Case number: TLQ/11/0953

Neutral Citation Number: [2012] EWHC 521 (QB)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand
London WC2A 2LL

Friday, 17 February 2012

BEFORE:

HIS HONOUR JUDGE PLATTS
(Sitting as a Judge of the High Court)

BETWEEN:

MR TF COOMBS

Applicant/Claimant

- and -

(1) DORSET NHS PRIMARY CARE TRUST
(2) NOTTINGHAM HEALTHCARE NHS TRUST

Respondents/Defendants

MR M SPENCER QC and DR T MANGAT (instructed by Moore Blatch) appeared on behalf of the Claimant

MS J RICHARDS QC and MS SCOTT (instructed by DAC Beachcroft) appeared on behalf of the Defendants

----

(Transcript of the Handed Down Judgment of
WordWave International Limited
A Merrill Communications Company
165 Fleet Street, London EC4A 2DY
Tel No: 020 7404 1400, Fax No: 020 7831 8838
Official Shorthand Writers to the Court)

Judgment
As Approved by the Court

Crown copyright©

1. JUDGE PLATTS: The claimant in this case was born on 29 August 1957. He has a long history of mental illness. On 30 November 2006 he was detained under section 136 of the Mental Health Act 1983 and was taken to the Forston Clinic in Dorset where he was admitted under section 2. On 18 December 2006 his continued detention was authorised under section 3.

2. On 27 December 2006 he suffered a serious head injury as a result of the admitted negligence of the defendants. He remained subject to detention under section 3 and is currently contained at Llanbedr Court, a low-secure but locked unit near Newport in Gwent. Judgment has been entered against both defendants on 11 May 2011.

3. As part of his claim, the claimant contends that he does not need the level of security to which he is subject at Llanbedr Court and he has intimated a claim for the ongoing cost of future care and treatment at whichever institution it is in his best interests to attend.

4. The defendants do not accept that the claimant needs to or should move from his current placement, which is provided under the National Health Service and is funded by the Bournemouth and Poole Primary Care Trust. However, they have raised an objection in principle, namely that it is not open to any person who is detained under the 1983 Act to pay for his own care or treatment. If that proposition is correct then a substantive part of the claimant's claim against the defendants will fail.

5. The dispute was identified in correspondence at an early stage and so on 25 May Master Yoxall ordered a trial of this preliminary issue:

> "... whether or not a person detained under a provision of the Mental Health Act 1983 is, as a matter of public policy or otherwise, prevented from paying for his own care/treatment."

6. There are three points about this issue which became apparent during argument: (1) as it is framed, the issue is of general application and relates to the rights of all persons detained under the Mental Health Act. It is not framed with reference to the factual background of this case or to personal injury claims as a whole. The issue of whether or not such costs, if they can be incurred, are reasonably incurred, or whether they are recoverable from a tortfeasor is not before me. (2) As will be seen, there are different ways a person can have his liberty restricted under the Act, most importantly by civil detention under Part II, or by the criminal courts under Part III. The issue as framed does not distinguish between the different reasons for detention. (3) Although in this case the claimant is a protected party and has a deputy appointed under the Mental Capacity Act 2005, there will be many patients detained who have the legal capacity themselves to make decisions that are relevant to the issues in this case. I shall address all of those points during the course of this judgment.

7. The defendants' argument is put in three ways, which are related, if not three different ways of putting the same point: (1) it is said that the payment by a detained patient for his own care and treatment is fundamentally inconsistent with the scheme and nature of the 1983 Act; (2) it is said that the right to make such a payment is necessarily or by implication excluded by the Act; and (3) it is said that payment should not be permitted as being contrary to public policy.

8. The claimant on the other hand argues that there is no good reason why the detained patient should be any different from any other patient and therefore be free to pay for his treatment if he wishes, while accepting that as a detained patient he must remain subject to the restrictions of liberty and other controls provided by the Mental Health Act.

The scheme of The Mental Health Act 1983

9. It is necessary first to go to the scheme of the Mental Health Act in so far as it is relevant. As I have said, there are two broad avenues to compulsory detention: first under Part II, and second under Part III of the Act. Part II detention arises as the result of an application made by two approved mental health professionals. Under Part III, a person is detained by order of a criminal court.

