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The Human Rights Act 1998 and Mentally Disordered Offenders in Private Healthcare Organisations

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LLM (Legal Aspects Of Medical Practice) Dissertation

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Contents

Page No.

Declaration
Abstract
i) Acknowledgements
ii) Table of Statutes and Statutory Instruments
iii) Table of Cases

Introduction	10

Chapter 1

Background to Human Rights Legislation	21

Chapter 2

Legal Status of mentally disordered offenders	27

Chapter 3

Legal status of Private Mental Healthcare Institutions	46

Chapter 4

-Areas of mental health practice liable to challenge under HRA 1998:

Article 2	Right to Life	55
Article 3	Prohibition of Torture.	71
Article 4	Prohibition of Slavery and forced Labour	82
Article 5	Right to Liberty And Security.	84
Article 6	Right to a Fair Trial.	95
Article 7	No Punishment Without Law.	100
Article 8	Right to Respect for Private and Family Life.	102
Article 9	Freedom of Thought, Conscience and Religion.	107
Article 11	Freedom of Assembly and Association.	109
Article 12	Right to Marry.	110

Conclusion/Summary	111
Bibliography	114

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Abstract

This dissertation analyses the impact of The Human Rights Act 1998 on the mentally disordered offender, with particular reference to those detained in private healthcare organisations.

The prison population of The United Kingdom has increased dramatically over the last few years, with predictions that it is likely to continue to do so for the foreseeable future. The incidence of mental illness within the prison population is such that neither the Prison Service nor the National Health Service hospitals are able to effectively cope. This has led to an increase in the services provided by the private sector.

An explanation of the European Convention on Human Rights and the establishment of The Human Rights Act 1998 is given. The legal status of mentally disordered offenders is then examined. This is followed by analysis of the legal status of private mental health institutions and the applicability of the Act to them. The outcome of this being that the Human Rights Act 1998 is found to be applicable and that the private organisations do fulfil functions certain of which functions are of a public nature.

Analysis of areas of mental health practice that have been challenged, or might be challenged, under the European Convention on Human Rights then follows. Specific references to practices within private healthcare organisations are made, with comments regarding what might be required to avoid the healthcare provider from falling foul of the Human Rights Act 1998.

i) Acknowledgements

This dissertation has been written with the support of a number of people, without whom it would have been impossible.

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ii) Table of Statutes and Statutory Instruments

Bail Act 1976

Care Standards Act 2000

Coroners Act 1998

Crime (Sentences) Act 1997

Criminal Justice Act 1991

Criminal Justice And Court Services Act 2000

Criminal Justice and Public Order Act 1994

Criminal Procedure (Insanity) Act 1964

Criminal Procedure (Insanity and Unfitness to Plead) Act 1991

Fatal Accidents Act 1976

Health Authorities Act 1995

Human Rights Act 1998

Magistrates Court Act 1980

Marriage Act 1983

Mental Health Act 1959

Mental Health Amendment Act 1982

Mental Health Act 1983

Mental Health Act 1983 (Remedial) Order 2001, SI 2001 No. 3712

Mental Health (Patients in the Community) Act 1995

National Assistance Act 1948

National Health Service Act 1977

NHS and Community Care Act 1990

Nursing Homes and Mental Nursing Homes Regulations 1984

Police and Criminal Evidence Act 1984

Powers Of Criminal Courts Act 1973

Registered Homes Act 1984

Residential Care Homes Regulations 1984

The Lunatic Asylums Act 1845

The Lunacy Act 1890

The Mental Deficiency Act 1913

Trial of Lunatics Act 1883

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Aerts v Belgium, [1998] E.H.L.R. 777

Aksoy v Turkey, (1997) 23 E.H.R.R. 553

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E v Norway (1994), Application 11701/85 17 E.H.R.R. 30

Eriksen v Norway, Judgement of 23 April 1997

F v Switzerland, (1988) 10 E.H.R.R. 411

Grare v France, (1992) Application 18835/91

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R. (On the Application of Amin) v Secretary of State for the Home Department, [2001] E.W.H.C. Admin. 719

R. (On the Application of B) v Mental Health Review Tribunal, [2002] E.W.H.C. 1553 (Admin)

R. (On the Application of Barry) v Gloucestershire County Council, [1997] 2 W.L.R. 459

R. v Birch, (1989) 11 Cr.App.R.(S.), 202, 212

R. v Bournewood Community Mental Health NHS Trust Ex Parte L, (1998) 3 All E.R. 289

R. v Canons Park Mental Health Review Tribunal, ex parte A, [1994] 2 All E.R. 659.

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R. (On the Application of KB and others) v Mental Health Review Tribunal and another, [2003] All E.R. (D) 168 (Feb); [2003] E.W.H.C. 193 (Admin)

R. (On the Application of KB) v Mental Health Review Tribunal, [2002] E.W.H.C. 639

R. (On the Application of M.) v Secretary of State for Health, [2002] All E.R. (D) 107

R. (on the application of Mellor) v Secretary of State for the Home Department, [2001] H.R.L.R. 38

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Introduction

It has been said that up to 90% of prisoners have a diagnosable mental health problem[1], and 20% of male and 40% of female prisoners have, at some time, attempted suicide[2]. The Director General of the prison service has further stated that the prison service “has failed to meet the health needs of some of society’s most vulnerable people”[3].

If one looks at the estimates of psychiatric morbidity then, given a current (March 2003) prison population of nearly 72,500 inmates[4], (an increase of some 2500 in the last year alone) then figures for prisoners with a diagnosable mental disorder are somewhere between 16000 and 65000, which is a significant number by any estimation.

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1 Others put these figures as low as 18%, Office for National Statistics, (1998), *Psychiatric Morbidity Amongst Prisoners*, HMSO, London and Badger, D., et al, (1999), *CRD Report 15 - Systematic Review of the International Literature on the Epidemiology of Mentally Disordered Offenders*, NHS Centre for Reviews and Dissemination, University of York, amongst others.

2 “Prisons worse than kennels”, *Health Service Journal*, 12 July 2001, p16.

3 Op cit and conference notes

4 Prison Service Statistics as at 7/3/03 < http://www.hmprisons.gov.uk/statistics/> (This figure of 72,476 does not include a further 2,983 prisoners under Home Detention Curfew; It is made up of 57,642 adult males, 3,789 adult females, 10,457 male young offenders [ie 15-21 year olds] and 588 female young offenders.) The Certified Normal Accommodation (C.N.A.) is 65,429, which is the in use uncrowded capacity of the prison estate. The Operational Capacity is 75,546, which is the maximum, safe overcrowded capacity of the prison estate.

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A large proportion of imprisoned mentally ill offenders, as with those who are mentally ill in society at large, will not require specialist treatment in mental health hospitals. However, the prisons, National Health Service (NHS), Special Hospital Authorities (Rampton, Ashworth and Broadmoor), and other state facilities (e.g. probation and social services) do not have the capacity to deal with even a small proportion of such a vast number of potentially mentally ill people, in addition to the demand for services from the public. This has led to the development of a relatively small, but increasing, number of “forensic”, or "medium secure" facilities being provided by the private sector, specialising in the care of mentally disordered offenders.

The concept of ‘the Mentally Disordered Offender’ is quite an emotive one, given society’s general unease with issues surrounding mental health, together with large amounts of publicity surrounding people with dangerous severe personality disorder (DSPD) and high profile cases involving mentally ill people[5]. However, the number of people who are diagnosed as DSPD and detained in prisons or secure hospitals together with those in the community is very small (estimated at 2,100 to 2,400) [6] in comparison with the general prison population (a large number, estimated at 18-76% depending on diagnosis[7], of the latter, who

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5 See for example the Jonathon Zito and Christopher Clunis cases

6 *Reforming The Mental Health Act*, Cm 5016-II, (2000), TSO, London. Para. 1.5

7 Singleton, N., et al, (1998), *Psychiatric Morbidity Among Prisoners: Summary Report*, Office of National Statistics, London.

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suffer from other clinically diagnosable mental illnesses). In addition to this, 20% of male and 40% of female prisoners had received help or treatment for mental or emotional problems in the year prior to entering prison, together with 8-10% of male and 15-22% of female prisoners having previously been admitted to mental hospital[8]. Prisoners whilst detained in prison cannot, currently[9], be treated without their consent, except in common law emergency situations. They therefore require transfer to establishments where treatment is allowed to be administered without consent, usually under the auspices of the Mental Health Act 1983, when their condition requires it.

In order to place the issues in context, within the "medium secure" area in 2000 over one third of the provision (662 out of 1962 beds in total) for those with mental illness and nearly 50% of the provision for learning disabilities (262 out of 559 beds) was in the private sector[10]. These private sector proportions show a 10% increase over 1999, with projections that the number of private medium secure beds will increase by 5-10% for at least the next 5 years. There is also provision in low secure and open units / nursing homes within the private sector for mentally disordered offenders, although the specific figures for these are not available due to the data collection methods utilised by both the Home Office

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8 Op.cit.

9 There are proposals, which have created intense debate, in the current *Draft Mental Health Bill*, Cm.5538, to amend this.

10 Personal research

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and Department of Health/Welsh Assembly not including these categories.

The Human Rights Act[11] (HRA) came into force on 2nd October 2000, and incorporated into UK law various rights as laid out in the European Convention on Human Rights[12] (the Convention). Section 6 of the Human Rights Act makes

> it unlawful for a public authority to act in a way which is incompatible with a Convention right[13].

Whilst the status of the prisons, NHS facilities and Special Hospitals as 'public authorities' is incontrovertible, that of the private sector healthcare facilities, whilst initially appearing somewhat more complex, is also quite clear, as will be demonstrated, particularly when looking at formally detained patients[14].

There has been much written regarding rights, but with these rights come responsibilities: one individual having the same fundamental rights as another. By way of clarifying this issue, it is worth quoting the words of Lord Steyn thus

> The fundamental rights of individuals are of supreme importance, but these rights are not unlimited: we live in communities of individuals who also have rights. The direct lineage of this ancient idea is clear: the European Convention (1950) is the descendant of the Universal

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11 Human Rights Act 1998 Ch.42

12 Cmnd 8969 (1950)

13 Human Rights Act 1998 Ch.42 S 6.(1)

14 *R.(on application of A) v Partnerships in Care Ltd*, [2002] EWHC 529, as will be discussed in some depth later.

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> Declaration of Human Rights (1948) which in Article 29 expressly recognised the duties of everyone to the community and the limitation on rights in order to secure and protect respect for the rights of others.[15]

Despite much press speculation, prior to the incorporation of the Human Rights Act, that there would be a massive number of claims made, it would appear that this has not been the case, with the Judiciary adopting a firm policy on not allowing claims that do not raise genuine human rights issues. The Lord Chancellor's Department in its statistical review of the first three months following the implementation of the Human Rights Act[16] confirms that, to date, the "floodgates" have not opened.

It should be remembered that the rights of the accused person who is, or who appears to be, mentally disordered are exactly the same as those of someone who does not appear to be mentally unwell. At the earliest stage, and throughout and following any criminal proceedings, this includes the right to bail[17] and parole subject to the limitations or restrictions that apply to any accused person[18] .

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15 *Brown v Procurator Fiscal*, [2001] H.R.L.R.9; J.P. 2000, 164 (41), 794-795.

16 The Lord Chancellor's Department, 2001, *Human Rights Act 1998: A Statistical Update*, LCD, London.

17 Bail Act 1976

18 See for example, Criminal Justice and Public Order Act 1994, Sections 25 and 26.

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However, another option is that of “diversion”. Home Office and wider Government policy is that

> Wherever possible, mentally disordered persons should receive care and treatment from the health and social services……….careful consideration should be given to whether prosecution is required by the public interest. It is desirable that alternatives to prosecution, such as cautioning by the police, and/or admission to hospital, if the person’s mental condition requires hospital treatment, or support in the community, should be considered first before deciding that prosecution is necessary.[19]

Whilst acknowledging that this statement was from a previous Government, current policy follows the same line. Also, widespread diversion schemes have yet to materialise, although there are a variety of local schemes in operation.

A small proportion of mentally disordered offenders are eventually treated via the provisions of the Mental Health Act, although the provision of appropriate services for this to take place is very limited. However, the vast majority of mentally disordered offenders remain in prison despite a variety of options being available.

The clearest recent statement of Government thinking on mental disorder can be considered to be the Draft Mental Health Bill considering the reform of the Mental Health Act 1983[20], of

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19 Home Office Circular No 66/90, as amended by MNP 96 1/55/10 (9th April 1996)

20 Draft Mental Health Bill, Cm.5538, (London, TSO 2002)

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which **Part III** considers patients who are involved in the criminal justice system. The previous White paper clarifies this with

> ….whatever the circumstances of the individual case, people who are before the Courts or in prison should be assessed and if appropriate receive treatment from specialist mental health services at the earliest opportunity.[21]

There is also a requirement under the Criminal Justice Act 1991 for the Court to obtain and consider a medical report on a person who is or appears to be mentally disordered, prior to imposing a custodial sentence.

This sentiment reiterates Government statements from a variety of sources and is consistent with policy over a number of years[22], if not decades.

It has been estimated that around one thousand people per year in England and Wales are compulsorily admitted to hospital instead of prison, via the Courts, as a result of criminal offences[23]. Further, in excess of 2800 mentally disordered offenders are currently detained in hospital, with the number transferred from prison to hospital being, on average, over 700 per year[24]. Overall, in 2001-2002, in England, Court and prison disposals of offenders

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21 *Reforming The Mental Health Act* Cm5016 Pt.I s.4.2 (White Paper)

22 See, for example, Home Office Circular 66/90 and *Review of Health and Social Services For Mentally Disordered Offenders"*, ("The Reed Review"), 1992, Department of Health/Home Office, London.

23 *Reform of the Mental Health Act 1983: Proposals for Consultation* Cm 4480, 1999, Ch.8 Para 2.

