholland submits that in reality JS was accommodated in hospital because it was considered unsafe for her to return home in the absence of a robust package of care.

55. The local authority required time to put that package of care in place and in the intervening period it was considered safer for JS to be in a hospital setting. That was the purpose, it was not so she could be given medical treatment for her mental health or otherwise. Any medical treatment was either consequent on her being in an unsuitable placement or would have been administered to her irrespective of where she was residing. Her discharge was dependent on the availability of the package of care not the completion of any treatment plan.

56. Ms Mulholland submits this is demonstrated by the fact that JS *was 'accommodated on an acute adult medical ward (not a psychiatric or mental health ward) run by an NHS Trust that employed no mental health staff'.* She submits the order under s 16(2)(a) MCA 2005 authorised the Trust to prevent JS from leaving hospital through the use of supervision, physical restraint and oral sedative medication. It was not a mechanism,

submits Ms Mulholland, for the court to authorise JS being accommodated in hospital so that she could receive medical treatment for a mental disorder.

57. Ms Mulholland agreed the three key questions posed by the Official Solicitor provides a useful framework; taking them in turn.

58. First, in considering whether JS is a mental health patient, Ms Mulholland submits it is necessary for the court to consider whether she was (a) receiving medical treatment for mental disorder, and, if so, what that treatment was and (b) what the purpose was of JS being accommodated in hospital.

59. The Trust accepts JS's diagnoses of autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD) and learning disability (LD) meet the criteria of JS having a mental disorder. It is accepted JS was receiving some medical treatment for her mental disorder while in hospital but Ms Mulholland submits that JS being required to remain in hospital with round the clock supervision could not amount to medical treatment for mental disorder. If anything, Ms Mulholland submits, the detention in hospital made JS's symptoms and manifestations worse as she continued to self-harm, express suicidal ideation, damage property and injure staff. Ms Mulholland submits the Judge failed to address the purpose for which JS was being accommodated in hospital.

60. Ms Mulholland contends the purpose was not to receive medical treatment for mental disorder and her date of discharge was dependent on when resources would be available for her in the community. She submits the physical and medical sedation was required because JS was in an unsuitable environment. The only reason JS was in hospital was due to the strain on resources, as was acknowledged by the Judge in his judgment below (at [44] – [45]). As a consequence, she submits, JS was not a mental health patient and there could not have been a relevant instrument authorising JS to be a mental health patient.

61. There is no issue between the parties as to the second question: is JS an 'objecting' mental health patient; JS did object.

62. The third question, could JS be detained under s3 MHA 1983? If not, she was not ineligible within the meaning of Schedule 1A MCA 2005 and the Court of Protection had jurisdiction. Ms Mulholland submits the court needs to consider first whether JS could be detained under s3 MHA 1983, and then whether the criteria for detention under s3 are met. She accepts for the purposes of MCA 2005 the decision maker is either the supervisory body for a standard authorisation or a Court of Protection judge for an order under section 16 MCA 2005. She submits the Judge considered the matter in the judgment below through the prism of JS's treatment rather than analysis of s 3 and as a result fell into error.

63. In her written submissions she raises the issue of a 'stalemate' where there is a dispute between the decision maker under the MHA 1983 and MCA 2005. She submits an adapted *GJ* test should be adopted where the MCA 2005 decision-maker interferes with the MHA 1983 decision maker only *'if their decision is not logical or rational'.* This is not a measure of negligence but much more akin to a public law test; it asks whether the decision should be interfered with. This would, she submits, avoid the stalemate situation. She invites the court '*not to overrule GJ but to distinguish it, and to equip decision makers with the tools to manage the inevitable 'stalemate' that arises from its application in cases such as this'.*

Official Solicitor

64. The Official Solicitor opposes the appeal. Mr Allen submits that the two grounds of appeal can be readily conflated to one ground: did the judge err in concluding that JS was ineligible by virtue of MCA 2005 Schedule 1A? He submits the leading case is *GJ* and Schedule 1A paras 5, 12, 16 and 17 determine case E eligibility.