10. Dealing with Part II first, section 2 provides the detention for a limited period of 28 days for assessment or assessment followed by treatment. Section 3 provides:

> "(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) [I do not deal with (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;
> (d) appropriate medical treatment is available for him."

11. Section 13(1A) imposes a duty upon an approved mental health professional to make an application for the patient's admission under the Act if he is satisfied that such an application ought to be made and that it is necessary or proper to make the application having regard to all the circumstances.

12. The effect of admission under section 3 is that a patient is taken to a specified hospital, as provided in section 6(1), and the managers of that hospital then have authority to detain him (section 6(2)). The hospital managers have the power to discharge the patient under section 23, or to authorise the transfer of the patient to another hospital under section 19 and regulation 7 of the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008.

13. By section 34(1) of the Act, a patient's responsible clinician is:

> "The approved clinician with overall responsibility for the patient's case."

The responsible clinician has the power under section 17 to grant the patient leave of absence, which may involve leave to reside at another hospital or facility.

14. Under Part III of the Act, the patient can be ordered to be detained by a criminal court under sections 35 and 36 before sentence and under section 37 following conviction. The requirements for an order under section 37 largely mirror those requirements for detention under section 3. Section 37(2) provides that:

> "The conditions referred to in subsection (1) above are that -
> (a) the court is satisfied, on the written or oral evidence of two registered medical practitioners, that the offender is suffering from a mental disorder and that either -
> (i) the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and appropriate medical treatment is available for him; or
> (ii) in the case of an offender who has attained the age of 16 years, the mental disorder is of a nature or degree which warrants his reception into guardianship under this Act; and
> (b) the court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under this section."

15. Section 40(4) provides that a patient who is admitted to a hospital in pursuance of a hospital order under section 37 is to be treated as if he had been admitted under section 3. If, when making a hospital order, a higher court considers that it is necessary to the protection of the public from serious harm, it may make a restriction order under section 41 of the Act. If so, the patient will be subject to further restrictions as provided for by section 41(3), in particular he is not liable to be discharged unless by the Secretary of State or the Mental Health Tribunal. The power to grant leave of absence under section 17 or to transfer the patient to another hospital under section 19 can only be exercised with the consent of the Secretary of State.

16. By section 117 of the Act, once a person is discharged then the local Primary Care Trust and local authorities have a duty to provide aftercare until such time as they "are satisfied that the person concerned is no longer in need of such services."

17. Finally, in terms of the Act, Part IV deals with the power to administer treatment without the patient's consent. I need say no more about that.

<u>Funding of treatment</u>

18. As for the funding of the care and treatment of a person detained, the core duty is contained within section 3 of the National Health Service Act 2006, which provides that:

> "(1) The Secretary of State must provide ... to such extent as he considers necessary to meet all reasonable requirements [a number of things including] -
> (a) hospital accommodation,
> (c) medical ... services,
> (e) such other services ... the care of persons suffering from illness."

By section 1(3) of the Act, those services must be free unless other legislation permits charging.As a result of statutory instrument, the functions of the Secretary of State are to be exercised by Primary Care Trusts.

19. There is no legislation that permits making charges for the care or treatment in hospital of detained patients. In R v Manchester City Council (ex parte Stennett) [2002] UKHL 34 it was held that the local authority was not entitled to charge for aftercare services under section 117 of the Act.

20. It is common ground that the effect of these funding provisions is, first, that an ordinary patient has a basic entitlement to free hospital care and treatment and that there is no power to charge for that treatment; and, second, that the provisions do not prevent a patient who is not compulsorily detained from choosing to arrange and to pay for his own care and treatment. The issue in this case is whether the fact of compulsory detention under the Act deprives the patient of the right to choose and pay for the treatment and care himself, which right he would enjoy if he were not detained.

The Defendants' Submissions

21. The defendants have pointed out that in a number of cases it has been recognised that detained patients are regarded differently from ordinary patients. I have to say that that in itself is not a surprising proposition; they are clearly different from other patients precisely because they are subject to detention under the Act. However, their status has been the subject of some judicial comment, to which reference has been made.