24 "*Statistics of Mentally Disordered Offenders in England and Wales 1998*" Home Office Circular 7/00, March 2000.

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accounted for approximately 6% of all formal mental hospital admissions. In 1991-92 these figures were 2079 admissions; in 1996-97, 1873 admissions and in 2001-2002 the figures were 1493 admissions[25] (a drop of over 28% in 10 years). Of the Court and prison disposals in Wales during 1999-2000 there were a total of 132 hospital admissions, out of a total of 1565 formal hospital admissions, which at 8% gives a slightly higher total than that for England[26]. As with England, Welsh admissions in this manner appear to have decreased, however in Wales this has been somewhat greater (in the order of 50%).

The writer's personal experience, together with anecdotal evidence, would suggest that this statistical reduction in admissions to psychiatric hospitals, together with an increase in numbers actually detained under the Mental Health Act, would be more due to the lack of availability of appropriate medium secure psychiatric hospital places, rather than a reduction in need. In other words those who are mentally ill and in prison are more likely to remain in prison and be unable to access the clinical facilities that they need.

The above assumption can be further developed by the statistic that in 2001-2002 in England and Wales there were 3393

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25 "*Inpatients formally detained in hospitals under the Mental Health Act 1983 and other legislation, England: 1991-92 to 2001-02*" , Bulletin 2002/20, Nov. 2002, Department of Health.

26 *"Admission of Patients to Mental Health Facilities in Wales, 1999-00"*, Statistical Report SDB: 116/2000, National Assembly For Wales/ National Statistics Office. Section 4.

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admissions[27] to hospital via uses of police powers[28] of removal to a place of safety; the equivalent figure for 1991-1992 being 928, ie an increase of some 366%.

Notwithstanding the figures quoted above, it should be acknowledged that, as with society at large, a significant proportion of the prison population who are suffering with mental health problems will not require specialist mental hospital treatment, but will be treated by the prison medical officer (who will not necessarily have any specialist mental health experience), as a member of the public would be by their General Practitioner or other primary healthcare services. However, as is also acknowledged by the Home Office:

> Local prisons and remand centres have to deal with a very large number of prisoners…every day…the remand population will contain the highest percentage of seriously ill people with physical and mental disease[29]

Further, they say

> The many mentally disordered offenders who fall outside the 1983 Mental Health Act, and are thus cared for within establishments, are not adequately provided for[30].

and in the same document

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27 *"Inpatients formally detained in hospitals under the Mental Health Act 1983 and other legislation, England: 1991-1992 to 2001-2002"* , Bulletin 2002/26, Nov.2002, Department of Health. Table 5 And *"Admission of Patients to Mental Health Facilities in Wales, 1999-00"*, Statistical Report SDB: 116/2000, National Assembly For Wales/ National Statistics Office. Table 4.4

28 Mental Health Act 1983, Sections 135 & 136

29 "*Annual Report of H.M. Chief Inspector of Prisons 1993-1994*", Home Office, London. S.5.02

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> All prisoners requiring healthcare must be seen as patients given the same care as provided in the community……..healthcare provided by the prison medical service does not match that provided by the NHS.

Regardless of the above statements, and despite the fact that they were written some years ago, seriously mentally ill people are still being detained in prison. Whilst policy is to develop close links with NHS services and develop joint working initiatives[31]to improve the standards of healthcare within prisons in general and specifically within hospital wings, and despite these ideas being voiced since the early 1990's, together with a few "initiatives", little has yet to materialise by way of tangible change. Both prison and health authorities remain under much financial pressure, although extra funding has been allocated to certain areas (e.g. £47 million between 1993-96 for capital investment in medium secure services, with the aim of developing 1,250 extra beds)[32]. This should be considered in the light of £70 million being allocated for a 3 year programme of pilot studies to assess and treat dangerous serious personality disordered offenders (DSPDs)[33].

Added pressures on medium secure beds come from the need to admit, via the civil route, patients who are difficult to

30 *"Patient or Prisoner?",* Discussion paper,1996, Home Office.

31 *"Corporate Plan 1993-96",* Prison Service, London

32 *"The Provision of Mental Health Care in Prisons",* (1997) Health Advisory Committee for The Prison Service, London

33 Home Office, News Release 289/2000, 22 September 2000.

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manage in less secure environments, together with pressure to take patients from the high secure special hospitals to aid their reintegration to society.

Given the preceding, the increase in the provision of private psychiatric hospital services impresses the need on one to consider the implications of the Human Rights Act in relation to these institutions.

In order to analyse the issue of Human Rights Act and Mentally Disordered Offenders in Private Healthcare Organisations, Chapter 1 will describe the legislation and background governing human rights in the United Kingdon, before Chapter 2 examines the legal status of mentally disordered offenders. Chapter 3 will proceed to describe private mental healthcare organisations and examine the issue of the nature of their public functions and applicability of the Human Rights Act 1983.

The issues concerning practices, with particular reference to those in private establishments / organisations, that are liable to challenge, or have been challenged, together with relevant case law, will then be described and analysed in depth in Chapter 4, prior to a conclusion and summary being given.

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Chapter 1

Background to Human Rights Legislation

The History and Operation of The Human Rights Act 1998 and the European Convention on Human Rights

This chapter is intended to give the reader a brief understanding of the history and workings of the European Convention on Human Rights ('ECHR' or 'the Convention'), together with its different methods of objective and purposive interpretation, as opposed to those more traditionally practised in the UK. This is of particular importance, given the reception of the Convention into the legal systems of The United Kingdom, by means of the Human Rights Act 1998[34].

Following on from this background, Chapter 4 will examine each of the Articles of the Convention and analyse those areas of legislation or practice that either have already violated, or are potentially likely to violate, the legislation as now included in the Human Rights Act.

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34 The sources for the material in this chapter, are as follows, unless otherwise specifically referenced:- Beddard, R, (1995), *Human Rights and Europe*, (3rd Ed), Cambridge University Press; Betten, L., (ed.), (1999), *The Human Rights Act 1998: What it Means*, Martinus Nijhoff Publishers, The Hague; Coppel, J., (1999), *The Human Rights Act 1998:Enforcing the European Convention in the Domestic Courts*, John Wiley, Chichester; Harris, DJ., et al, (1995), *Law of the European Convention on Human Rights*, Butterworths, London; Merrills, J.G. & Robertson, A.H., (2001), *Human Rights in Europe: A study of the ECHR*, (4th ed.), Juris Publishing, Manchester; Starmer, K., (1999), *European Human Rights Law: The Human Rights Act 1998 and the European Convention on Human Rights*, Legal Action Group, London; de Mello, R.(ed.), (2000), *Human Rights Act 1998: A Practical Guide*, Jordans, Bristol.

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The contemporary concept of a human rights charter or Convention was originated in the aftermath of the Second World War, with the broad aims of promoting European unity and preventing further atrocities, not least by means of the (not legally binding) Universal Declaration of Human Rights which was adopted in 1948 by the General Assembly of the United Nations. In the subsequent years, there were a number of proposals considered. In 1950, the Council of Europe (which was formed in 1949 to formalise the aims and ideals of social and economic progress, together with democracy and human rights), published the European Convention for the Protection of Human Rights and Fundamental Freedoms. This was, and is, an international treaty to which the UK was an original signatory (5th November, 1950).

Despite the fact that the UK Government played a major role in the drafting of the Convention and thereafter accepted its binding nature in international law, it did not incorporate it into UK legislation until October 2000, by means of the Human Rights Act 1998. Prior to this date, any claims against the UK had to be made by private petition to the Commission of Human Rights and subsequently the European Court of Human Rights ('ECtHR') in Strasbourg.

The effect of ECtHR judgements on UK domestic law was, prior to the enactment of the Human Rights Act, not binding. This was because Convention rights were only enforceable in

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Strasbourg and had no formal legal status within the domestic legislative framework. However, Convention case law could be used as an aid to interpretation, as was clarified in the case of **Brind**[35]. Lord Bridge stated

> …it is already well settled that, in construing any provision in domestic legislation which is ambiguous in the sense that it is capable of a meaning which either conforms or conflicts with the Convention, the Courts will presume that Parliament intended to legislate in conformity with the convention, not to conflict with it.[36]

The incorporation of the Convention now means that the Convention rights are given a formal status within UK domestic law, and are capable of being invoked in any Court or tribunal, without having to take action in Strasbourg. Domestic law must now take into account previous judgements of the European Court, together with acting in a compatible manner, thus:

> 2.(1) A Court or tribunal determining a question which has arisen in connection with a Convention right must take into account any
> (a) judgement, decision, declaration or advisory opinion of the European Court of Human Rights,
> (b)…
> (c)…
> (d)…
> whenever made or given, so far as, in the opinion of the Court or tribunal, it is relevant to the proceedings in which that question has arisen.[37]

It should be noted that not all of the Convention rights have been incorporated: only **Articles 2-12** and **14**, together with **Articles 1-3 of the First Protocol** and **Articles 1 and 2 of the**

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35 *R. v Secretary of State for the Home Department Ex Parte Brind*, [1991] 1 A.C. 696; [1991] 1 All E.R. 720

36 op cit at para. 747H-748A

37 Human Rights Act 1998, s.2(1)

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Sixth Protocol. As discussed by Coppel[38] amongst others, the actual method of incorporation into the domestic sphere is complex, together with not having the power to repeal any inconsistent legislation. (A "Declaration of Incompatibility"[39] must be made and then the Government must amend the existing, or issue new, legislation.)

Regardless of this potential complexity, the wider principles can be considered as follows:

A) the Convention must be viewed as a "living instrument"[40]; in other words the language and content must be examined in a modern context and previous decisions on cases may not necessarily apply to any other cases. This applies both to cases that have succeeded and those that have previously failed.

B) it is an "instrument designed to maintain and promote the ideals and values of a democratic society".

C) it is intended to be interpreted so that its rights are "practical and effective", not "theoretical and illusory"[41], in other words it is purposive.

The concept of "subsidiarity" is also crucial when examining this field. This fundamentally means that the role of the European

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38 Op Cit

39 Human Rights Act 1998, s.4 & s.5

40 *Tyrer v UK* (1979-80) 2 E.H.R.R. 1

41 Starmer, op cit para 4.1

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Court of Human Rights (ECtHR) is a supervisory one, performing only those tasks that cannot be effectively dealt with at a local or national level. This is further developed by the "margin of appreciation" given by the ECHR to domestic authorities, recognising that they are better placed, at least in the first instance, to, make decisions about the merits of a case.

Although the rights contained within the Convention are described as "fundamental", they can, in certain circumstances, be restricted. The ECHR has recognised three different categories, with the rights being formulated in different ways thus:

Absolute rights cannot be restricted in any circumstances and are **Article 2** [Right to life], **Article 3** [Prohibition of Torture], **Article 4(1)** [Prohibition of slavery and forced labour] and **Article 7** [No punishment without law].

Limited, or derogable but otherwise unqualified rights can be derogated by the Government. This is applicable to **Articles 4(2), 4(3), 5** [Right to liberty and security] and **Article 6** [Right to a fair trial]. The Human Rights Act has one designated derogation, relating to the pre-trial detention of suspects under legislation relating to the prevention of terrorism.

Qualified rights are written in a positive form, but are subject to limitation or restriction clauses, and are **Article 8** [Right to respect for private and family life], **Article 9** [Freedom of

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thought, conscience and religion], **Article 10** [Freedom of expression] and **Article 11** [Freedom of assembly and association], together with **Protocol 1, Article 1** [Protection of property] and parts of **Protocol 1, Article 2** [Right to education]. Interference with these qualified rights is only permissible if i) it has a basis in law; ii) it is done to secure an aim that is permissible in the relevant article or iii) it is necessary in a democratic society e.g. it fulfils an urgent social need. This balancing of needs has led to the concept of proportionality, i.e. the steps taken to support the competing aim must, in the circumstances, be proportionate.

> **Section 6** of the Human Rights Act states
>
> 6(1) It is unlawful for a public authority to act in a way which is incompatible with a Convention right.
> (2)…
> (3) in this section "public authority" includes-
> (a) a court or tribunal, and
> (b) any person certain of whose functions are functions of a public nature,...

and it is the question of the nature of the public nature of the functions of private healthcare organisations that is central to the issue of the applicability of the HRA to mentally disordered offenders who are detained in those private facilities.

This central issue will be investigated in Chapter 3, following an analysis of the legal status of mentally disordered offenders, in Chapter 2.

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Chapter 2

Legal Status of Mentally Disordered Offenders

The relationship between mental health and criminal justice systems has long been very complex. The development of formal mental health legislation in the 1800s[42] up until the present day has tied the two together on what has been an often uneasy road. The ideological conflict of "medicalism" and "legalism", as described by K.Jones[43], amongst others[44], has also done little to ease the relationship. However, the arguments and discussions regarding this are beyond the remit of this dissertation, so this chapter will be restricted to describing the law as it is currently.

When dealing with the mentally disordered offender, as with the non-disordered, factors such as the nature of the offence, the role of the defendant, premeditation, previous convictions, background, medical and psychiatric problems are taken into account[45]. The majority of those mentally disordered offenders who are detained in hospital are there under the provisions of the Mental Health Act 1983. However, some are detained under other

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42 See for example The Lunatic Asylums Act 1845, Trial of Lunatics Act 1883, Lunacy Act 1890, The Mental Deficiency Act 1913, Mental Health Act 1959 etc

43 Jones, K., (1955), *Lunacy, Law and Conscience*, Routledge & Kegan Paul, London.

44 See, for example, Fennell, P., "Historical Development of Mental Health Legislation To The Present Day" in Thomas, P.A., (Ed) (1996), *Legal Frontiers*, Dartmouth, pp 208-264.

45 Criminal Justice and Public Order Act 1994

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legislation, notably the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991.

This chapter will describe the Mental Health Act 1983 and its relevance under which mentally disordered offenders may be detained in private hospitals, together with patients' rights.