65. Taking the key questions outlined above, he submits that in relation to the first question, is the person a 'mental health patient' this means in accordance with Schedule 1A paragraph 16 *'a person accommodated in a hospital for the purpose of being given medical treatment for mental disorder'.* It requires the MCA 2005 decision maker to determine what is the purpose of hospital confinement; is it to give treatment for physical or mental disorder? Often the treatment is for both physical and mental health issues, hence the rationale of Charles J to adopt the 'but for' test: 'but for' the need for the package of physical treatment should P be detained in hospital? If the answer is 'no', the person is a physical health patient and eligible. If the answer is 'yes' because of the need for treatment of mental disorder, the decision maker needs to proceed to the second question.

66. Mr Allen acknowledges that it is not always straightforward to distinguish between treatment for mental and physical ill-health. Paragraph 17 Schedule 1A assists, stating 'medical treatment' has the same meaning as in the MHA 1983. Section 145 (1) MHA 1983 provides that this includes *'nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care'* and explains at s145(4) *'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, a worsening of the disorder or one or more of its symptoms or manifestations'.* 'Mental disorder' has the same meaning as in the MCA Schedule 1A paragraph 14 which refers to the meaning in the MHA 1983, s1 MHA 1983 defines mental disorder as *'any disorder or disability of mind'* excluding drug or alcohol dependency.

67. As a consequence Mr Allen submits first, medical treatment is broadly defined but in relation to mental disorder it must have the purpose of alleviating or preventing a worsening of the disorder or one or more of its symptoms or manifestations. It requires the purpose of the treatment to be to alleviate or prevent a worsening. Chapters 23 and 24 of the MHA Code provide further explanation which, he says, supports his submission. Second, treatment for mental disorder is not limited to treating an 'underlying' or 'core' mental disorder. It includes addressing its manifestations, as

summarised by Charles J in *GJ* in [52], demonstrating the breadth of the MHA 1983 and its purpose insofar as medical treatment for mental disorder is concerned. Examples from previous cases illustrate the point, such as feeding was considered treatment for autism, dialysis was treatment for personality disorder and why treating wounds self-inflicted as a result of mental disorder also falls within the definition.

68. Turning to the second key question whether JS is an objecting mental health patient, Mr Allen notes that Schedule 1A paragraph 5 (6) and (7) are broadly drafted and include consideration of P's behaviour. This breadth is reflected in both the DoLS Code (at paragraph 4.46) and the MHA Code (at paragraph 13.51). The reasonableness of the objection is irrelevant and decision makers should err on the side of caution, and if in doubt treat the person as objecting.

69. Finally, the third key question; 'could' the person be detained under MHA 1983? The Official Solicitor supports the *GJ* test as determined by Charles J. Parliament entrusted the eligibility decision to the Deprivation of Liberty Safeguards assessor and ultimately the Court of Protection judge. The suggested change contended by the appellant is not supported by the Official Solicitor as it risks greater uncertainty and satellite litigation. Mr Allen submits *'It also conflicts with the aim of case E which is to put P on an equal footing with their capacitous counterpart.'* It risks undermining the safeguards of the MHA 1983 as there is a risk they would be routinely denied to those lacking capacity. The 'what the decision-maker thinks' test adopted in *GJ* means each decision-maker must consider the circumstances and reach their own decision based on the situation and available evidence. The reasoning of each can legitimately be probed by the other but in the final analysis neither can be compelled to change their decision.

70. Mr Allen submits the risk of stalemate is reduced as the statutory assumptions in Schedule 1A paragraph 12 play a key role in ensuring such reasoning is properly based. As Charles J observed in *GJ* at paragraph 58 the statutory assumptions assume that an alternative solution is not available under the MCA 2005 and aim to equate the position of P with that of their capacitous counterpart.

71. Part of this includes requiring the MHA 1983 decision-maker to assume that the MCA 2005 is not available . In *GJ* Charles J dealt with this at [46]:

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.

72. These assumptions are required only for mental health patients who are, or are to be, confined to hospital. As Mr Allen observed, removing the MCA 2005 presents the decision-maker with a stark choice: either the person is confined under the MHA

1983 or they are not confined at all. It provokes them to consider explicitly P's capacitous counterpart for whom similarly the MCA 2005 is not available. Based on the nature and degree of P's mental disorder, the risks arising, the options available, and P's objections: the question is does P meet the MHA 1983 grounds? If not, they cannot be deprived of their liberty in a hospital.