22. First in R v Secretary of State for Health (ex parte N) [2009] EWCA Civ 795, the claimants were or had been detained in Rampton's high-secure hospital under Part III of the Act. They claimed that the ban on smoking in the hospital infringed their rights under Article 8 of the European Convention on Human Rights. In giving the judgment of the court, Lord Clarke, Master of the Rolls, and Moses LJ said in paragraph 62:

> "The Trust owes duties both to its staff and to its patients. We will focus on its duties in the case of Rampton, although it of course owes duties to its staff and patients in many other hospitals. The fact that patients at Rampton are in compulsory detention under the MHA makes its relationship with its patients very different from its relationship with other patients who might wish to smoke. The Trust exists to deliver health care to its patients in Rampton in a secure and clinically appropriate environment. It owes a duty of care to them which covers both their physical and their psychological health and which includes a duty to take reasonable steps to prevent patients from causing themselves self harm."

23. Next, a reference was made to the Court of Appeal decision in R v Broadmoor Special Hospital Authority (ex parte S, H & D) [1998] COD 199. In this case, three patients objected to the policy of random and routine searches, with or without their consent, at Broadmoor Hospital. Giving judgment, Auld LJ said:

> "Sections 3 and 37 of the 1983 Act provide for detention, not just for its own sake, but for treatment. Detention for treatment necessarily implies control for that purpose … Both statutes [and by that he means the 1983 Act and its predecessor the 1929 Act] leave unspoken many of the necessary incidents of control flowing from a power of detention for treatment, including: the power to restrain patients, to keep them in seclusion, to deprive them of their personal possessions for their own safety and to regulate the frequency and manner of visits to them (although not the power of compulsory treatment, for which the 1983 Act now expressly provides in Part IV)."

Hence it is submitted by the defendants, and I think unobjectionably, that the courts have clearly recognised that, beyond the fact of detention, detained patients are not treated the same as ordinary patients. That however does not mean that they are declined of all the rights of ordinary patients.

24. It is central to the defendants' argument that the suggestion that a patient pays for his own hospital care must mean that he should be able to choose the hospital he is cared at and the treatment to be received. It is submitted that to allow such a choice would be contrary to the purpose and scheme of the Act, which is that the patient cannot have any choice in these matters. Such decisions are made by the responsible clinician and/or the hospital managers, or in the case of restricted patients require the consent of the Secretary of State.

25. Reliance is placed on the case of Savage v South Essex Partnership NHS Foundation Trust [2008] UKHL 74. This was a case where the claimant claimed damages from the defendant following the death of her mother who absconded while detained under section 3 and then committed suicide. The claim alleged a breach by the defendants of their duty of respect for her mother's life under Article 2 of the European Convention. In her speech in the House of Lords, Baroness Hale said at paragraph 97 the following:

> "All of these patients have been deprived of their liberty within the meaning of article 5 of the Convention. All are under the control of the hospital (or in the case of restricted patients, the Secretary of State). They may not leave when they wish to leave. Their visits and correspondence with the outside world may be controlled. They may be given most forms of treatment for their mental disorder without their consent (although special safeguards apply to some treatments). They may be detained in a wide variety of settings, ranging from high security institutions such as Broadmoor to open wards from which it is relatively easy to escape. But they cannot choose where they are placed. They cannot choose their doctors. They cannot choose their medical treatment. In short, although their circumstances may be a great deal pleasanter than

> those of other detainees, they are deprived of more of their ordinary civil rights than are other detainees."

So, against that background, it is submitted that to allow the patient any degree of choice would be incompatible with the consequences of detention under the Act.

26. Further, it is suggested that, if the State chooses a hospital, and the patient then pays for it, then that is tantamount to, or at least comes very close to, charging for treatment, which is expressly prohibited by the funding scheme to which I have referred.

27. The next broad submission of the defendants is that, to allow a patient to pay would be to give rise to a contractual relationship between the hospital and the patient, with the patient thereby acquiring private rights and indeed liabilities. This, it is suggested, potentially has a number of consequences.

28. First, what if the patient or the patient's deputy does not pay, he could be sued for a failure to pay and it is said that such litigation would not be conducive to a therapeutic relationship. Further, either the State would have to take over the funding of the placement or the treatment, or the patient would be subjected to a change of placement or treatment, which would be an undesirable interruption of treatment.