Civil Admissions

Part II of The Mental Health Act 1983 (MHA) provides for the admission of non-offenders (ie Civil Admissions) and **Part III** sets out powers of detention that apply to mentally disordered offenders. In practice, there is a possibility that people who have committed criminal offences may not be proceeded against in the criminal Courts, but may alternatively be diverted into psychiatric services including, on occasion, formal hospital admission under **Part II**. Private healthcare organisations accept patients under these criteria.

Part I[46] of the MHA sets out Statutory definitions of what allows someone to be detained under the MHA. The definitions applied are broad and laid out thus:

> In this Act
> **"*mental disorder*"** means mental illness, arrested or incomplete development of mind, psychopathic disorder

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46 Mental Health Act 1983 Ch 20, 1(2)

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and any other disorder or disability of mind and "mentally disordered" shall be construed accordingly;

"*severe mental impairment*" means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned and "severely mentally impaired shall be construed accordingly;

"*mental impairment*" means a state of arrested or incomplete development of mind (not amounting to severe mental impairment) which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned and "mentally impaired" shall be construed accordingly;

"*psychopathic disorder*" means a persistent disorder or disability of mind (whether or not including significant impairment of intelligence)which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned;

Despite, or perhaps because of, the brevity of this part, much has been written and much time has been taken up in Court, Mental Health Review Tribunals and elsewhere regarding what actually constitutes the criteria that allow for detention.

Article 5 of The European Convention on Human Rights allows for

> the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants[47]

and it is this that allows formal detention, given objective evidence of true mental disorder. The Courts have so far declined to give an absolute definition of what constitutes "persons of unsound mind",

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47 ECHR, Article 5 (1)

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but the Court in the case of **Winterwerp**[48] looked at this in some depth and led to what have become known as the Winterwerp Criteria, as is discussed later[49].

The terminology used in the Mental Health Act is currently consistent with the interpretation of the European Convention on Human Rights by the European Court of Human Rights[50].

The two sections which are of most importance in the civil context are **Section 2** and **Section 3**:

Section 2 includes a broad concept of what constitutes mental disorder and is a power that allows for the compulsory admission and detention of a person for the purposes of assessment for a period of up to 28 days

> ......on the grounds that
> (a) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and
> (b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.[51]

Application for compulsory admission under these powers is by written recommendation, following the form prescribed by the

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48 *Winterwerp v The Netherlands* (1979), 2 E.H.R.R. 387.

49 See Page 84

50 *The House of Lords and House of Commons Joint Committee on Human Rights Report*, (HL Paper 181, November 2002) expresses some grave concerns regarding the changes in definition proposed in the Draft Mental Health Bill, (See particularly paras 27-49)

51 Mental Health Act 1983, c.20, s2(2)(a)&(b)

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Act, of two registered medical practitioners[52], together with an Approved Social Worker[53]. It should be noted that **Section 12** of he MHA restricts the provision of recommendations for admission by certain categories of doctor in private practice[54], which fundamentally means that if a patient is to be admitted to a registered establishment, then neither recommendation can come from a doctor on the staff of that hospital or establishment.

The right of appeal against this admission exists and is to the Mental Health Review Tribunal[55] (MHRT) and The Hospital Managers[56] (MHA Managers). Treatment can be given without the consent of the person concerned, subject to the provisions and limitations contained within **Part IV** of the Act[57].

The use of **Section 2** powers, in the context of offenders, and in the writer's experience, often follows petty or minor offences when the person concerned is detained initially by the Police, often following procedures under **Section 136**[58].

Section 136 allows a constable to remove from

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52 Mental Health Act 1983, c.20, s12 (1) & (2)

53 Mental Health Act 1983, c.20, s145(1)

54 Mental Health Act 1983 Code of Practice (Revised) (1999) HMSO, London. Para. 4.1

55 Mental Health Act 1983, c.20, s.65

56 Mental Health Act 1983, c.20, s145; Code of Practice Mental Health Act 1983, s22 & 23

57 Mental Health Act 1983, c.20, Part IV.

58 op cit. S136(1)&(2)

> …..a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of the person or for the protection of other persons, remove that person to a place of safety…

This power can be exercised whether a crime has been committed or suspected or not and allows for detention for up to 72 hours so that an assessment can be made. There is no automatic right of appeal against this detention, apart from that of Habeus Corpus. “Place of Safety” is defined under **Section 135 (6)** but, based on discussions with serving police officers and the writer’s own national experience, is, or has been until very recently, almost exclusively to a police station. However, as is being developed by a number of local partnership agreements between police and health services, good practice suggests that a mental health unit/psychiatric hospital should be the preferred "place of safety" unless the person:

a) is under the influence of drugs/alcohol or
b) is violent or threatening violence or
c) is requiring treatment for a physical injury and/or
d) has committed a criminal offence. (However, in legal terms, this offence and its investigation takes primacy).

Should detention of a seriously mentally disturbed suspect be required in a police cell then good practice directs that the services of a suitably experienced registered nurse should be

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obtained to continually closely monitor the patient / suspect and to liase with custodial and other health professionals regarding that person's care whilst in custody. There are schemes being piloted whereby mentally ill people will no longer be detained in cells awaiting a hospital assessment or, if they have to be, they will definitely be cared for by qualified nurses within the police station[59], although the extent of these schemes is extremely limited.

Section 136 of the current Mental Health Act does not allow for treatment of the detainee without consent.

The person detained under the Mental Health Act has the right to information under **Section 132.** This area of the right to information is covered by **Article 5(2)** of The European Convention on Human Rights and requires that anyone detained (which is interchangeable with the term "arrest" in Convention language) should be

> ….informed promptly, in a language which he understands, of the reasons for his arrest….

This has been tested on a number of occasions in the Courts, most notably in **Van der Leer v Netherlands** [60]. In this particular case the applicant only found out by accident about a Court order confining her to a psychiatric hospital ten days after the

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59 See for example, *"Mentally ill will not be held in cells",* The Times, November 18, 2000, p13.

60 (1990) 12 E.H.R.R. 567, See particularly paras 27 & 28

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event and a breach of **Article 5(2)** was found. The issues raised are discussed in further depth in Chapter 4.

In the context of the private/independent sector, **Section 2** and to an increasing extent, **Section 136** are mostly applicable to the small, but increasing, number of 'low secure' psychiatric intensive care units (PICUs), particularly with reference to "petty" crimes dealt with by diversion at point of arrest, and where charges are unlikely to proceed.

Admissions to medium secure services under **Section 2** are made, but are quite uncommon, mainly as a result of many mentally ill offenders being well known to the services and, having been previously assessed, are able to be dealt with by means of **Section 3**.

Section 3 of the Mental Health Act allows for the admission and detention of a person for treatment, initially for a period of six months, renewable for a further six months and then renewable at yearly intervals, subject to appeals to Mental Health Review Tribunals[61] and Hospital Managers,

> .....on the grounds that
> (a) he is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and

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61 Mental Health Act 1983, c.20, s.20

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> (b) in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition; and
> (c) 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 detained under this section.[62]

Application for admission under **Section 3** is very similar to that for **Section 2**, and can either follow admission under **Section 2**, or be direct for patients previously assessed and known to be meeting the prescribed grounds.

Most treatments can be given, again subject to the provisions laid out in **Part IV** of the Act, either with a person's consent or without their consent; the latter which then requires a second opinion, subject to **Section 58**. The Secretary of State delegates the approving of "second opinion approved doctors" (SOADs) to the local health authorities. Other treatments, most notably "surgical operations for destroying brain tissue, or the functioning of brain tissue"[63] require both consent of the patient together with the opinion of a second doctor, as laid out in **Section 57**.

Admission of mentally disordered offenders under **Section 3** powers is again primarily as a result of diversion from the

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62 Mental Health Act 1983, c.20, s3(2)

63 op cit s57(1)(a)

penal/custodial system and is quite common within both State and Independent hospitals[64].

Patients concerned in criminal proceedings or under sentence

Part III of the Mental Health Act deals directly with patients concerned in criminal proceedings or under sentence. Under this Part, access to the mental health system can be made via a number of routes and the fundamentals of these areas follow[65]:

- **Following Arrest (Awaiting Trial)**

Section 35 allows for remand to hospital of the person in custody, by either The Crown Court or the Magistrate's Court for reports to be prepared on the accused's mental condition. It is valid for 28 day periods up to a maximum of 12 weeks. The detention has to be renewed by the Court at up to 28 day intervals, but the accused does not have to attend Court, as long as he is represented by a solicitor or counsel in Court.

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64 National Assembly For Wales, 2000, *Statistical Report: Patients in Psychiatric Hospitals and Units in Wales* (SDB 94/2000), Health Statistics Unit, National Assembly For Wales, Cardiff; Home Office, 2000, *Statistics of Mentally Disordered Offenders in England and Wales 1998 (Issue 7/00*), Home Office, London.

65 Unless otherwise referenced, this material is compiled from: Hoggett, B.(1996), *Mental Health Law*, Sweet & Maxwell, London; Jones, R.(2001*), Mental Health Act Manual* (7th Edition), Sweet & Maxwell, London; *Mental Health Act 1983: Code of Practice*, (1999) Department of Health and Welsh Office and Mental Health Act 1983; *Memorandum on Parts I to VI, VIII and X*, (1998) Department of Health and Welsh Office.

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It is not necessary to establish a link between the person's alleged offence and any suspected mental disorder, but a recommendation from a doctor who is approved under Section 12 of the Act must be submitted to the satisfaction of the Court that there is good reason to suspect that the accused is suffering from one of the four specific terms used in **Section 1(2)**. Further there must be an assurance that a bed for the accused will be available within seven days of an order being made.

The accused is also entitled, at his own expense, to commission an independent psychiatric report[66]. Detention under this section does not allow treatment without the patients' consent, except for in emergencies under Common Law. The right of appeal is to the Court and not to the Mental Health Review Tribunal or the Hospital Managers.

Section 36 allows for the Crown Court to remand an accused person to a hospital for treatment, rather than remanding in custody. This, as discussed by Jones[67], provides an alternative to **Section 48** detention, as will be described later, allowing the accused, if he is responsive to treatment, to be dealt with by means of a full trial, rather than by means of The Criminal Procedure (Insanity) Act[68], which would then involve the accused

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66 Mental Health Act 1983 s35(8)

67 Jones, R., 2001, *Mental Health Act Manual*, 7th Ed., Sweet & Maxwell, London, para. 1-455

68 Criminal Procedure (Insanity) Act 1964

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being dealt with as a "restricted" patient, which might not be appropriate, depending on the nature of the alleged offence.

Two medical recommendations are required by the Court that the person is suffering from "mental illness or severe mental impairment of a nature or degree which makes it appropriate for him to be detained in hospital for treatment" [69].

As the remand is to hospital for treatment, this can be given against the patient's wishes, subject to the provisions of **Part IV** of the Act. Detention in hospital is for periods of 28 days up to a maximum of 12 weeks in total. The accused does not have to appear in Court, as long as he is represented in Court by Counsel or a solicitor. Appeal against detention is to the Court and not the Hospital managers or The Mental Health Review Tribunal.

- **Court (Awaiting Sentence)**

Section 38 provides for the making of an "interim hospital order" and can be used following conviction of an offence, but prior to sentencing, by both Crown and Magistrates Courts, to assess a person's mental disorder or to evaluate responsiveness to treatment. This is fundamentally to determine whether a "hospital order" (**Section 37,** as will be discussed) may be appropriate when

69 Mental Health Act 1983 s36(1)

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sentencing is considered. Detention is initially for a period of up to 12 weeks, but can be extended to up to 12 months, in blocks of 28 days. Two medical recommendations are required. Treatment is subject to the provisions of **Part IV** and can be given without consent. The right of appeal is again to the relevant Court under The Criminal Appeal Act 1968[70], as the interim hospital order is a form of sentence.

Section 48 (removal to hospital of other prisoners) provides for the detention in hospital for treatment and requires that

> the prisoner is in urgent need of such treatment[71]

and is usually (by the ratio of fifteen to one)[72] used in conjunction with **Section 49,** which is a Restriction Order imposed by the Home Secretary. This restriction can be terminated at any time by the Home Secretary and he/she can also discharge directly from hospital; similarly the patient can be recalled to prison at any time on the Home Secretary's instruction, with no right of appeal against recall.

Section 48 only applies to persons suffering from mental illness or severe mental impairment and

> (a) persons detained in a prison or remand centre, not being persons serving a sentence of imprisonment or persons…

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70 Criminal Appeal Act 1968, s.50(1)

71 Mental Health Act 1983, s.48(1)

72 *"Inpatients formally detained in hospitals under the Mental Health Act 1983 and other legislation, England: 1991-1992 to 2001-2002"* , Bulletin 2002/26, Nov.2002, Department of Health. Table 5

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(b) …remanded in custody by a magistrate's Court,
(c) civil prisoners…….
(d) Persons detained under the Immigration Act 1971[73]

The right of appeal is to the Mental Health Review Tribunal, within six months of the making of the order.

- **Sentence**

Section 37 provides for the making of a hospital order by the Crown Court or Magistrate's Court. It is fundamentally the same as a **Section 3**[74] detention under civil admission, the primary difference being that it is imposed by the Court.

The Court requires evidence from two doctors that

> (a)….the offender is suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment and that….
>
> (i)…..the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and, in the case of a psychopathic disorder or mental impairment, that such treatment is likely to alleviate or prevent a deterioration in his condition…[75]

Section 37 can also be used as a guardianship order, particularly where mentally ill people do not require hospital treatment, but do require care and protection.[76] The guardianship means that the guardian (usually the local authority) has the power to compel the offender to live at a specific place; to attend specific

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73 Mental Health Act 1983, s.48(2)

74 Mental Health Act 1983, s.3

75 op cit s.37(2)(a)

76 Mental Health Act Code of Practice (Revised), 1999, HMSO, London, para. 13.11

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places at specified times for medical treatment (but, notably, not to compel him to accept treatment), training, education or occupation and to allow access to his accommodation by a variety of professionals.