73. He submits the proper application of the statutory framework and statutory assumptions that apply to both sets of decision-makers serve to reduce, if not avoid, the risk of any gap developing between the two procedures.
74. In the event of a dispute, each decision-maker can legitimately probe the reasoning of the other. When a party, usually a hospital Trust, applies to the Court of Protection for authorisation to deprive liberty it will need to convince the judge that P is not ineligible. Evidence of the reasoning of the MHA decision-maker should be provided as part of the evidence in support of the application. In the interim, pending that decision, provided the stringent conditions are met, s4B MCA 2005 provides interim authority to deprive liberty whilst the court makes directions and determines P's eligibility. Subject to any appeal the parties are likely to accept the Court's determination on eligibility.

75. As Mr Allen notes, this case demonstrates how in practice some people have fallen through the gap in the procedures prescribed by Parliament and it is not limited to young people. The MHA Code paragraph 13.69 provides '*In the rare case where neither the Act nor a Dols authorisation nor a Court of Protection order is appropriate, then to avoid an unlawful deprivation of liberty it may be necessary to make an application to the High Court to use its inherent jurisdiction to authorise the deprivation of liberty'.*

76. In relation to this case Mr Allen submits JS was confined to a MHA registered hospital for the purpose of being given medical treatment for mental disorder. He submits this is clear from the care plan of restrictions dated 9 February 2023. As a result, JS was a mental health patient. JS was objecting to being accommodated and to treatment for her mental health disorder. Having considered the written and oral evidence, the Judge correctly decided that based on the statutory assumptions JS 'could' be detained under s3 MHA 1983.

Local Authority

77. Ms Sharron, on behalf of the local authority, supports the Official Solicitor's analysis. She rejects the appellants' submission that the Judge failed to apply the criteria under section 3(2) MHA 1983 or that he failed to give sufficient weight to the clinical opinion when applying the statutory criteria.

78. She submits that at [81], [88], and [90] of the judgment the Judge addresses section 3(2) MHA 1983 dealing with JS's mental disorders, the nature and degree of those orders and why detention in hospital was appropriate for treatment of those disorders.

79. The Judge clearly weighed in the balance Dr K's written and oral evidence, in particular at [42], [69], [70], [71] and [88] of the judgment. He did not disagree what was appropriate in terms of JS's care and treatment, only in relation to what the legal implications of it were. Dr K's evidence was that what they were providing did not meet the threshold under the MHA. The Judge disagreed and gave his reasons.

80. At [91] the Judge addresses s 3(2)(c) MHA 1983 in terms of why detention in hospital was necessary, referring to JS's health and safety or the protection of others noting *'The medical treatment she did receive as a detained patient in hospital was necessary to keep her safe and to prevent her from absconding or harming herself'.* The treatment could not be provided unless JS was detained because, as noted by the Judge *'There was not a readily available alternative when she was receiving it'.*

81. Section 3 (2) (d) MHA 1983 is addressed by the Judge at [69] – [71], [92] and [97] of the judgment. The Judge sets out at [67] – [71] how the treatment that JS was receiving meets the definition of treatment in accordance with s145 MHA 1983. There was no issue before the court that the measures set out in the care plan were necessary and appropriate.

82. As Ms Sharron emphasises, the issue was whether the provisions in the care plan represent treatment for mental disorder which was necessary for JS to be detained in order to receive it. In addition to the provisions in s145 MHA 1983, Ms Sharron relies on the MHA 1983 Code of Practice:

    '*23.5 Symptoms and manifestations include the way a disorder is experienced by the individual concerned and the way in which the disorder manifests itself in the person's thoughts, emotions, communication, behaviour and actions…'*

    Further the Code addresses the breadth of what may be considered appropriate treatment under the MHA 1983 :

    '23.17 Appropriate medical treatment does not have to involve medication or psychological therapy – although it very often will. There may be patients whose particular circumstances mean that treatment may be appropriate even though it consists only of nursing and specialist day-to-day care under the clinical supervision of an approved clinician in a safe and secure therapeutic environment with a structured regime.'