29. Second, it is said that it raises the prospect of the patient being able to sue for breach of contract if he considers that the hospital has failed to deliver the proper care, and indeed the defendant goes on to submit that it may lead to a right for the patient to dictate his treatment. These consequences are not only undesirable, but contrary to the underlying purpose of the Act, which is to take control of the treatment and care choices out of the hands of the patient.

30. In the course of her submission, Ms Richards suggested that in this context there is and should be no material difference between a detained patient under the Act and a prisoner serving a sentence of imprisonment. If it is accepted that a prisoner cannot pay for his own care or incarceration in different penal institutions (as it is), then there can be no case for a detained patient to have a similar right.

31. Some reliance is placed on the observations of Lord Rodger in <u>Savage and South Essex</u>, which I have referred to above. He said at paragraph 49:

> "The fact that Mrs Savage was not only a patient, but a detained patient, is also relevant to the authorities' obligations under article 2. Any auction in the comparative vulnerability of prisoners, voluntary patients, and detained patients would be as unedifying as it is unnecessary. Plainly, patients, who have been detained because their health or safety demands that they should receive treatment in the hospital, are vulnerable. They are vulnerable, not only by reason of their illness, which may affect their ability to look after themselves, but also because they are under the control of the hospital authorities. Like anyone else in detention, they are vulnerable to exploitation, abuse, bullying and all the other potential dangers of a closed institution. *Mutatis mutandis*, the principles in the case law, which the European Court has developed

> for prisoners and administrative detainees, must apply to patients who are detained."

However, he did continue later in that paragraph:

> "The hospital authorities are accordingly responsible for the health and well-being of their detained patients. Their obligations under article 2 include an obligation to protect those patients from self-harm and suicide. Indeed, as explained at paragraph 28 above, the very fact that patients are detained carries with it a risk of suicide against which the hospital authorities must take general precautions."

32. In looking at those passages, in my judgment, Lord Rodger was directing his mind specifically to the duty of care owed by a detaining authority to a vulnerable detainee, be it in prison or in hospital. In that context, he was saying the rights of those detained in hospital are to be equated with those of prisoners. However, I do not take from that passage a principle that the rights of detainees are to be equated with the rights of prisoners in all respects.

33. Finally, on behalf of the defendants, it is argued that, in so far as the statutory regime does not expressly prohibit a detained patient paying for his own care, it would be contrary to public policy to allow them to do so. Examples were given where the courts have relied upon public policy to deny a citizen a right, which he or she might otherwise have enjoyed. Reference is made to the cases of R v Registrar General (ex parte Smith) [1991] 2 QB 393; R v Secretary of State for the Home Department (ex parte Puttick) [1981] 1 QB 767; and R v Secretary of State for Health (ex parte YA) [2009] EWCA Civ 225. All these decisions are examples of where a court has relied to an extent (if not exclusively) on public policy considerations to achieve a result, which it considers to be just. It is submitted by the defendant that such considerations come into play in this case, since it will be against public policy for a detained patient to use his own funds to achieve an end, which was incompatible with his detention under the 1983 Act.

34. I have to say, that I do not think that these authorities take the matter much further. The public policy on which the defendants seek to rely in this case are certainly not the same policy considerations as relied upon in those authorities. The policy relied upon here is effectively a repetition of the other arguments, which I have summarised above. I am not persuaded that public policy arguments take the matter any further.

The Claimant's Submissions

35. Broadly the claimant submits that there is no reason at all why detained patients should not be free to choose to pay for treatment from his own resources. Importantly, it is accepted on the claimant's behalf that the claimant will at all times remain subject to detention under the Act and that any hospital facility or treatment plan, which he pays for, will necessarily be and remain within the umbrella of the Act. It is therefore conceded that he would not be in a position to choose which hospital he goes to; that will remain the decision of the detaining authority (within the case of a restricted patient, the consent of the Secretary of State if necessary), nor can he choose what treatment he receives; that will remain the decision of the responsible clinician, albeit

in consultation with the patient. All the claimant will be doing is providing the money to pay for such treatment and care as will be considered appropriate by the detaining authority.