Section 37 can be used, in the case of more serious offences, in conjunction with a **Section 41** restriction order if the Court considers it necessary for the protection of the public from serious harm. This can be either finite or without limit of time and can only be ordered by the Crown Court. Magistrates, who can however direct detention under **Section 43**, whilst awaiting committal to the Crown Court for consideration of a restriction order due

> to the nature of the offence, the antecedents of the offender and the risk of him committing further offences if set at large, that if a hospital order is made a restriction order should also be made[77].

The consent to treatment provisions in **Part IV**, as described previously, apply to **Section 37** hospital orders, but not to guardianship orders. Under a hospital order, the patient has the right of appeal to the Mental Health Review Tribunal between six and twelve months after the initial making of the order, and subsequently in any twelve month period. Under guardianship, the patient can apply to the MHRT within the first six months and subsequently once during each renewal period.

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77 op cit S.43(1)(b)

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As detention under **Section 37** is a form of sentence, the person detained can also appeal to the Court of Appeal[78], where the Court can, if it sees fit, substitute the hospital order for a prison sentence.

- **Prison (Post Sentence)**

Section 47 provides for the making of a transfer direction and this allows the Home Secretary to direct the transfer of a person serving a sentence of imprisonment to a named hospital, following reports from two doctors:

(a) that the said person is suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment; and
(b) that the mental disorder from which that person is suffering is of a nature or degree which makes it appropriate for him to be detained in hospital for medical treatment and, in the case of psychopathic disorder or mental impairment, that such treatment is likely to alleviate or prevent a deterioration of his condition;[79]

The Home Secretary usually[80] applies a "restriction direction" under **Section 49** to **Section 47** transfers, the restrictions being the same as under **Section 41**[81] restrictions. However, under **Section 47/49** detention, where the offender was

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78 Criminal Appeal Act 1968, s.50(1)

79 Mental Health Act 1983, s.47(1)(a)&(b)

80 See *Inpatients formally detained in hospitals under the Mental Health Act 1983 and other legislation, England: 1989-1990 to 1999-2000* , Bulletin 2000/19, October 2000, Department of Health. Appendix B, Tables 3 & 4 for details.

81 Mental Health Act 1983, s.49(2)

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sentenced to a fixed term of imprisonment, when that term expires, then so does the restriction. Also, when it is decided, either by the responsible medical officer (RMO) or the Mental Health Review Tribunal (MHRT) that the "restricted" person no longer needs treatment in hospital, or that no effective treatment can be given then the Secretary of State can do one of the following[82]:

a) release him on parole (if eligible),

b) return him to prison to serve out his sentence, or

c) take no action.

If the patient is not "restricted", then the RMO or the MHRT are able to exercise the same powers as if it were a civil detention. For both restricted and unrestricted patients, applications can be made to the MHRT once in the six months following the making of the order, once in the following six months and then at yearly intervals. Consent to treatment provisions are as in **Part IV**.

To summarise this chapter, patients admitted to hospital, whether NHS or private and whether Under **Part II** or **Part III** are statutorily entitled to information under **Section 132**. The hospital managers must take "such steps as are practicable"[83] to ensure that the patient understands which of the provisions of the Mental Health Act apply to him and what rights of appeal are open to him.

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82 *R. v Birch* (1989) 11 Cr.App.R.(S.) 202, 212

83 Mental Health Act 1983, s.132(1)

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There are various rights of appeal by prisoners/patients detained under the MHA, depending on the section under which the detention occurs, and it is in this area, amongst others, as will be discussed in Chapter 4, that have raised human rights issues to date.

Part IV of the MHA lays out the issues regarding consent to treatment and, in particular, **Section 58** explains the need to obtain a second opinion prior to commencement of administration of medication, if the patient is not consenting. **Section 60** clarifies that even if a patient is consenting, then they can withdraw that consent at any time.

If a patient is detained under **Section 3** or **Section 37** then, if the detention is to be renewed, it is the duty of the responsible medical officer, under **Section 20**, within two months ending on the last day of the current detention, to provide the Hospital Managers with a report that

a) the patient is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment, and his mental disorder is of a nature or degree which makes it appropriate for him to receive treatment in hospital; and
b) such treatment is likely to alleviate or prevent a deterioration of his condition; and
c) 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 that it cannot be provided unless he continues to be detained;

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> but, in the case of mental illness or severe mental impairment………, alternative to b)…that the patient, if discharged is unlikely to be able to care for himself, or to obtain the care which he needs or to guard himself against serious exploitation.[84]

Private organisations share all of the preceding statutory duties and obligations with NHS establishments, together with their patients enjoying the same rights. The following chapter will now address the issue of to what extent are private hospitals exercising State functions and whether they are therefore are fulfilling public functions for the purposes of the Human Rights Act 1998.

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84 Mental Health Act 1983 s.20(4)

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Chapter 3

Legal Status of Mental Healthcare Institutions

This chapter is primarily concerned with the description of the legal status of private mental healthcare institutions in relation to the question of whether they can be considered Public Authorities for the purposes of Section 6 of The Human Rights Act 1998, which states:

> 6-(1) It is unlawful for a public authority to act in a way which is incompatible with a Convention right.

and

> 6-(3) In this section "public authority" includes-
> (a) a Court or tribunal, and
> (b) any person certain of whose functions are functions of a public nature…………

The features of private mental hospitals that are of importance here are

a) that they are providing private care for NHS patients,
b) that they are exercising State powers to detain and treat patients, usually the Mental Health Act 1983 (MHA), and
c) that the managers of such hospitals have to further exercise statutory powers in order to renew the detention of patients detained under **Section 2** and **Section 3** of the MHA

There have been a number of cases that have previously looked at the relationship between private facilities and public

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duties[85], although recently two cases have been brought specifically regarding the question of whether private organisations come under the auspices of the Human Rights Act.[86]

Private psychiatric / mental health hospitals were, until recently registered as "private mental nursing homes" under the Registered Homes Act 1984 and those that had patients detained under, or subject to the provisions of, the Mental Health Act 1983 were registered under Section 23, separately from other private nursing homes.

The Care Standards Act 2000[87] was introduced to establish a new regulatory body, the National Care Standards Commission, for social care and private and voluntary healthcare services, as a result of extensive review of the previous system. The Act also allows for the Secretary of State to maintain a list of individuals considered unsuitable to work with vulnerable people. The new arrangements under the Act will eventually take over from those under the Registered Homes Act, which will be repealed in its entirety when the transfer has been completed.

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85 See, for example, *R. v Servite Houses Ex p. Goldsmith* (2000) 2 L.G.L.R 997 and *Poplar Housing and Regeneration Community Association Ltd v Donoghue* [2001] EWCA Civ 595

86 R. (*On the Application of Heather) v Leonard Cheshire Foundation* [2002] All E.R. 936; [2002] E.W.C.A. Civ. 366. And *R.(on the Application of A and Others) v Partnerships In Care Ltd [2002]* 1 W.L.R. 2610; [2002] E.W.H.C. 529 (Admin.)

87 Care Standards Act 2000 pt.1 s.2

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The Act defines independent / private hospitals as follows[88]:

(1)….

(2) A hospital which is not a health service hospital is an independent hospital.

(3) "Hospital" (except in the expression health service hospital) means-
(a) an establishment-
(i) the main purpose of which is to provide medical or psychiatric treatment for illness or mental disorder or palliative care; or
(ii) in which (whether or not other services are also provided) any of the listed services are provided;
(b) any other establishment in which treatment or nursing (or both) are provided for persons liable to be detained under the Mental Health Act 1983.

(4) "Independent clinic" means an establishment of a prescribed kind (not being a hospital) in which services are provided by medical practitioners (whether or not any services are also provided for the purposes of the establishment elsewhere).
But an establishment in which, or for the purposes of which, services are provided by medical practitioners in pursuance of the National Health Service Act 1977 is not an independent clinic.

(5) …

(6) References to a person liable to be detained under the Mental Health Act 1983 do not include a person absent in pursuance of leave granted under section 17 of that Act.

(7) …

(8)….

The fact that a private psychiatric hospital is outside what would be normally considered as the traditional concept of a "public authority" does not necessarily mean that it does not fall under the control of the Human Rights Act, as it might be

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88 Care Standards Act 2000 pt.1 s.2

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considered to be carrying on "functions of a public nature"[89], therefore becoming liable to the full weight of public law, for certain activities.

The first of the cases brought under the Human Rights Act was **R. (on the application of Heather) v Leonard Cheshire Foundation**[90]. This concerned 3 residents of a Leonard Cheshire Foundation (LCF) nursing and residential care home. The accommodation was provided for by funding under the National Assistance Act 1948. The residents claimed that a decision to close that home and relocate the residents to another home was in breach of their Convention rights.

The submission was that LCF exercised public functions given that it received public funding, that the home was State regulated and that, had care not been provided by LCF, it would have been provided by the State which would have been accountable under public law

One of the preliminary questions addressed by the Court was whether LCF was a "public authority" under the Human Rights Act. In this instance it was found that LCF did not exercise public functions. Although LCF was acting as a contractor to the NHS and considering he fact that the local authority / state funded the

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89 Human Rights Act 1998 S6 (3) b.

90 [2002] 2 All ER 936; [2002] EWCA Civ.366

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accommodation and care, together with providing a regulatory function in relation to the services provided this did not impart the function of a public authority onto LCF. The Court of Appeal found that although the National Assistance Act provided for the authorities to contract out services, LCF had no statutory powers and was not exercising any statutory powers in regard to the claimants.

The Court further held that in circumstances where Article 8 rights[91] might be affected, then the local authority contracting out the service had to include private body rights within the contract, in order to comply with article 8.

The second case is that of **R (On Application of A & Others) v Partnerships in Care Ltd**[92] and specifically relates to a 31 year old patient formally detained under Section 3 of the Mental Health Act 1983, in a private psychiatric hospital, Stockton Hall Hospital, which was owned and operated by Partnerships in Care Ltd.

The primary issues at stake in this case were whether the decision was made in the exercise of a public function[93] and whether the hospital managers constituted a "public authority",

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91 Right to respect for Private and Family Life

92 [2002] EWHC 529 (Admin); [2002] 1 WLR 2610

93 Civil Procedure Rules

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therefore being liable to uphold the Convention Rights, against which a claim was being made. Both these claims were upheld on the basis that The Nursing Homes and Mental Nursing Homes Regulations 1984[94] gave a statutory duty to the hospital to provide adequate professional staff and treatment. There was also a public interest in the hospital's patients receiving care and treatment, as at sometime they might be living back in the community. Further, as the claimant, and other patients, were compulsorily detained under the Mental Health Act 1983, then the managers' decision was one that was an act made in relation to the exercise of a public function.

Partnerships in Care Ltd was therefore classed as a functional public authority and held to be amenable to judicial review.

The facts of the case were that the claimant, in common with two other claimants (who later withdrew their claims as suitable alternative placements were found), had a severe personality disorder and was placed on Farndale Ward which was a single sex ward that specialised in the care and treatment of females with a primary diagnosis of personality disorder. The claimant was admitted to the ward on 12th June, 2001, following a two year wait, with the funding for the placement coming from her home area health authority.

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94 Reg. 12 (1)

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On 6th August, 2001, a decision was made by the hospital to change the clinical focus of the ward to one that dealt with women with a primary diagnosis of mental illness. This decision was made as a result of the resignation of the consultant psychiatrist, who had expertise in working with women with personality disorders. The current patients would be able to remain on the ward for up to eighteen months, being moved to other units as places became available, in order to complete their treatment. The claimant alleged that this transfer of clinical focus, together with the lack of appropriately experienced staff, had denied her the care and treatment that she required. Despite the 2 other original claimants having found alternative placements, A had not and in February 2002 she sought judicial review that this was unlawful and irrational and infringed her rights under **Articles 3** and **8** of the ECHR.

Keith J, delivering judgement in the Partnerships In Care case[95], gave extensive analysis of the legal framework in relation to healthcare in public and private fields. The Judge referred to the authority of **Donoghue**[96], which related to a decision on whether a housing association, to which a local authority had transferred a large percentage of its housing, and which tried to repossess a property from the defendant, was a functional public authority. In this case the Court found that the "housing association 'was no

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95 Op Cit Paras 14 - 25

96 *Poplar Housing and Regeneration Community Association Ltd v Donoghue* [2002] QB 48

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more than the means' by which the local authority sought to perform its statutory duty…."[97], and "the more closely the acts that could be of a private nature are enmeshed in the activities of a public body, the more likely they are to be public".

To summarise, the judge considered[98] that although the hospital was not part of the National Health Service, it was registered as a mental nursing home under Part II of the Registered Homes Act 1984 and as one able to receive patients under the Mental Health Act 1983. The Nursing Homes and Mental Nursing Homes Regulations 1984 give the Secretary of State, and the registration authority, by way of delegated authority, a degree of control and supervision of the hospital. Importantly for the Judge, **Section 12(1)** [99] of the regulations state

> The person registered shall, having regard to the size of the home and the number, age, sex and condition of the patients therein
> (a) provide adequate professional …staff…
> (d)provide….adequate treatment facilities.

Secondly, the hospital accepted patients detained under statutory powers and the Judge commented[100]

> In its corporate capacity as the body which owns and runs the hospital, the defendant may be a private company run on commercial lines free to admit whichever patients it chooses. But in its statutory capacity of manager of the hospital, the defendant is a body upon whom important statutory functions have devolved, albeit as a result of the contractual

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97 *In R (On Application of A & Others) v Partnerships in Care Ltd* [2002] EWHC 529 (Admin); [2002] 1 WLR 2610 at para. 19

98 op cit at paras. 16 and 24

99 The Nursing Homes and Mental Nursing Homes Regulations 1984, s.12

100 op cit at para. 17

> agreements which it has made with the health authorities to which the responsibility for the care and treatment of the hospital's patients who are not being treated privately have been delegated by the Secretary of State…..