83. Ms Sharron submits the psychotropic medication, mental health reviews, nursing, restraint and therapeutic containment that the care plan provided, which should be considered holistically, was intended to alleviate or prevent a worsening of the symptoms and manifestations of JS's mental health disorders. As she observed, *'Whilst the treatment in the care plan may not have been the optimum treatment plan for [JS], no party sought to suggest that it was not, in and of itself, necessary and in [JS]'s best interests, given the lack of alternative available, and the risk to [JS] if she was discharged without suitable care being in place'.*

84. Ms Sharron referred the court to one entry to illustrate her point. On 28 January 2023 after a particularly difficult incident when JS tried to run off twice, she had to be restrained, additional security staff had to be called, medication was administered and the mental health team were called. The record notes *'they didn't turn up as they were short staffed'*. Additional medication was administered under physical restraint, there were '*10 security guards with a female support worker to hold and comfort her. She should be seen and cared for by MH team, as staff in assessment unit are not trained to handle mental health issues….'* There are similar entries on 29 and 31 January 2023 and the staff who cared for her recognised she was inappropriately placed in an acute ward area.

85. Ms Sharron submits 'appropriate treatment' under s 3(2)(d) is subject to the provisions in s3(4) MHA 1983 which provides *'In this Act, references to appropriate medical treatment, in relation to a person suffering from mental disorder, are references to medical treatment which are appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case'*.

86. The MHA 1983 Code of Practice provides further explanation

'23.11 The test requires a balanced and holistic judgment as to whether, medical treatment available to the patient is appropriate, given the nature of the patient's mental disorder, and all other circumstances of the patient's case. In other words , both the clinical appropriateness of the treatment and its appropriateness more generally must be considered'

One of the examples given at paragraph 23.12 of the Code as to what other circumstances may be considered is *'the consequences for the patient, and other people, if the patient does not receive the treatment available'.*

87. At the time of JS's detention, Ms Sharron submits, there were no alternatives available, the consequences to her would be severe, giving rise to a risk of significant self-harm or even death, unless she was detained, until a safe discharge plan could be put in place. She submits it is not uncommon for patients to be detained under MHA 1983 to remain subject to s3 until such time as a suitable discharge placement is available.

88. Ms Sharron rejects the appellant's submission that the treatment JS received was coincidental to being in a safe environment. She submits the evidence shows little change in the care JS was receiving when her s2 lapsed. There was no obvious change to the care plan and rejects any suggestion that JS was being provided with 'hotel type' services in the hospital, illustrated by just one example, the steps that had to be taken by the staff on 6 February 2023 to prevent JS securing a ligature. The risks remained very high for JS, they were largely caused due to her mental disorders and she needed the provisions in the care plan and to remain in hospital due to the high level of risk to JS.

89. As regards the test in *GJ*, Ms Sharron submits the 'but for' test applies to the first question, namely whether JS is a mental patient. The 'decision maker' test refers to the third question, namely whether JS could be detained under the MHA 1983 s2-3.

SHSC

90. On behalf of the SHSC Ms Kelly limits her written and oral submissions to assist the court on the framework of Schedule 1A MCA 2005. In her helpful analysis she agrees with the submissions of the Official Solicitor and local authority as to the legal framework.

91. If it is proposed that a person should be detained in hospital but authorisation has not been given under the MCA 2005 or MHA 1983, she submits professionals should meet and discuss the position in the spirit of co-operation to seek a resolution. Consideration should be given to what can be put in place to support the person in the community pursuant to s117 MHA 1983 and/or Care Act 2014 duties. She submits *'It cannot be an appropriate outcome for people to remain de facto deprived of their liberty in hospital without legal authorisation'.*

MIND

92. The helpful submissions on behalf of MIND provided some important context and highlighted the difficulties in the application of the legal framework which could have been better expressed, taking into account the stretched resources in the community. There is a need for the construction of Schedule 1A that makes clear: (1) who is making the decision; (2) what test they are applying; and (3) what should happen when there is disagreement between professionals or organisations. MIND supports the test regarding Schedule 1A as determined by Charles J in *GJ* at least in respect of the test to decide which regime should be used for a person not currently subject to either the MHA 1983 or MCA 2005.

Discussion and decision

93. Sadly, the circumstances that exist in this case reflect the wider problem of an alarming number of cases which involve legal issues that arise when a young person is deprived of their liberty where there are insufficient suitable places in the community. The Nuffield Family Justice Observatory has published research analysing data regarding applications under the inherent jurisdiction seeking orders that authorise deprivation of liberty relating to children. The latest data reveals that there are about 117 new applications per month, 60% relate to children who are 15 years and over, about 70 children a month within that age range.[1] Many of these cases involve significant difficulties about the suitability of placements the young people are in.