36. It is pointed out that treatment for mental disorder is often complex; there may be (and often are) different treatment options, be it the nature or dosage of medication, the use of various psychological therapies, or, perhaps most importantly in the circumstances of this case, the identification of an appropriate hospital or placement that will best serve the interests of the patient. Sometimes there may be two options for placement, both of which will meet the patient's basic needs, but one of which is felt by the patient or his relatives, or indeed on occasion by the responsible clinician, to be more suitable. These alternatives may be more expensive and the funding authority may be unwilling to pay. Why, the claimant asks, in those circumstances, should the patient (if he has the means to pay) not be able to pay for the placement that he prefers.

37. The problem is recognised by Sullivan J in a different context in R v Oxfordshire Mental Healthcare NHS Trust & Anor (ex parte F) [2001] EWHC Admin 535. In that case, the claimant was challenging the detaining authority's refusal to fund the cost of a move from Broadmoor to a medium-secure unit in Manchester. The move was supported by the patient's RMO. In holding that the Trust is not obliged to provide funding, Sullivan J said at paragraphs 64-67 the following:

> "64. Treatment is provided to all patients in the real world where the availability of facilities is constrained by resources. By way of example, the RMO may well consider that it would be beneficial for a particular Part II or Part III patient if he/she was given better facilities whilst in hospital: more privacy, more spacious accommodation, access to particular therapy, more attention by the nursing staff, etc. There is nothing in the 1983 Act to suggest that the health authority must then provide those facilities. Insofar as the 1983 Act confers additional powers on the RMOs, it does so vis-à-vis the RMO's patient, not the health authority.
> 65. Leave of absence is another example. The RMO may consider that leave of absence to a sheltered hostel type of environment would be a desirable part of a patient's treatment plan. The 1983 Act does not enable the RMO to demand that such accommodation be provided for the patient. The 'treatability condition' has to be considered, not in the abstract, but in the light of the facilities that are available for medical treatment in the real world.
> 66. In simple terms, since resources are limited, there is bound to be a queue of patients seeking treatment. I do not accept the proposition that the RMO's position under the 1983 Act is such as to propel his or her Part II or III patients to the head of the queue. The nature and severity of a patient's illness, the fact that the patient is detained, and that lack of or delay in providing particular treatment may result in the patient remaining longer in detention, are all relevant factors, but the health authority, in the exercise of its duty under section 3 of 1977 Act, is not bound to regard them as determinative."

38. It is also pointed out that pressures on funding are a fact of life, which the detaining authorities have to take into account when deciding on where a detained patient might be placed. Such is clear from the decision of the Court of Appeal in R v West London Mental Health NHS Trust (ex parte K) [2006] 1 WLR 1865. Dyson LJ, who had cited the decision of Sullivan J to which I have referred, then said at paragraph 56:

> "The duty of the Secretary of State is to provide hospital accommodation etc to such extent as he considers necessary to meet all reasonable requirements. These words are clear and unequivocal. It is for the Secretary of State to make a judgment of what is necessary to meet all reasonable requirements. That involves taking into account resource implications. It also involves establishing priorities (comparing the respective needs of patients suffering from different illnesses and determining the respective strengths of their claims to treatment) as well as the proven success or otherwise of the proposed treatment and the seriousness of the condition that the treatment is intended to relieve."

39. So, against that background, it is submitted that in these circumstances, while the claimant would not have the right to decide which hospital he went to, the fact that he might make payment for and towards the cost of treatment might release the detaining authority from the constraints of limited resources and thus widen the options available to him.

40. Reliance is placed by the claimant on the decision of Leveson J in Tinsley v Sarkar [2005] EWHC 192 (QB). That was a case involving a claim by a claimant against a tortfeasor for the cost of care following discharge from detention. Under section 117 of the Act, there is a duty on the local authority and the Primary Care Trust to provide aftercare services, so long as it is considered that the patient is in need of those services. The court held that in deciding whether a patient needed such services, the relevant authority could take into account the patient's resources. Consequently, if he had independent means to pay for such care himself, such that he did not have to resort to the use of public funds, the authority was not obliged to provide those services, and consequently the claimant could recover the cost of aftercare from the tortfeasor. It is submitted that, if a discharged patient can pay for his aftercare in this way, and not have to rely on public funding, why should not the detained patient.