Thirdly, there was a public interest in the hospital's activities owing to the potential of the discharge of patients back into the community[101].

The Partnerships in Care case is extremely important for managers of all private healthcare organisations where powers are exercised related to compulsory detention. Although this case was directly related to the adequate provision of staff, the judgment can be capable of encompassing a variety of other areas such as the acceptance of detained patients; medical recommendations for the renewal of detention and the administration of medication, amongst other treatments under statutory powers.

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101 op cit at para. 24

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Chapter 4

Areas of mental health practice liable to challenge under HRA 1998

Article 2: Right to Life

Article 2 of Schedule 1, Part 1 of the European Convention on Human Rights (ECHR, or "the Convention") states:

> 1) Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of Court following his conviction of a crime for which this penalty is provided by law.
> 2) Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:
> (a) in defence of any person from unlawful violence;
> (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
> (c) in action lawfully taken for the purpose of quelling a riot or insurrection.

From a broad perspective, this can be perceived as one of the most fundamental rights under the Convention, and is viewed as such by the ECtHR. The fact that one has the duty not to take life is, within the context of this dissertation, without question. However, the extent to which the right to have one's life protected or the duty to prevent one harming oneself might be applicable is more questionable.

There are two important aspects to **Article 2**, namely

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a) that the State (or its agents) may not deprive someone of their life, save for the exceptions given above, as found in **McCann v United Kingdom**[102] (concerning the deaths of three IRA suspects killed by the SAS in Gibraltar), and

b) the positive aspect under the State's duty to protect the right to life. The extent to which **Article 2** confers the right to have one's life protected or the right to be protected from self harm. There is extensive case law on this area, which will be examined below. Although the cases are primarily concerned with offenders whilst in prison or police custody, the general principles can be regarded to be the same for prison or hospital environments.

Duty To Provide Minimum Standard Of Healthcare

Wright[103] (which incidentally includes some in-depth analysis of **McCann**[104]) dealt with the alleged negligent death of an asthmatic prisoner and is a very important case when looking at **Article 2** Rights. (Claims were also made under **Article 3** and **Article 8**).

The facts of **Wright** are that Paul Wright, who was born in 1963, died in prison in November, 1996, as a result of a severe

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102 *McCann v United Kingdom* (1996) 21 E.H.R.R. 1997

103 *R. (On the Application of Margaret Wright & Another) V Secretary of State for the Home Department*, 2001 WL 606447; [2001] EWHC Admin 520. See Also BMJ "Prisoner dies after 'Seriously Deficient Care'" 2001; 322: 1565 (30 June 2001).

104 Op cit

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asthma attack. He had a long history (since three years old) of requiring emergency medical treatment for his condition and was prescribed a range of anti-asthmatic medication, including the use of a nebuliser on occasions, to maintain his health. He was arrested in November 1995, for a number of offences, and spent brief periods on remand and bail, prior to being sentenced, in July 1996, to three years and six months imprisonment, which he continued to serve at HMP Leeds.

Mr Wright's asthma was well known and he had regular contact with a number of Doctors / Medical Officers and other staff within the Prison Health Care Centre (having been seen on at least 26 occasions by at least 4 different doctors over a 10 month period). He kept inhalers with him in his cell (although their use was unmonitored and unrecorded) and there was a nebuliser kept in the Health Care Centre, which had had to be used on occasion to administer salbutamol ("Ventolin") to Mr Wright, following serious asthmatic attacks.

During the evening of 7th November, 1996, Mr Wright experienced a severe asthmatic attack, whilst on lock-down ie locked in cell. He told his cell mate that he needed a nebuliser and he pressed the emergency call button. A prison officer responded some time later (the period of time being the subject of some dispute) and a nurse was called. On her arrival Mr Wright was not breathing and an ambulance was called. Attempts at resuscitation

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proved fruitless and Mr Wright was certified dead at Leeds General Infirmary.

An inquest was opened and adjourned on 19th November, 1996. The adjourned inquest reconvened on 29th April, 1997 where the Prison Service were represented by counsel, but the Wright family were unrepresented, due to cost implications, in the absence of legal aid. Doctor Singh, who primarily dealt with Mr Wright's treatment, did not give evidence, but his written statement was read out. Mr Wright's cell mate was willing and able to give evidence, but was not called and his witness statement was declared inadmissible. After the one day hearing, in front of a jury, a verdict was returned of death by natural causes. Mr Wright's family remained unhappy regarding the circumstances of the death.

Subsequently the family learned that that Dr Singh had been suspended from HMP Leeds, and that he had been previously found guilty, by the General Medical Council, of serious professional misconduct and banned from working as a locum or single-handed general Practitioner, following the neglect and deaths of two patients. The family then proceeded with a claim for damages against the Prison Service under The Fatal Accidents Act 1976, on the basis of negligent treatment of Mr Wright's asthma. In April, 2000, the defendants denied negligence, but admitted liability, with damages being agreed. As a result of the admission

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of liability, there was not a Court case in which the allegations of negligence could be tested. The family's solicitor therefore tried, without success, to press the Prison Service into holding an independent investigation.

In August, 2000, the claimants applied to amend their claim under the Fatal Accidents Act by adding, firstly, a claim for bereavement damages based on the Prison Service's breach of **Articles 2, 3** and **8** of the ECHR in failing to provide proper care whilst Mr Wright was in prison and, secondly, a claim for damages based on the defendant's ongoing failure to carry out an independent inquiry, as required by the same Articles, together with a failure to disclose available information about the death.

In September, 2000, the amendment application was heard. The first amendment was disallowed, as the alleged breaches had occurred prior to the enactment of the Human Rights Act 1998, and was therefore unable to succeed. The second amendment was also disallowed, although on the basis that it raised public law issues, despite its prospect of success. As a result of these rulings the claimants commenced a separate action for judicial review.

It is the judgment of Jackson J, in the subsequent judicial review, ie **Wright**[105], that makes this case of particular importance to those whose remit is caring for patients in a secure environment.

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105 op. Cit

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Jackson J concluded that[106] the care given was negligent and involved positive acts as well as omissions. It was arguable that the Prison Service breached **Article 2** and **Article 3**, although the Judge stated that he did not have to decide on an actual breach, as Mr Wright had died before the Human Rights Act 1998 came into force.

Positive Duty To Investigate

In addition to Jackson J's judgment relating to the duty to provide a minimum standard of healthcare, the judge referred to **Assenov v Bulgaria**[107], which held that **Articles 2** and **Article 3** imposed an obligation to investigate, and that it should be capable of identifying and punishing those responsible.

Jordan v United Kingdom[108] was also considered and usefully listed the necessary features of an investigation that would be compliant with Article 2:

1) The investigation must be independent.
2) The investigation must be effective.
3) The investigation must be reasonably prompt.
4) There must be a sufficient element of public scrutiny.
5) The next of kin must be involved to the appropriate extent.

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106 op cit at part 6

107 *Assenov v Bulgaria* [1998] 28 E.H.R.R. 652

108 *Jordan v United Kingdom* (ECtHR, 4th May, 2001) at para.s 106-109

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Jackson J also reviewed other decisions and derived the following propositions[109]

1) Articles 2 and 3 enshrine fundamental human rights. When it is arguable that there has been a breach of either Article, the state has an obligation to procure an official investigation.
2) The obligation to procure an official investigation arises by necessary implication in Articles 2 and 3. Such investigation is required to maximise future compliance with these Articles.
3) There are no universal set of rules for the form which an effective official investigation must take. The form which the investigation takes will depend on the facts of the case and the procedures available in the particular state.
4) Where the victim has died and it is arguable that there has been a breach of Article 2, the investigation should have the general features identified by the Court in Jordan v United Kingdom.
5) The holding of an inquest may or may not satisfy the implied obligation to investigate arising under Article 2. This depends upon the facts of the case and the course of events at the inquest.

There is a fundamental legal obligation to investigate deaths in custody as is clarified in the Coroners Act 1998[110], although the specific format is not prescribed. Jackson J is very critical of the Wright inquest, which he concludes did not constitute an effective official investigation.

The case of **R.(On the Application of Amin) v Secretary of State for the Home Department**[111], further illustrates the need

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109 op cit at Part 4

110 S8(1)(c), (3)(b) & (6)

111 *R.(On the Application of Amin) v Secretary of State for the Home Department*, [2001] E.W.H.C. Admin. 719

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to carry out effective investigations. Zahid Mubarek was bludgeoned to death in his cell by a violent and racist prisoner, and the claim was made that the Secretary of State failed to hold an open and public investigation into the circumstances of the death. The High Court found that the internal inquiry by the Prison Service and the criminal trial of the assailant did not constitute an effective investigation for the purposes of the obligations under **Article 2**, fundamentally because neither established why Mr Mubarek was sharing the cell with his assailant.

The claimants were, therefore, entitled to a declaration that an independent public investigation with the family legally represented, provided with the relevant material and able to cross-examine the principal witnesses must be held, to satisfy the **Article 2** obligations.

Duty To Prevent Self Harm By Detainees

In the case of **Reeves**[112], which concerned a suicide in police custody, it was clearly found that there was a duty of care owed, as far as is practicable, to mentally competent detainees to prevent them from committing suicide. This ruling can equally be applied, in addition to professional duties of care, to detainees in any environment, particularly when there is a known risk of suicide and especially those suffering from mental disorder.

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112 *Reeves v Commander of Police of the Metropolis* [1999] 3 All ER 897

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The reason for this duty arises, as Lord Hoffman stated

> ……..from the complete control which the police or prison authorities have over the prisoner, combined with the special danger of people in prison taking their own lives.

Keenan[113] also concerned the death of a prisoner and is discussed at some length in **Wright**[114]. The prisoner was receiving anti-psychotic medication, which had been changed by a prison doctor who was unqualified in psychiatry. Following an assault on prison officers he was placed in solitary confinement, where he killed himself. This was found not to be in breach of **Article 2** as, fundamentally it was not proven that there was a causal link between the Prison Service actions and the death. However, there was a breach of **Article 3** on the grounds that it was inhuman and degrading to place a vulnerable person with mental illness in solitary confinement with no review and no appeal.

Regardless of the outcome the Prison Service has, as a result of this and other cases, highlighted the area of suicide prevention as one of great importance and has started to revise its suicide and self-harm prevention policies, together with providing training for all staff in contact with prisoners.[115]

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113 *Keenan v United Kingdom* (2001) 10 BHRC 319; Times 18 April 2001.

114 op cit

115 Safer Custody Group, “Safer Custody News”, No 4, June 2001

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The implications of the above to mental health practice are potentially quite profound. The assessment of mentally disordered offenders both within the healthcare environment and prior to admission will need to be effectively carried out. The need for effective review of any intervention, especially that of seclusion should be carried out regularly to ensure therapeutic safety.

However, whilst someone who is suicidal may attempt to kill themselves in a variety of often very inventive ways, it is the establishments' job to minimise this risk as far as is possible. It is not possible to prevent 100% of suicide attempts, even in hospitals when patients are being very closely observed, but, to avoid falling foul of Article 2 rights (which have a lower and different burden of proof to those of negligence), clear and accurate records of assessments, reviews and care planned and delivered must be kept.

Duty to protect the right to life of third parties against homicidal assaults by psychiatric patients.

This positive duty requires reasonable actions to be taken to protect life, under criminal law provisions, but also, under certain well defined circumstances, to take preventative measures to protect individuals whose lives are at risk from the criminal acts of others.

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A very significant case is that of **Paul and Audrey Edwards v The United Kingdom**[116] and concerned the killing of their son Christopher Edwards by Richard Linford in HMP Chelmsford. Christopher Edwards had been diagnosed as schizophrenic in 1991. He was arrested on 27th November, 1994 having been approaching young women in the street and making inappropriate suggestions. The bizarre behaviour before arrest, continued at Colchester police station and in Colchester magistrate's Court.

The family met with the duty solicitor and explained that their son was mentally unwell and that they wanted their son to receive medical treatment and not to be remanded in custody. The Court considered remand to hospital, but concluded that they had no power to do so. No consideration was given to any of the civil provisions (sections, 2, 3 or 4 of the MHA 1983) or to section 35, which provided for remand to a hospital for assessment. Christopher Edwards was remanded in custody for three days and transferred to HMP Colchester, where he was initially in a cell on his own and, subsequently, placed in a cell (D1-6) with Richard Linford.

Richard Linford had been arrested for assaulting a friend and her neighbour. He had a history of violent outbursts and

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116 *Paul and Audrey Edwards v The United Kingdom,* (2002) App. No. 46477/99, Judgment of ECtHR, 14 March, 2002. <http://www.echr.coe.int/Eng/Judgments.htm>

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assaults, including a previous assault on a cell mate. He had a diagnosis of schizophrenia.

At 2100 hrs on 28th November, 1994 a prison officer became aware that the call buzzer linked to cell D1-6 was not working properly, but did not report the fault. Shortly before 0100 hrs the prison officer responsible for D landing heard a buzzer, but did not locate the source. Sometime later he heard continuous banging on the door of D1-6. Officers entered the cell to find that Christopher Edwards had been kicked and stamped to death. Richard Linford was making continual reference to being possessed by evil spirits and devils. D Landing had been previously patrolled at 0043 hrs, meaning that up to seventeen minutes could have elapsed from the pressing of the cell call button.

Linford was subsequently convicted of manslaughter on the grounds of diminished responsibility and was detained in Rampton Special Hospital under Sections 37 and 41 of the Mental Health Act 1983.