94. In this case the application was brought in the Court of Protection, which provides the legal framework for such orders for persons between the ages of 16 and 18 who lack capacity and who are not ineligible in accordance with Schedule 1A. Where a person is aged 18 and above, then the legal framework will be provided by the Deprivation of Liberty Safeguards regime, where it is applicable.

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[1] **National deprivation of liberty court: Latest data trends - June 2023 – Nuffield Family Justice Observatory** (nuffieldfjo.org.uk)

95. In her written submissions Ms Kelly provided a helpful summary regarding Case E under Schedule 1A MCA 2005, it applies **only**:

> (1) where it is proposed that a person should be deprived of their liberty (para 2 Schedule 1A MCA 2005).
> (2) where the proposed detention would take place in a hospital (paragraph 12(1) Schedule 1A MCA 2005; 'hospitals' is defined to have the same meaning as under Part 2 MHA 1983 (paragraph 17(1) Schedule 1A MCA 2005).
> (3) where a detention in hospital is proposed for the purpose of giving medical treatment for mental disorder (Paragraphs5(3) and 16(1) Schedule 1A MCA 2005) . 'Mental disorder' and 'medical treatment' both have the same meaning as in the MHA (Paragraphs 17 (2)-(3) Schedule 1A MCA 2005). Case E is not relevant if the person is being detained for the purpose of treating physical health.
> (4) where the person is objecting either to being a mental health patient or to be given some or all of the mental health treatment (paragraph 5(4) Schedule 1A MCA 2005). Objections are construed broadly, taking into account both statements and behaviours, wishes, feelings, views, beliefs and values (paragraph 5(6) schedule 1A MCA 2005).

96. The criteria in Case E to determine eligibility was the subject of careful and detailed examination by Charles J in *GJ*. As set out above, Case E applies where it is proposed that a person should be deprived of their liberty, in hospital, for the purposes of medical treatment for mental disorder, to which the person objects, but is not subject to detention under the MHA 1983.

97. Like this court, Charles J had the benefit of the SHSC intervening to assist the court. Charles J's conclusion and reasoning as to the test the court should apply is detailed in that judgment at [69] – [80] (as set out above).

98. I do not consider there is any reason or sound basis to depart from that test and analysis, as set out in *GJ*. Ms Mulholland sought to suggest that it has caused difficulties and uncertainty on the ground, and to avoid that the court should re-visit the arguments advanced in *GJ* by the First and Second Respondents in that case and rejected by Charles J for the reasons he gave at [75] and [76] of that judgment.

99. I agree with the other parties that the tests advocated by Ms Mulholland, where the MCA 2005 decision-maker interferes with the MHA 1983 decision-maker only if their decision is not *'logical and rational. This is not a measure of negligence, but much more akin to a public law test'*, would probably lead to more uncertainty and risk undermining the purpose of the legislation. Such a development would not be welcome in this area, where the legal landscape needs stability rather than further uncertainty.

100. In the end it was far from clear whether the appellant was actually challenging the test. In her skeleton in response Ms Mulholland invites the court '*not to overrule* GJ *but to distinguish it, and to equip decision makers with the tools to manage the inevitable 'stalemate' that arises from its application in cases such as this'.* There was no basis to distinguish it. Charles J clearly set out the principles as to how the test should be applied, recognising that the application will be fact dependent on the circumstances of each case.

101. I agree with the Official Solicitor that the two grounds of appeal can sensibly be merged into one, namely: did the Learned Judge err in concluding that JS was ineligible by virtue of MCA 2005 Schedule 1A?

102. The focus of Ms Mulholland's submissions was the failure by the Judge to deal with the relevant parts of s 3(2) MHA 1983.

103. In his careful and well-reasoned judgment the Judge addressed each of the three key questions the parties agree provide a helpful framework to consider these issues, namely:

(1) Is P a 'mental health patient'?
(2) Is P an 'objecting' mental health patient?
(3) 'Could' P be detained under MHA 1983 s2-3?