41. I have to say, I am not persuaded that this is an apt analogy. The section 117 aftercare regime is a free-standing regime. By its nature, it applies to patients who are not detained. The issue in this case, relating as it does to a detained patient, in my judgment is different.

42. The next submission for the claimant is that, if the defendant's position were correct, then effectively detained patients will be treated as if they were prisoners. It is submitted that cannot be just or correct. A prison regime is wholly separate from and independent of the hospital regime where the primary purpose is treatment.

43. Further, it is pointed out that section 51 of the Prison Act 1952 provides as follows:

> "Payment of expenses out of moneys provided by Parliament.

> All expenses incurred in the maintenance of prisons and in the maintenance of prisoners and all other expenses of the Secretary of State or the Prison Commissioners incurred under this Act shall be defrayed out of moneys provided by Parliament."

It is submitted this provision would appear to exclude the ability of a prisoner to pay for or contribute to his incarceration in prison. There is no similar provision in relation to expenses incurred in the care or treatment of patients.

44. With regard to public policy, the claimant submits that the defendants have to but have failed to identify a public policy in its submissions. If the public policy is that the court should not allow something that is incompatible with the scheme of the Act, then given that is the defendant's primary position the concept of public policy adds nothing to the argument. As I have already indicated, I have some sympathy with that view. In any event, the claimant avers that what is proposed is not incompatible with the Mental Health Act for the reasons given, and indeed that public policy favours the granting of the claimant's right to choose to make such payments, because in a time of scarce resources, if the claimant were allowed to choose to pay from his own funds, that would release public resources for the treatment of others in the system who cannot afford to pay.

45. Finally, the claimant submits that, to deny him the ability to make a payment in these circumstances would amount to a breach of his right to liberty and security under Article 5 of the European Convention on Human Rights. It is submitted that, if a patient were not allowed to choose to pay for treatment when suitable, the State would be assuming on itself rights against individuals, which go significantly beyond those that are necessary for the purpose of the detention, and would treat the patient significantly less favourably than persons who were not detained.

46. I note that the claimant in his skeleton argument has sought to draw a parallel between the current case and the recovery of damages for the private provision of care when there is an entitlement to such care under section 21 of the National Assistance Act 1948. I do not find that parallel particularly helpful. In those cases, there is no doubt that the claimant has the right to choose to pay privately for care. The question for the court in those cases is the extent to which the cost of such care is recoverable from a tortfeasor. In this case, I am addressing the first question; namely whether the claimant has the right to choose to pay. It precedes in the issue in those cases and I therefore do not propose to deal with them any further.

<u>Discussion and Conclusions</u>

The position of Part II and Part III patients

47. For the purposes of this preliminary issue, and with one possible exception, I see no reason in principle or practice why there should be a distinction between patients detained under Part II of the Act and those detained under Part III, or even between patients subject to a restriction order under section 41 and those who are not. Although in argument Mr Spencer QC suggested that the position, in particular the restriction in particular of a restricted patient may be different I see nothing in the statutory regime to lead to that conclusion. The additional restrictions of the section 41 order are effectively that the control of the patient is moved to the Secretary of State rather than the detaining authority.

48. The one possible exception might be in relation to prisoners who are transferred to hospital from prison under section 47 of the Act. There may be different considerations applicable there, but their position has not been specifically argued before me and I do not think it necessary or desirable to consider them further in this case.

The position of patients and prisoners

49. I am not persuaded that detained patients must be treated in the same way as prisoners. In my judgment, the primary purpose of detention is to treat the patient. That was referred to as the "target duty" in a different context by Sullivan J in R v Oxfordshire Mental Healthcare NHS Trust, to which I have referred. At paragraph 60 he said this:

> "The starting point has to be the 1977 Act. Health authorities owe the same 'target' duty under section 3 to those who suffer from physical or mental illness. While some patients in the latter category will be compulsorily detained in hospital under Part II or Part III of the 1983 Act, I do not consider that this factor alters the underlying 'target' duty. The 1983 Act does not expressly provide for an 'enhanced' duty towards those suffering from mental illness who are compulsorily detained, nor is it possible to imply the existence of such an enhanced duty since the 1983 Act is intended to provide a comprehensive code for 'the reception, care and treatment of mentally disordered patients'. Where Parliament intended to impose additional duties on health authorities and local social services authorities in respect of such patients, it did so in express terms. It is significant that the criminal courts are not entitled to make a hospital order under section 37 merely because they are satisfied, on appropriate medical evidence, that a particular offender is suffering from, *inter alia*, psychopathic disorder and that treatment may alleviate or prevent a deterioration of that condition. Before making such an order, the court has to take account of the availability of resources. It has to be satisfied that arrangements have been made for the admission of the offender to hospital: see subsection (4). If no hospital place is available for treatment of that particular offender, then a hospital order may not be made."

In my judgment, that view helpfully reflects the wording of the Act.

50. It is right, as is pointed out by the defendants, that a prerequisite for admission under section 3 is that detention is necessary "for the health or safety of the patient or for the protection of other persons", but other important conditions also have to be satisfied: (1) the patient has to have a mental disorder; (2) that disorder must be of a nature or degree that makes it appropriate for him to receive medical treatment in hospital; and (3) appropriate medical treatment must be available. Further, unlike a prisoner who, unless subject to IPP or life imprisonment, is detained for a finite period the patient will not be discharged until his condition improves to the extent that the criteria for detaining him are not met.

51. In the circumstances, I am satisfied that there is a valid distinction to be drawn when considering the postions and rights of detained persons between those detained in prison and those detained under the Mental Health Act. The position of the two cannot be and should not be equated. The whole purpose of detention under the Act is to provide treatment, while at the same time protecting the public and/or the patient. There is no punitive element. A person detained under the Act is not a prisoner.

52. In any event, section 51 of the Prison Act 1952 (supra) effectively prevents a prisoner paying for or contributing to his costs of incarceration in prison. There is no similar provision in relation to the expenses incurred in the care or treatment of patients detained under the Act.

The capacity of the patient

53. I do not consider that the capacity of the patient is relevant when considering the preliminary issue in this case. Whether or not the patient acts through his appointed deputy under the 2005 Act, or in his own right, cannot in my judgment affect the fundamental issue I have to decide.

54. I do however recognise the fact that many patients, although they have capacity, may have little insight into their difficulties, and may (and frequently do) disagree with treatment either being proposed or given. Often that is the very reason they are detained. This lack of insight and vulnerability will undoubtedly make any decision as to whether or not to offer to fund treatment very difficult for a patient.

55. However, I make three observations: (1) in reality those patients with sufficient funds to be in that position, either in their own right or prospectively through a claim for damages, are likely to have some form of independent advice; (2) even if they do not, the decisions, as I have indicated, are ultimately not to be taken by them, but rather those by the detaining authority or the responsible clinician; and (3) the fact that a decision might be difficult it is not (at least not in my judgment) a good ground for depriving a person who has capacity from the right to make it.

Article 5

56. In my judgment, Article 5 of the European Convention on Human Rights has no application to this issue. The authorities show that Article 5 is directed to the fact and lawfulness of detention, and not the conditions of the detention. I have been helpfully referred to the decisions of the European Court of Human Rights in Ashingdane v United Kingdom [1985] 7 EHRR 528 and the decision of Silber J in MP v Nottinghamshire Healthcare NHS Trust & Ors [2003] EWHC 1782 (Admin). However, the position appears to be neatly summarised by the comments of Hale LJ (as she then was) in Munjaz v Mersey Care National Health Service Trust & Ors [2003] EWCA Civ 1036; at paragraph 69 she said this:

> "However, the jurisprudence of the [Strasbourg Court] distinguishes between the detention and its conditions. The detention itself has to be justified and challengeable in accordance with Article 5. The conditions under which a detained person is held have to comply with Article 3 and Article 8. Furthermore, there will be a breach of Article 5(1) where a person is detained in

> a type of institution which is inappropriate to meet the Article 5(1) purpose of his detention. Thus a person detained as a juvenile in need of educational supervision should not be detained in a prison where no education is available; and a person detained as a person of unsound mind should not be kept in a prison. But provided that the institution concerned is within the appropriate category, there is no breach of Article 5. Thus, in Ashingdane v United Kingdom, there was no breach where a patient was detained in the high security conditions of Broadmoor for 18 months after the Home Secretary had acknowledged that his condition no longer warranted it and he could be transferred to a local psychiatric unit. The difference was one of degree, not nature and quality."