The Coroner's inquest was closed following the conviction and a private, non-statutory inquiry was commissioned in 1995 and reported in 1998. The applicants were advised that there were no civil remedies available to them in the light of the inquiry findings. The Crown Prosecution Service maintained that there was insufficient evidence to proceed with a criminal prosecution. As a

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result of these decisions, the family lodged an application with the European Court of Human Rights, alleging that the authorities failed to protect the life of their son, under Articles 2, 6, 8 and 13 of the Convention.

The Court was satisfied that there was a series of shortcomings together with numerous failings in the management of both Christopher Edwards and Robert Linford. The primary aspect was the brief cursory way in which the admissions and medical screenings were carried out.

Given the information that should have been available to the Prison Service, but that was not communicated to them effectively and the inadequate nature of the screening process, the Court held that this was a breach of the State's obligation to protect the life of Christopher Edwards and therefore violated **Article 2**. Additionally, it was found that there was a failure to carry out an effective investigation, under **Article 2** together with a breach of **Article 13** in failing to provide an effective remedy (Article 13 was not incorporated into the HRA).

Osman[117] is another leading case in this area and concerns claims that the police failed to take adequate steps, despite a number of clear warnings, when a teacher became infatuated with a student. He persisted, over a considerable period of time, in

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117 *Osman v UK* (1998) 29 E.H.R.R. 245; (1999) 1 F.L.R. 193; [1999] E.H.R.L.R. 228

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harassment and vandalism and even changed his name to that of the student. Finally he wounded the student and killed the student's father.

Although in **Osman** the Court found that, on the facts, there was no breach of **Article 2**, a number of important principles are described, as summarised below[118]:

a-There is an obligation on the state beyond that of just putting in place criminal law provisions.

b-There is an obligation, in certain well-defined circumstances, to take preventative measures to protect an individual who is at risk from another.

c-The obligation must be interpreted in such away that does not impose a disproportionate or impossible burden on the authorities, given a wide variety of other demands placed on them.

d-It must be interpreted in a way that fully respects due process.

e-What must be shown, is a failure to take reasonable measures to avoid "a real and immediate" risk to life.

The significance of the preceding to those caring for mentally disordered offenders is potentially quite profound. This is perhaps more so with regard to private organisations than NHS, as private hospitals generally have the benefit of choosing which patients they do, or do not, admit. Given that hospital wards often contain a disparate range of patients, the need for effective, objective and clear communication of the history and risks associated with each

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118 See Starmer "European Human Rights Law" , 1999, Legal Action Group, London. Para.14.10

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patient is paramount. The need to take effective measures to protect the patients' right to life is not optional, but a fundamental necessity.

Risk Of Death from Psychiatric Treatment

Wilkinson[119] is a significant Court of Appeal judicial review case that raises questions of the lawfulness of treatment under the Mental Health Act 1983. The treatment was not necessary to prevent the death of the patient and was administered without the patient's consent, following procedures under **Section 58** of the Mental Health Act 1983. The claim was, amongst others under **Articles 3** and **8**, that injecting the patient with anti-psychotic medication whilst he was struggling posed a threat to his life, and therefore suggested a potential breach of **Article 2**. The existence of a) the capability of consenting or refusing consent to treatment and b) the therapeutic necessity of forcible administration of medication is of prime importance here in considering the outcome. A breach is not inconceivable.

The right to life is fundamental. Firstly there is the negative aspect that the State or its agents must not take action to threaten the right to life. Secondly, there is the positive duty conferred on

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119 *R. (on the Application of Wilkinson) v Responsible Medical Officer Broadmoor Hospital, The Mental Health Act Commission Second Opinion Appointed Doctor, and the Secretary of State for Health*, [2001] E.W.C.A. Civ. 1545; [2002] 1 W.L.R. 419; [2002] M.L.R. p.p. 218-223.

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public authorities, including private healthcare organisations (since the **Partnerships in Care** [120]case). Private healthcare organisations that accept patients that are detained under statutory powers assume the duties of the State in relation to the exercising of those powers. These functions are of a public nature and the are therefore liable to claims under this area.

Managers of private healthcare organisations should be aware of the nature of the areas of challenge that have been made under **Article 2** of the Convention, namely:

-Duty to provide minimum standard of healthcare

-Positive duty to investigate

-Risk of death from treatment

-Duty to prevent self harm by detainees

-Duty to protect third parties against homicidal assaults by psychiatric patients.

The managers need to ensure that best practices are followed in the assessment prior to admission, the decision to admit and subsequent care planning and treatment of their patients in order to not violate the fundamental rights under **Article 2**.

120 Op cit

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Article 3: Prohibition of Torture

Article 3 of the Convention states:

> No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

It can be applied to conditions of detention, however the threshold for these conditions is set at a high level[121]. For private healthcare organisations to be guilty of a breach, conditions need to reach a minimum level of severity of physical damage or minimum recognised level of psychological damage thus:

1)*Torture*.
Deliberate inhuman treatment causing very serious and cruel suffering.

2)*Inhuman treatment/punishment*.
Treatment/punishment that causes intense physical and mental suffering.

3)*Degrading treatment/punishment*.
Treatment/punishment that arouses in a victim a feeling of fear, anguish and inferiority capable of humiliating and debasing the victim and possibly breaking his or her physical or moral resistance.[122]

In one of the earlier cases brought specifically in the field of mental health, **A v UK**[123], a Broadmoor patient was detained in seclusion for 5 weeks and claimed that he had inadequate opportunity for association or exercise, together with being kept in humiliating conditions, amongst others. Whilst the claim was

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121 *Ireland v UK* , (1979) 2 EHRR 25, concerning the detention of IRA prisoners.

122 Op cit

123 *A v UK*, Appl 6840/74 Commission (16 July 1980)

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declared admissible, no outright breach was established. It is felt that the limits of the rights were tested to their utmost in this situation and an amicable settlement was achieved following a visit of the European Commission to Broadmoor; the latter then changing their policies and procedures.

It is worth reiterating the comments made previously in that the Convention being a living instrument, and remembering that acts deemed acceptable previously may not be acceptable presently or in the future.

Two particular cases, **Selmouni v France**[124] and **Aksoy v Turkey**[125]**,** (in addition to **Assenov**[126], as discussed under Article 2) are important in that, although they relate to police custody, they develop principles that are applicable to anyone detained, or carrying out the detention as a public authority. The Court in **Aksoy** stated

> Where an individual is taken into police custody in good health but is found to be injured at the time of release, it is incumbent on the State to provide a plausible explanation as to the causing of the injury, failing which a clear issue arises under Article 3 of the Convention.

Selmouni concerned a Moroccan/Netherlands national who was arrested in Paris, in November 1991, on suspicion of drug trafficking (for which he was subsequently convicted). During his

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124 *Selmouni v France*, ECtHR Application no. 25803/94, Judgement 28 July, 1999.

125 *Aksoy v Turkey*, (1997) 23 E.H.R.R. 553

126 *Assenov v Bulgaria* [1999] E.H.R.L.R. 225

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detention in the police cells he received a number of injuries as the result of ill treatment by the police concerned. As his uninterrupted detention continued, so did the extent of his injuries, as was supported by unequivocal medical findings (there are at least thirty separately identifiable wounds referred to[127]) and these were consistent with the statements given by Mr Selmouni regarding his ill treatment. There were convictions of four policemen related to these assaults.

In its judgement[128], the Court discusses the differences between "torture" and "inhuman and degrading treatment", refers to **The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,** Article 1 of which states

> "1. For the purposes of this Convention, the term 'torture' means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. …"

and Article 16

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127 *Selmouni v France,* ECtHR Application no. 25803/94, Judgement 28 July, 1999. At para. 20

128 ibid at para. 97

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> "1. Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in Article 1, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. In particular, the obligations contained in Articles 10, 11, 12 and 13 shall apply with the substitution for references to torture of references to other forms of cruel, inhuman or degrading treatment or punishment."

In this case the Court finds that the treatment received by Mr Selmouni was, apart from the violent nature of the acts, "heinous and humiliating for anyone". It found that the conduct must be regarded as "acts of torture" under **Article 3**, which was therefore violated.

Conditions Of Detention

In **Aerts v Belgium**[129] a prisoner was detained for an extended period in the psychiatric wing of a Belgian prison, awaiting suitable hospital placement. Aerts claimed that the conditions were inhuman and degrading. Whilst the Court noted that the Committee for the Prevention of Torture had inspected the wing and found the standards to be below that which was acceptable ethically or from a humanitarian viewpoint, there was no breach of **Article 3** (there were however breaches of **Articles 5** and **6**, as will be discussed in the appropriate sections).

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129 Judgement of The European Court of Human Rights, 30th July 1998; & [1998] EHRLR 777

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Could medical treatment ever be inhuman or degrading?

Again, in the case of **Herczegfalvy**[130], where a patient was handcuffed to a bed, no infringement was found. The judgement was based on the question of whether the actions taken conformed to the "psychiatric principles generally accepted at the time." The central issue was that of therapeutic necessity and the Court said that it "must….satisfy itself that the medical necessity has been convincingly shown to exist".[131]

The Court held that medical treatment could, in principle, reach a level of severity to amount to "inhuman and degrading treatment" and said

> ……the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible, such patients nevertheless remain under the protection of Article 3, the requirements of which permit no derogation.[132]

In this case the Court further commented that the evidence before the Court was not sufficient to disprove the Government's

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130 *Herczegfalvy v Austria,* (1992) 18 B.M.L.R. 48; (1993) 15 E.H.R.R. 437.

131 Ibid. at para.82

132 Ibid. at para.82 & 83

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argument that medical necessity justified the treatment in issue, together with it being in line with the psychiatric principles generally accepted at that time.

There is currently little, if any, use of mechanical restraint (e.g. handcuffs, straight jackets, straps etc) within mental health practice in the United Kingdom. However, seclusion, isolation of patients from the general ward population and physical/manual restraint, together with pharmacological sedation is widespread. Another generally accepted practice is that of "specialling" a patient, whereby they are constantly observed by staff. Although none of these are directly regulated by specific legislation, their usage is covered by The Mental Health Act Code of Practice[133].

In **R (on the Application of M) v Secretary of Sate For Health**[134], the claim was that Ashworth Special Hospital's policy of periodically reviewing M's, as with all patients', detention in seclusion was insufficient and constituted a breach of **Article 3** of the ECHR. The Secretary of State contended that, where good reasons were given, it was acceptable to depart from the Code of Practice. In this case the reasons offered in defence were that due to extreme behavioural problems presented by patients within the

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133 Mental Health Act 1983 Code of Practice (Revised) , (1999), HMSO, London. See particularly Section 19.1-19.23

134 [2002] All ER (D) 107

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Special Hospital, then there was no benefit to the patients from having more frequent reviews.

The Court considered the central issue of whether any seclusion policy had to comply exactly to the Code of Practice in order to be valid. The Court held that although the Mental Health Act 1983 placed a Statutory requirement on the Secretary of State to publish a Code of Practice, and those acting under the Act were obliged to pay due regard to it, that was the extent of their obligation, as The Code was no more than guidance, despite previous reports from The Mental Health Act Commission to the contrary. The Court stated that it would only wish to overturn any reasons given for departure from the Code of Practice if those reasons were so unreasonable as to be perverse. In this case, the reasons were not perverse and the treatment could not be said to amount to inhuman or degrading treatment, so did not breach The Human Rights Act.

In relation to private healthcare providers, the significance of this case is that if departures are made from the Code of Practice, then they must be clear and reasonable. The decision to deviate from guidance should be made objectively on an individual basis, with the rationale being well documented, as the particular facts of any case could well produce a different outcome, if considered in Court.

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In other countries throughout Europe and the rest of the world mechanical restraint is widely used. It can be seen that what might be deemed as inhumane or degrading in one country may be the norm elsewhere. However, it should be remembered that this is an absolute right which cannot be derogated.

Side Effects Of Medication

It has been claimed that unpleasant side effects from medication can constitute a breach of this right. The leading case regarding this is **Grare v France**[135] where the Commission rejected this argument on the basis that the side effects were not serious enough. It is felt that as long as treatment, in its broadest sense[136], whether it be drugs or other therapeutic forms, is in keeping with current medical opinion and practice, together with being in line with the provisions of the other areas of the Convention, then claims for this are likely to be unsuccessful.

Allocation Of Resources

Paradoxically, there may be a situation whereby those in private healthcare institutions may be at an advantage over those in public facilities, where the private organisation may have access to more expensive drugs and other therapies, often with lesser side effects or more efficacy, and not widely available in the public

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135 *Grare v France* (1993) 15 EHRR CD 100

136 A leading case on the definition of 'medical treatment' comes from the Court of Appeal and concerns the treatment of an anorexic patient, viz. *B v Croydon Health Authority* [1995] All ER 683

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sector. This could potentially lead to claims regarding the equity of the services provided, possibly under **Article 14** (Prohibition of discrimination). It should be noted that the Courts, of all levels, have traditionally been very reluctant to interfere with clinical judgements. As Sir Thomas Bingham MR said in **R v. Cambridgeshire Health Authority, ex Parte B**[137],

> I have no doubt that in a perfect world any treatment which a patient, or a patient's family, sought would be provided, if a doctor were willing to give it, no matter how much it cost.........Difficult and agonising judgements have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients........This is not a judgement which the Court can make.

Further analysis of this area is included in the comments of Sullivan J in **R (on the application of "F") v. Oxfordshire Mental Healthcare NHS Trust and Oxfordshire NHS Health Authority**[138], which dealt with the issue of the allocation of resources and the question of the placement of a psychiatric patient. This involved disagreement over whether the patient should be transferred to what is technically her home area, or be funded by the "home" health authority for an extra-contractual referral to a facility nearer to where her family now live; the cost of the latter option being some £100,000 per year[139].

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137 [1995] 1 WLR 898

138 [2001] EWHC Admin 535

139 This figure is in keeping with the costs of the majority of private providers and many "specialist" NHS establishments. In common with most areas, these costs have risen since the case was heard.