104. Was JS a mental health patient? As the Judge noted in [22] of his judgment, her care plan remained the same as it had been when she was subject to s2 MHA 1983 noting *'with exactly the same purpose namely to treat [JS's] challenging behaviour, largely by physical containment and the use of restraint both by physical intervention and medication.'* After detailing the medication the Judge stated [23] '*It seems entirely obvious to me those treating [JS] considered her behaviour to be a manifestation of her mental disorder. This pharmacological treatment was intended to combat it'.* Put simply, he concluded the purpose had not changed, she remained a mental health patient. As set out above, medical treatment is broadly defined but in relation to mental disorder it must have the purpose of alleviating or preventing a worsening of the disorder or one or more of its symptoms or manifestations. Treatment for mental disorder is not limited to treating an underlying or core mental disorder, it included addressing its manifestations. The conclusion the Judge reached was entirely justified on the evidence.

105. At [6] of his judgment the Judge identified her mental health diagnoses; ASD, ADHD, learning disability and an attachment disorder. He had evidence from the registered nurse that confirmed she was medically fit for discharge on 10 January 2023. The statement detailed evidence of what nursing was being provided to JS, that she continues to self-harm, wishes to end her life and the detailed incidents that had taken place since the s2 lapsed, including seeking to swallow a plastic cup and trying to self-ligature with a shower cord. The nurse's statement confirmed JS was not permitted to leave her room due to the risk of absconding and the severe risk of the consequences of that.

106. The statement from JS's treating psychiatrist, Dr K, confirmed at JS's review on 25 January 2023 the clinical view is that *'much of her difficulties relate to ASD, ADHD and LD'.* Later in the statement, he states these neurological disorders *'affect her ability to manage emotional, psychological distress, manage daily distress and relationships, changes to environment, limit her ability to adapt to changes. Her rigid thinking prevents her from considering other options…these therefore manifest in agitation and self-harm. She isn't able to identify triggers and cannot remember incidents of severe agitation. She is impulsive. All this makes her behaviour unpredictable. When she is in an agitated state she isn't able to think and consider the risks that her actions pose. She is not able to appraise her arousal and control herself and this therefore has required that restrictions are placed to maintain her safety in hospital'.* This evidence is all connected to JS's mental disorder. In the letter from the Trust to the social worker on 26 January 2023, it sets out how the risks relate to her neuro-developmental difficulties, again confirming that it is her mental disorder that gives rise to these risks and why the hospital needed to put in place the care plan.

107. The care plan includes medical treatment for the manifestation of her mental disorder, including physical and chemical restraint, regular room review by the nurse to remove any risky objects that JS could use to harm herself or others, restriction on leaving the hospital and a high level of supervision. The care plan provides detailed provision for sedative medication in the event JS's behaviour is not managed any other way. When undertaking the *GJ* 'but for' test the detail in this care plan is clearly not treatment for physical health but treatment for mental disorder.

108. The appellant submits the Judge did not ask the question regarding s3 MHA 1983, however the notes of Dr K's oral evidence make clear the Judge was probing this issue in connection with the care plan and that the treatment in it relates to her mental disorder, which Dr K acknowledged. The Judge explored with Dr K in his oral evidence why the provisions of the MHA 1983 had not been used.

109. As regards the second key question, there is no issue between the parties that JS objected.

110. Turning to the third key question, could JS have been detained under the MHA 1983 s2-3, the Judge considered this issue in some detail.

111. At [67] and [68] he set out s 3(2) and (4) MCA 1983. At [69] the Judge analysed the purpose of JS's care plan, concluded at [71] that JS's behaviours were '*manifestations of her mental disorder'*. As he states *'…put another way, [JS's] mental disorder causes her to abscond from safe environments, such as her home or hospital. It causes her to place herself at great risk of danger. It causes her to injure herself using sharp objects or taking overdoses. She has done this with alarming regularity. Nothing that those responsible for her care have been able to do has prevented her from doing so. However, that is what they were trying to do, and their treatment was aimed at that'.*