57. Here, it is not alleged by the claimant that his detention is in any way unlawful. All he is seeking to do is to facilitate, by providing funds, his move to what he believes to be a more suitable facility. That is all about the conditions where he is detained, not the fact of detention. So I reject the Article 5 arguments as being relevant.

Conclusion

58. I accept the defendants' submission that the detained patient is in a very different position to one who is not subject to compulsory detention. The detaining authority has powers to control, not only the patient's placement and treatment, as provided for in the Act, but also many more general activities and freedoms as illustrated in more general contexts by the authorities to which I have referred. I therefore accept that the position of a detained patient cannot automatically be equated with that of an ordinary patient. However, that in itself cannot be determinative. The real issue is whether the claimant's case is incompatible with detention under the Act.

59. I have no doubt, if a patient, by electing to pay for treatment or care, thereby gains the ability or right to choose the treatment, then that would be inconsistent with the statutory scheme. Such a situation would amount to an ability to override the wishes of the detaining authority and would be inconsistent with the Act. If that were the effective position of the claimant on preliminary issue, in my judgment it would not be permitted.

60. However, in my judgment, that is not the position. So long as a person remains detained, any decision about his placement must be made in accordance with the Act by the managers of the hospital where he is currently detained. Any decision about his treatment must be made by his responsible clinician. If either of those did not agree with any proposal that the claimant might make, then the claimant would not have the option of pursuing that proposal. The right to make a decision is and remains with the detaining authority by virtue of the statutory provisions, so long as the patient remains a detained patient.

61. It may be the fact that the patient has funds from which he can contribute to or pay for a particular treatment or placement and that will increase the options that may be available to the detaining authority, but the decision will always be with the detaining authority and not the patient.

62. Further, if the detaining authority does agree to a proposed treatment plan or future placement to be funded by the patient himself, it seems to me that any such agreement would have to be necessarily subject to a condition, whether by way of an implied term of a contract or otherwise, that the patient would remain subject to detention so long as the criteria for detention remain met. That means that he would remain under restrictions imposed by the Act and all that goes with that until such time as he was discharged. His status as a detained patient would not and could not be affected.

63. Indeed the claimant concedes that this is necessarily the case. Decisions as to where he is treated would remain with the managers of the hospital; decisions about treatment with the responsible clinician. All he is choosing to do is provide the money to facilitate placement or treatment, which is deemed appropriate by the detaining authority, and I see no difficulty with that.

64. I do not categorise this as charging for the provision. The detaining authority would always have to be in the position to provide suitable and appropriate care and treatment without the patient contributing. If the patient however chooses to pay for that, or for any other option, and the detaining authority agree, then why should he not be able to?

65. I accept that there are legitimate practical concerns about this conclusion. I have already made reference to the likely vulnerability of the patients who may have to make these decisions. I also acknowledge the concerns raised by the defendants as to what might happen if the funding of the placement by the patients break down, either through an unwillingness or through an inability to pay on the part of the patient or his deputy. Issues will arise as to who takes over the funding. Will the patient have to be moved to another hospital that the State is prepared to fund? Can or will the provider sue the patient for unpaid fees? There is no easy answer to these questions. However, difficulties of management and funding are sadly not uncommon in this field and in my judgment such problems as might arise from this decision are not insurmountable. I am not persuaded that these concerns are sufficient to deprive the claimant of the option of choosing if he so wants.

66. There is also the prospect of a patient who funds his own placement being more likely to challenge the nature of his care and treatment. His expectations of a positive outcome might be higher if he is paying. These expectations may have to be managed carefully. However, so long as it is clear that he remains subject to detention and that he has to accept the treatment and placements as directed by the detaining authority, I see no reason in principle why those practical difficulties should deprive a patient of the right to choose to pay if he so wishes.

67. For those various reasons, on the preliminary issue, I answer it as follows: I find that a person detained under a provision of the Mental Health Act 1983 is not as a matter of public policy, or otherwise, prevented from paying for his own care/treatment.