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Non-Provision Of Treatment

Another important aspect considered on a number of occasions by the European Commission and Court of Human Rights is that of the non-provision or withdrawal of treatment. **Hurtado v Switzerland** [140]was a case where a detained suspect with a fractured rib was not x-rayed for 6 days, but a leading case is that of **Tanko v Finland**[141], concerning a Ghanaian who was seeking asylum in Finland and was diagnosed with glaucoma, but in the interim was subject to an expulsion / deportation order. He claimed that returning to Ghana would, due to poor facilities, cause him to lose his sight, and therefore infringe his **Article 3** rights, as well as those under **Articles 8** and **14**. No breach of **Article 3** was found, but the Commission commented

> A mere possibility of ill treatment is not in itself sufficient to give rise to a breach............The commission does not exclude that a lack of proper care in a case where someone is suffering from a serious illness could in certain circumstances amount to treatment contrary to Article 3.

In contrast to this, in **D v UK**[142], a terminally ill man appealed against extradition to St Kitts and this was upheld as a breach of **Article 3.**

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140 A/280-A (1994)

141 Application No 23634/94

142 (1997) 24 EHRR 423

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Keenan, together with **Wright**, as discussed previously, clearly establish the duty for those caring for people detained in the name of the State to provide adequate medical and psychiatric treatment.

Managers of private healthcare organisations are, in common with NHS facilities, as has been described previously, liable to claims against them under the Human Rights Act 1998. In considering how not to violate **Article 3** rights, they need to examine:

-The physical conditions of detention.

-Whether the treatment proposed, or given, is of therapeutic necessity.

-Potential side effects of treatment against therapeutic benefit.

-Whether physical restraint or seclusion is therapeutically necessary, or whether alternative interventions are more therapeutically beneficial.

-Whether any actions taken are clinically in the patients' best interests, or whether they are they for ease of management from a staffing perspective.

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Article 4: Prohibition of Slavery and Forced Labour

Article 4 of the Convention states:

(1) No one shall be held in slavery or servitude.

(2) No one shall be required to perform forced or compulsory labour.

(3) For the purpose of this Article the term 'forced or compulsory labour' shall not include:
(a) any work required to be done in the ordinary course of detention imposed according to the provisions of Article 5 of this Convention or during conditional release from such detention;
(b) any service of a military character or, in the case of conscientious objectors in countries where they are recognised, service exacted instead of compulsory military service;
(c) any service exacted in case of an emergency or calamity threatening the life or well-being of the community;
(d) any work or service which forms part of normal civic obligations.

Article 4(1) is absolute, whilst **4(2)** is derogable. As discussed in **Van der Mussele v Belgium**[143], "slavery" and "servitude" are principally related to a person's condition or status, whereas forced or compulsory labour is a broader concept related to dues paid as punishment.

It is generally accepted that those within the mental health system, including mentally disordered offenders, within the UK, are not subject to penal or punitive elements. However, some patients may individually state that what they perceive as enforced

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143 (1984) 6 EHRR 163

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attendance at therapeutic or vocational sessions is a form of slavery. As long as the provisions relating to lawful detention are complied with and the work carried out forms part of an agreed therapeutic program or treatment[144], then it is unlikely that a breach of **Article 4** will be found.

The applicability to mentally disordered offenders is that of potential exploitation in the name of therapeutic intervention, where no clear rehabilitation, clinical or therapeutic goals are stated for the patient, together with another person benefits substantially as a result of that patient's efforts and the patient is not paid.

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144 See, for example, the discussions *in De Wilde, Ooms and Versyp v Belgium*, (1979-1980) 1 E.H.R.R. 373.

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Article 5: Right to Liberty and Security

The authority to detain a person under the Mental Health Act 1983 is derived from **Article 5** of the Convention which states:

> (1) Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
>
> (a) the lawful detention of a person after conviction by a competent Court;
> (b) ….
> (c) ….
> (d) ….
> (e) the lawful detention of persons for the prevention of spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;
> (f) ….
>
> (2) Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him.
>
> (3) Everyone arrested or detained in accordance with the provisions of paragraph 1(c) of this Article shall be brought promptly before a judge or other officer authorised by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release pending trial. Release may be conditioned by guarantees to appear for trial.
>
> (4) Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a Court and his release ordered if the detention is not lawful.
>
> (5) Everyone who has been the victim of arrest or detention in contravention of the provisions of this Article shall have an enforceable right to compensation.

This is perhaps the area of the ECHR that has had the most attention in relation to the field of mental illness, particularly

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within the United Kingdom. It is the only article that specifically mentions "persons of unsound mind", which is taken to mean mental disorder, and it is under **Article 5(1)(e)** that detention on account of unsoundness of mind is allowed. However, the ECtHR has so far declined to give an absolute definition of what this constitutes.

The case of **Winterwerp**[145] examined the issues in some depth and led to what have been widely called "The Winterwerp Criteria" and lay down three basic requirements of detention under **Article 5(1)(e)**, namely:

1) The medical disorder relied upon to justify detention must be established by objective medical expertise;
2) The nature or degree of the disorder must be sufficiently extreme to justify detention; and
3) The detention should last only as long as the medical disorder (and its required severity) persist.

The case noted that 'unsound mind' could not be taken as simply as a person holding differing views from that of the society in which he or she lived. There was a need for objective and reliable medical evidence that a psychiatric illness was present and that it was of a nature and degree warranting compulsory detention. The disorder had to be of such persistence to justify continued detention.

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145 *Winterwerp v The Netherlands*, (1979) 2 EHRR 387

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The reasoning it gave for not defining 'persons of unsound mind' was that its "meaning was continually being evolved by advances in medical understanding and treatment and by changes in societal attitudes".

Article 5(2) is directly related to provision of information regarding detention. This is covered in **Section 132** of the Mental Health Act 1983, as described in chapter 2 of this dissertation.

Article 5(3) and **Article 5(4)** give the right of review of detention, and this is especially important in the light of the need for the presence of persistence of the disorder to allow detention. Prior to the Mental Health Act 1983, the legislation[146] did not include these rights, but the existing legislation (ie MHA 1983) was drafted to include them. The proposed Mental Health Bill[147] develops this further. Despite this, there have been, and continue to be, claims and subsequent amendments to the statutes and procedures as a result of decisions and other developments, as will be discussed.

Article 5(1) clearly states that detention must be in accordance with the law. Most of the different routes by which a mentally disordered offender can become a detained patient, with

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146 Mental Health Act 1959

147 Cmnd 5538

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the exception of **Section 136** of the MHA, together with the Home Secretary's power of recall of a restricted patient, require medical recommendations. As such they are unlikely to breach **Article 5** rights.

There are restrictions[148] on the provision of medical recommendations by certain categories of doctor in private practice.

K v United Kingdom[149] was a case where the Home Secretary recalled a patient on the basis of a report from a probation officer, but failed to obtain up to date medical reports, thus leading to breaches of both **Articles 5(1)** and **5(4)**.

X v United Kingdom[150] concerned a patient from Broadmoor Hospital who had been on conditional leave for 3 years. He was recalled to hospital and claimed that this was unjustified, together with not being told promptly of the reasons for his recall, in addition to not having any effective way of challenging the decision. In this situation there was found to be a breach of **Article 5(4)**, but not **Article 5(1)**.

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148 Mental Health Act 1983, s.(12)(3-5); Mental Health Act 1983 Code of Practice (Revised) (1999) s.4

149 Application 17821/91, Decision of the Committee of Ministers, 20-21 September, 1994.

150 (1982) 4 EHRR 188

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Another case, that of **van der Leer v The Netherlands**[151], is one where a breach of **Article 5(1)(e)** was found due to the Court that ordered the patient's detention not having consulted either a doctor or the patient himself.

Aerts v Belgium[152], as discussed under **Article 3**, involved the prolonged detention of a patient in the hospital wing of a prison. There was, according to the Court, a breach of **Article 5(1)** as he had not been convicted and detention could not be justified under **Article 5(1)(a)**. The only other justification possible was that under **Article 5(1)(e)**, but this would only be valid if the patient was in a hospital, clinic or other appropriate institution: the prison was not deemed appropriate and there was therefore a breach.

Johnson v United Kingdom[153] involved complaints of breaches of both **Article 5(1)** and **Article 5(4)**. Johnson was a patient of Rampton Hospital and detained under **Sections 37** and **41** of The Mental Health Act 1983. Three successive Mental Health review Tribunals (MHRTs) spanning three years (1989-91) had found that he was not suffering from mental disorder that warranted his detention in a Special Hospital, and conditionally discharged him. This discharge was deferred pending the making of suitable arrangements for him. The applicant's history, together

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151 (1990) 12 E.H.R.R. 567

152 [1998] E.H.L.R. 777

153 (1997) 27 E.H.R.L.R., 1 105-108

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with his reported unfavourable attitude whilst visiting potential accommodation (including the assault of staff at one unit) led to his continuing detention at Rampton. He was then unconditionally discharged in 1993.

The Court held that there was a breach of **Article 5(1)(e)**, despite acknowledging the margin of appreciation afforded to national authorities and Mr Johnson's less than favourable attitude.

For the purposes of detention under The Mental Health Act 1983, the 'Court' referred to in **Article 5(4)** of the ECHR is either the Mental Health Act Managers Meeting (MHA Managers) or the Mental Health Review Tribunal (MHRT).

In relation to private healthcare organisations, it is the Mental Health Act 1983 requirement[154] that the Responsible Medical Officer (RMO) furnishes the MHRT or MHA managers with reports, that brings in the third "Winterwerp Criteria".

If reports are not provided as required, then the continued detention of the patient would not be lawful in accordance with either national law or the Convention. Similarly, if MHA managers do not hear claims "speedily", then the private healthcare organisation could be the subject of a claim for damages.

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154 s.20

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In **R (on the Application of KB and others) v Mental Health Review Tribunal and another**[155] claims were made for compensation under **Article 5(5)** for delays under **Article 5(4)**. The claimants were patients detained under The Mental Health Act 1983 and had made applications to the MHRT for the review of their respective detentions. There were delays in the hearing of their appeals and it was subsequently found[156] that this breached their rights under **Article 5(4)**. Subsequently, a claim was made for due compensation.

In the judgement[157], Stanley Burnton J analysed in some depth the various authorities for awarding damages, and declared that damages were payable for the delays experienced by the claimants. It should be noted that the ECtHR has recently awarded damages where the only claim related to frustration and distress.[158] Stanley Burnton J concluded[159] that a substantial award of damages was necessary, bearing in mind what amounted to unlawful detention and the length of delay before an effective hearing. Accordingly damages awarded of between £750 and £4000 were awarded.

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155 [2003] E.W.H.C. 193, [2003] All E.R. (D) 168 (Feb)

156 *R. (On the application of KB and others) v Mental Health Review Tribunal*, [2002] E.W.H.C. 639 (Admin)

157 *R. (On the application of KB and others) v Mental Health Review Tribunal* [2003] E.W.H.C. 193, [2003] All E.R. (D) 168 (Feb)

158 ibid. at para. 37

159 ibid. at para. 122

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As suggested in **Johnson** as in others, such as **R. (on the Application of Barry) v Gloucestershire County Council**[160], patients who are found not to be suffering from mental disorder of a nature or degree warranting compulsory detention, often find themselves held in hospitals due to the lack of community care or other provisions, usually on the basis of lack of resources to fund such care. This argument could well fall foul of **Article 5** rights, as a failure to provide care means that a person will be detained when they would otherwise not need to be.

Looking at **Article 5(4)**, the MHA Managers and MHRT do not have to have the full powers allocated by **Article 6**. They must, however, as discussed in **X v United Kingdom**[161], be able to make sufficient enquiries and decisions as to the review of the detention of the patient. There is a requirement that detention is reviewed 'speedily' , and it is on these grounds that the MHRTs have been found to be lacking.

R (on the Application of C) v Mental Health Tribunal London and South West Region[162] was one of the first cases to be heard regarding speed of access, with the Court of Appeal subsequently finding that the routine scheduling of MHRTs, by way

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160 [1997] 2 WLR 459

161 (1981) 4 EHRR 188, 1 BMLR 98

162 [2001] E.W.C.A. Civ. 1110

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of administrative convenience, for eight weeks after application was in breach of **Article 5(4)**. It did qualify this by saying that the complexity of some cases may require eight weeks to prepare, but this should not be the norm. It is likely that the MHRTs will find themselves, despite their best efforts, to be in breach on many more occasions, as the resource constraints and pressures on finding appropriate personnel, not to mention the backlog of cases, lead to extended delays.

A final and very important case is **R (on the Application of H) v Mental Health Review Tribunal**[163] which was heard in the Court of Appeal in March 2001 and established that under exceptional circumstances hospitals can seek a stay of MHRT decisions. The applicant was detained in Broadmoor Hospital under **Sections 37** and **41** of the Mental Health Act 1983 in 1988, following conviction for manslaughter. In March 2000 the MHRT decided that he was not liable to discharge as he was still experiencing auditory hallucinations and as, if discharged, he would stop taking his medication. The decision was made on the basis of **Section 72** and **Section 73** of the MHA, and stated that it "was clear that this patient needs to be detained in hospital for treatment for his own health and safety".

The applicant applied for judicial review of the MHRT decision, which was denied by the High Court in September 2000.

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163 [2001] EWCA Civ 415

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He then, in December 2000, obtained leave to appeal. The main question for the Court of Appeal was whether **Section 73** of the MHA 1983 was, or otherwise, compatible with the ECHR.

Fundamentally, **Sections 72** and **73** of the MHA put the burden of proof onto a person to prove to the MHRT that they are not suffering from a mental disorder of a nature and degree that warrants detention, rather than the MHRT proving that they do have a mental disorder. As the MHA does not require the MHRT to discharge the patient if the absence of mental disorder is not shown, then this negative burden of proof was found to be incompatible with **Articles 5(1)** and **5(4)**.