112. The Judge set out his reasoning at [90] – [97] as follows:

> *90. Firstly, that she was accommodated at the Hospital as a place of safety because there was nowhere else for her to go and, once the physical damage caused by her overdose was successfully treated, she needed no in patient medical treatment. The answer to that is: of course, she did. She was a danger to herself. She needed to be nursed safely and medicated to address the effects of her mental disorder (viz. to injure herself and abscond away for safety).*
>
> *91. It was submitted that although [JS] suffers from a mental disorder it was not of a nature or degree to make it appropriate for her to receive medical treatment for that disorder in a hospital. This is clearly wrong. The medical treatment she did receive as a detained patient in hospital was necessary to keep her safe and to prevent her from absconding or harming herself. There was no readily available alternative when she was receiving it.*
>
> *92 It is submitted that the outcome of the MHA Assessments was that inpatient care for [JS's] condition was neither available nor desirable because she could be treated in the community under the MCA. This too is plainly wrong. She could only be treated in the community once a suitable package of care was available for her. Until then she could not safely leave hospital. That was the situation with which I was confronted at the first hearing. At that point hospital was the only option.*
>
> *93. This is quite a familiar situation for those who practise mental health law. Patients who have been detained under the MHA (like [JS]) can theoretically be discharged into the community with a suitable package of care, but only when that package is actually available. Many weeks or months can be spent putting such packages together (funding, placement, support etc) and in place. During which time patients remain detained. The whole s. 117 process is designed to speed that up so as to ensure detained patients get out and stay out of hospital. Of course, because [JS] was never detained under s. 3 of the MHA, s. 117 aftercare was not available to her.*
>
> *94. The hospital thought that utilising the MHA to detain [JS] would be harmful to her mental health, as would her remaining in Hospital. This is an invalid argument which contains two fallacies. First, she was detained by her care plan which I have summarised above. What jurisdictional label is placed on the care plan is immaterial to its restrictive nature, whether that be MHA, MCA, "common law", the High Court's inherent jurisdiction is irrelevant to whether she was detained for treatment. That was the care plan's doing.*
>
> *95. Secondly, keeping her in Hospital for a day longer than was necessary was also nothing to do with the regime she was subject to. Good clinical practice and the operation of Article 5 of the European Convention requires a patient to be detained only for so long as is necessary. The MHA does not prolong detention. In fact, as I have already said, proper use of s. 117 should reduce the overall time a patient spends in Hospital because professionals inside and out of Hospital concerned with health and social care should all work together to put together an effective discharge plan speedily.*
>
> *96. There seems to be a belief, not just in this case but in others which I have heard recently, that the decision to use the MHA should be viewed in isolation from what is available elsewhere at the time the decision to detain or not detain is taken. Ideally, a 17-year-old vulnerable young person would not be detained in a*

psychiatric facility, let alone a mixed adult general ward. However, where there is literally no option in which that young person will be safe, or as safe as possible in the circumstances, I cannot see how the MHA decision maker can avoid the decision I have had to make in this judgment. If the patient has to be detained for treatment for their mental disorder, and there is no alternative outside the hospital setting, and no other treatment plan available, then it seems clear to me the patient should not be detained under the MCA but rather under the MHA.

97. In my judgment, [JS] was receiving medical treatment for her mental disorder. The order I was asked to make in the Court of Protection was intended to authorise that care plan which inevitably led to [JS] being deprived of her liberty for that purpose.

113. The Judge was entitled to reach the conclusions he did on the evidence he had. He anxiously considered the provisions of s3, the evidence he had available to him and clearly set out his conclusions with admirable clarity and reasons in support. He was not wrong, did not fall into error and there is no other basis upon which this appeal should be allowed. Accordingly, the appeal is dismissed.

Wider issues

114. The court has had written and oral submissions about what has been termed 'the stalemate' that could arise in these situations. The Official Solicitor, the local authority and the SHSC submit that if the legal framework is applied correctly there should be no stalemate or gap. If there is it relates to a gap in practice, rather than the legal framework.

115. Any judge who sits in this area will have encountered these difficult cases involving young people where an issue has arisen as to the appropriate legal framework under which the deprivation of liberty is sought to be authorised. There remain some misunderstandings, as there was in this case. The Trust case record referred to the continued authorisation of JS's deprivation of liberty when the s 2 lapsed prior to issuing these proceedings was under common law. Ms Mulholland rightly accepted that was incorrect.

116. A practical step that could be taken in cases where Schedule 1A Case E issues are likely to arise, is for evidence to be provided to address that issue, utilising the *GJ* framework. That would not only assist the court and the parties, but also focus the minds on what needs to be addressed both in terms of any decisions to date under the MHA 1983, the basis of the application in the Court of Protection and addressing the key questions outlined above.

117. As regards the issue of stalemate more generally, the practical suggestions outlined by Ms Kelly on behalf of the SHSC provide a useful road map for the parties to resolve any issues. They are set out below. Ms Kelly takes issue with what Ms Mulholland stated was one of the issues that caused the stalemate in this case, that the Trust did not have any approved mental health professionals ('AMHPs') to proceed with any

application under the MHA 1983. This perhaps illustrates Ms Kelly's first point below, as far as Ms Kelly is aware there is no evidence in this case that any attempt was made to contact an AMHP to try and resolve this issue.

118. Ms Kelly's practical suggestions are:

(1) The MHA and MCA decision-makers should arrange for discussions between the relevant professionals. They should be undertaken in what Ms Kelly describes as *'the spirit of cooperation and appropriate urgency'*. This will ensure the relevant professionals have reviewed and considered relevant evidence and if required further inquiries can be made.

(2) If these discussions do not result in a detention being authorised under the MCA the hospital has a number of choices:

(i) It can seek the person's admission under the MHA 1983 to authorise the deprivation of liberty, including on a short term basis while it seeks to advance the person's discharge;

(ii) It can seek for the person to be detained in an alternative setting, such as a care home, in which Case E has no application, with consideration being given to what can be put in place to support the person in the community under s 117 MHA 1983 and/or Care Act 2014 duties.

(iii) It can stop depriving the person of their liberty if it considers the person should not be detained under MHA 1983, even with the knowledge that the person will not be detained under the MCA 2005.

(iv) If the hospital does not consider that an application for assessment or treatment under MHA 1983 is warranted but does consider it is in the person's best interests to be detained in hospital for treatment of a mental disorder, it should consider carefully its reasons for drawing this distinction. The hospital could apply to the Court of Protection for a determination of whether the person is eligible for detention under the MCA 2005.

119. I can see the sense in the suggestion of an application to the Court of Protection for a determination being a possible route to resolve these issues, but that is not said with any encouragement for such applications to be made unless it is necessary, and only after all other options have been explored. It will be a matter for each individual judge whether such an application is accepted, depending on the particular circumstances of the case.

120. Although not advocated by the SHSC or MIND, the other parties submitted the inherent jurisdiction could, in certain circumstances, be resorted to. For those under 18 years that happens within the principles outlined by the Supreme Court in *Re T (A Child) (Appellant)* [2021] UKSC 35. Against the chronic shortage of provision of secure children's homes in England and Wales, it was determined in that case that the inherent jurisdiction of the High Court can be used to authorise the deprivation of liberty of a child who meets the criteria in s 25 Children Act 1989 (CA 1989) in a place other than approved secure accommodation, subject to safeguards.

121. For 16 and 17 year olds there is concurrent jurisdiction with the Court of Protection. There is provision in The Mental Capacity Act 2005 (Transfer of Proceedings) Order 2007 (SI2007/1899) for the transfer of proceedings in relation to such children between the Court of Protection and a court having jurisdiction under the CA 1989.

122. As Senior Judge Hilder noted in *Bolton Council v KL* [2022] EWCOP 24 at [46] the Court of Protection has been receiving and determining applications for authorisation of deprivation of liberty in the living arrangements of 16 and 17 year olds both with and without a care order in place. A recent increase has been noted of applications being made for this cohort of young people, as well as applications which begun as proceedings under the inherent jurisdiction that are transferred to the Court of Protection.

123. Drawing these threads together the following matters may provide a guide in these difficult cases:

    (1) In any application seeking authorisation to deprive the liberty of a 16 or 17 year old, the applicant should carefully consider whether the application should be made in the Court of Protection and, if not, why not.
    (2) If a Schedule 1A Case E issue is likely to arise any evidence filed in support of an application should address that issue, so the relevant evidence is available for the court, thereby reducing any delay.
    (3) In the event that the Court of Protection determines that P is ineligible the professionals should urgently liaise in the way outlined above.

124. I do not underestimate the challenges these cases cause in circumstances where there is a lack of appropriate placements for these vulnerable young people, however it is important there is a clear understanding about the respective legal frameworks that govern these decisions so that the obligations under the ECHR are complied with, in particular Article 5.