The Courts are unable to alter legislation when they find incompatibility, only being able to issue a Declaration of Incompatibility[164], with it being up to Parliament to amend the Statutes accordingly to make them compliant. The MHA 1983 was amended[165]. The Draft Mental Health Bill seeks to address it further[166], however it has been stated in the report of the Joint Committee [167] that the wording of the Bill does not remove the ambiguity and that it should be reworded.

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164 As described on page 23 of this dissertation

165 Mental Health Act 1983 (Remedial) Order 2001, SI 2001 no. 3712

166 Cm. 5538-I, Clause 29

167 op cit at para 59

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The primary implications for the managers of private healthcare institutions are to consider

-that on receiving a patient that the documentation is checked thoroughly to ensure that the detention is in accordance with the law.

-That the patient is informed promptly of his rights under Section 132 of the Mental Health Act.

-That the rules regarding medical recommendations by doctors in private practice are strictly adhered to.

-That recommendations for renewal of detention are produced in good time.

-That reports include objective evidence of mental disorder, if the detention is to be renewed.

-That hearings, especially by Mental Health Act managers are scheduled and occur promptly.

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Article 6: Right to a Fair Trial

Article 6 of the Convention states:

(1) In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. Judgement shall be pronounced publicly but the press and public may be excluded from all or part of the trial in the interest of morals, public order or national security in a democratic society, where the interests of juveniles or the protection of the private lives of the parties so require, or to the extent strictly necessary in the opinion of the Court in special circumstances where publicity would prejudice the interests of justice.

(2) Everyone charged with a criminal offence shall be presumed innocent until proved guilty according to law.

(3) Everyone charged with a criminal offence has the following minimum rights:

(a) to be informed promptly, in a language he understands and in detail, of the nature and cause of the accusation against him;
(b) to have adequate time and facilities for the preparation of his defence;
(c) to defend himself in person or through legal assistance of his own choosing or, if he has not sufficient means to pay for legal assistance, to be given it free when the interests of justice so require;
(d) to examine or have examined witnesses against him and to obtain the attendance and examination of witnesses on his behalf under the same conditions as witnesses against him;
(e) to have the free assistance of an interpreter if he cannot understand or speak the language used in Court.

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In **Aerts v Belgium**[168], it was held that there was a violation due to the prevention of Aerts from making an application to the legal aid board with a view to appealing against his detention on points of law. This, according to the judgement, "impaired the very essence of the applicant's right to a tribunal".

In **Winterwerp v Belgium**[169], a violation again occurred, but this was due to the Dutch law automatically assuming that a detention on the grounds of mental illness automatically removed a patient's capacity to administer his own affairs.

More recently there have been a number of issues raised in relation to the operation and methodology applied in Mental Health Review Tribunals. The European Convention raises some problems regarding the definition of "civil rights and obligations" in the context of non-criminal cases, of which Mental Health Review Tribunals form part. The problem relates to the differences between public and private law, which are subject to different boundaries and different interpretations in different countries.

For the purposes of the mentally disordered offender within the UK, the issues primarily surround those of the function and operation and functions of Mental Health Review Tribunals and Mental Health Act Managers Meetings, as described in the

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168 Op cit

169 Op Cit

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previous chapter. Bodies fulfilling Court-like functions (Under **Article 5**), such as these, do not have to have the full powers of **Article 6**, but must be analogous. In other words, the means must exist elsewhere to challenge their decisions in law, e.g. judicial review.

Issues that have been raised are

1) the nature of the original detention of patients, especially when using 'civil' sections of the Mental Health Act[170], such as **Section 3**, whereby detention is initially solely in the control of social workers and doctors, and not by a Court-like body[171]. It is unlikely that initial detentions under Court applied sections[172] would fall foul of this, as the medical opinions/reports are usually considered in open Court and open for challenge.
2) those of the length of time taken for appeals against detention to be heard (as also discussed under **Article 5**)
3) the role of the "medical member" of Mental Health Review Tribunals, where he/she is considered as judge and jury. They are also technically not open for questioning by the patient or his/her representatives, although, on a practical note, this is sometimes allowed dependent on who the medical member is together with who the President of the

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170 Mental Health Act 1983 Part II

171 These issues are being proposed to be rectified in new legislation, as suggested in the White Paper and Draft Mental Health Bill.

172 Mental Health Act 1983 Part III

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Tribunal is. Again, changes are proposed within the draft Bill[173].

4) The role of The Mental Health Act Managers is particularly of importance to the private sector, primarily due to potential questionable impartiality, as discussed in the previous chapter. The role of this body is also subject to review under the Draft Mental Health Bill.

Turning to the Draft Bill, it is proposed that there will be a new Mental Health Tribunal (MHT) and a Mental Health Appeal Tribunal (MHAT) [174] to hear appeals against MHT decisions. Both would be advised by an independent expert drawn from a newly established Expert Panel. This is proposed in order to remove the need for the medical member of the panel (as is possible currently, under the MHA 1983) to be both 'judge and jury', thus strengthening the impartiality.

Part III of the Draft Bill relates specifically to those patients who are involved in the criminal justice system. As previously, it is proposed that special restrictions may be imposed on the patient, if necessary[175]. However, there is a significant difference in that the MHT would be obliged to discharge the mental health detention order if it was not satisfied that the conditions for making the order

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173 op cit

174 Cm. 5538-I, clauses 3 & 4

175 op cit Clauses 84 & 85

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were still being met. Unlike presently, if the order was discharged, then any restriction would cease to be valid, and therefore remove the Secretary of State's power to over-rule or delay discharge.

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Article 7: No Punishment Without Law

Article 7 of the Convention states:

> (1) No one shall be held guilty of a criminal offence on account of any act or omission which did not constitute a criminal offence under national or international law at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the offence was committed.
>
> (2) This Article shall not prejudice the trial and punishment of any person for any act or omission which, at the time when it was committed, was criminal according to the general principles of law recognised by civilised nations

There do not appear to have been any cases brought by mentally disordered offenders under the above. However, despite the fact that diversion of the mentally disordered from imprisonment is generally viewed as non-retributive, but based on values of treatment together with possibly a preventative element, some offenders might claim that their prolonged detention under the Mental Health Act far exceeds the sentence that they would have been likely to serve in prison. Their perception is that this is excess punishment, particularly in the case of those detained under **Section 37/41** of The MHA, where there is often an indefinite period of detention (although subject to periodic review).

However, assuming that the detention was authorised in accordance with the methods prescribed by law, then breaches are unlikely to be found. Claims under **Article 5**, as discussed

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previously, are more likely to be applicable.

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Article 8: Right to Respect for Private and Family Life

Article 8 of the Convention covers a number of different aspects such as respect for correspondence (including mail and telephone); confidentiality and sanctity of the person and states:

> (1) Everyone has the right to respect for his private and family life, his home and his correspondence.

These rights cannot be interfered with except in accordance with the following:

> (2) There shall be no interference by a public authority with the exercise of this right except as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the protection of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

The issues raised in claims or potential claims under the above are those that are often viewed as day to day activities that are curtailed or denied to mentally disordered offenders. It should be stressed that **Article 8(2)** allows the rights to be limited, for the reasons stated above.

Areas such as interference with correspondence are allowed as a result of **Section 134** of the Mental Health Act 1983 and the

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Code of Practice[176]. The monitoring of telephone calls as a routine practice (except in Special Hospitals where there are separate rules governed by Statutory Instrument; these rules having been found to be allowable[177] on the basis of proportionality) cannot be justified.

However, in circumstances where there are clear and definable risks in other establishments with individually identified patients, monitoring could be justified under a duty of care towards either the patient or the recipient of the call, or to prevent a breach of the law, notwithstanding that calls (as with correspondence) to legal representatives etc should not be monitored or otherwise interfered with. It is important in these circumstances to ensure that adequate agreed multi-disciplinary care plans are in place, clearly stating the rationale for the action.

Personal autonomy is, by definition, severely curtailed by involuntary hospital admission. Areas such as those of the administration of medication and consent to treatment, together with supervised visits from friends and families and leave outside the hospital often cause conflict between patients and staff. However, whilst patients may not like these restrictions, as long as the procedures are prescribed in law and that they are

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176 Department of Health and Welsh Office, 1999, Code of Practice: Mental Health Act 1983, London: The Stationery Office, para. 22.14-22.15; Further detail / clarification is given in Department of Health and Welsh Office, 1998, Mental Health act 1998: Memorandum on Parts I to VI, VII and X , The Stationery Office, London. para. 303-305.

177 *R. (on application of N) v Ashworth Special Hospital Authority* [2001] HRLR 46

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proportionate to the risks involved, then they would probably not infringe **Article 8** rights.

The right to privacy and sexual expression can be limited in the interests of mental and physical wellbeing of the patient and others, even when both parties can be deemed mentally capable. Where capacity does not exist, particularly with those defined as severely mentally impaired (who are de facto 'incapable') then consent is not possible and offences may well be committed if sexual activity is allowed. The case of **Mellor**[178] raised the issue in regards of a prisoner serving a life sentence, who wished to have a child with his partner by artificial insemination, but the prevention of this was declared not in breach of **Article 8**. There do not appear to have been any specific mental health cases brought to date.

Issues of confidentiality are very important in this area and the Courts have been quite firm in their interpretation of this[179]. Any divulging of information outside the circle of professionals who need to know and without specific consent are likely to be in breach of the domestic data protection legislation (which have been amendments to prior legislation in order to take European Court findings into account), in addition to many professional codes of conduct. As such they are unlikely to be raised as breaches of **Article 8**.

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178 *R. (On the Application of Mellor) v Secretary of State for the Home Department* [2001] H.R.L.R. 38

179 See, for example *Z v Finland* and *MS v Sweden*

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The case of **Wilkinson**[180], (as discussed previously under **Article 2** issues), was one where medication, via injection, was administered immediately a certificate was obtained from the second opinion approved doctor[181] (SOAD), without an explanation being given to the patient. This raised significant issues under **Article 8** and Brooke L.J. observed[182] that the case left no doubt as to the fact that the sanctity of the person was so highly held by the common law that there was a clear duty to give reasons to that person for any decision to administer medication to a non-consenting adult.

Finally, another Court of Appeal case, that of **R. (On the Application of John Wooder) v Dr Graham Fegetter and the Mental Health Act Commission**[183], revisited the issue of informing patients of the reasons for administration of medication against consent. The applicant claimed that he should 1) be given the right to see the RMO's letter and medical report to the SOAD prior to being interviewed by the SOAD and 2) that he should be given the reasons for the administration of medication against his will. The first claim was dismissed, but the second was upheld.

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180 *R. (on the Application of Wilkinson) v Responsible Medical Officer Broadmoor Hospital, The Mental Health Act Commission Second Opinion Appointed Doctor, and the Secretary of State for Health*, [2001] E.W.C.A. Civ. 1545; [2002] 1 W.L.R. 419; [2002] M.L.R. p.p. 218-223.

181 Mental Health Act 1983 s.58

182 Ibid. at para. 25

183 [2002] E.W.C.A. Civ. 554

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Sedley L.J. considered[184] that the common law and **Article 8** entitled the patient

> …not as a matter of grace or of practice, but as a matter of right, to know in useful form and at a relevant time what the SOAD's reasons are for his opinion on the RMO's proposal to override his will.

Clearly there are a number of issues raised under **Article 8** that impact directly on the normal day to day activities of psychiatric hospitals. Private healthcare organisations are no more or less liable to these claims than their NHS counterparts.

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184 ibid. at para. 49

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Article 9: Freedom of Thought, Conscience and Religion

Article 9 of the Convention states:

> (1)Everyone has the right to freedom of thought, conscience and religion. This right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.
>
> (2)Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.

Whilst this Article is very important, there are few circumstances within current UK mental health practice which are likely to infringe it. There are some patients who, when psychotic, or not for that matter, hold very deep rooted beliefs about others, but it should be remembered that the others also have the same rights. The fact that offensive ideas about others, for example sexist, racist or otherwise derogatory, may be expressed, could well fall foul of existing domestic law, and so would not become an **Article 9** issue.

Assuming that a patient's religion, beliefs and their needs are accommodated as far as is practicable, without infringing the rights of others, then claims are very unlikely to be upheld.

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One area that has raised itself in discussion, rather than in case law, is that of some beliefs and religions where illicit drugs are used. For example, some followers of Rastafarianism claim the right to smoke cannabis. Whilst not denigrating their belief, the use of cannabis is restricted by domestic statute, generally making it illegal, and therefore any claim for infringement is inadmissible. Even if it were not illegal, its use could be stopped on the basis of it potentially adversely affecting the mental state of a patient who already was detained because of a mental disorder, much in the way that access to alcohol is generally forbidden.

Finally, patients from time to time decide, for whatever reason, to change their religion. As long as the patient has capacity, in a legal sense, then this desire cannot be infringed, even if there are irreversible consequences to their actions, e.g. circumcision.

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Article 11: Freedom of Assembly and Association

Article 11 of the Convention states:

> 1) Everyone has the right to freedom of peaceful assembly and association with others, including the right to form and join trade unions for the protection of his interests.
>
> 2) No restrictions shall be placed on the exercise of these rights other than such as are prescribed by law and are necessary in a democratic society in the interests of national security or public safety, for the prevention of disorder or crime, for the protection of health or morals or for the protection of rights and freedoms of others. This Article shall not prevent the imposition of lawful restrictions on the exercise of these rights by members of the armed forces, of the police or of the administration of the State.

It is felt that, with regard to mentally disordered offenders, the only real claim under this Article would be if patients were prevented from forming or join a patients' council or similar organisation, in order to represent their and others' rights.

Some patients may feel that the restriction on their movement within a locked hospital or unit, or the limitation of whom they can associate with and when, is an infringement. As with other areas, assuming that the limitations are proportionate to the risks and in keeping with other legislation, then breaches are unlikely.

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Article 12: Right to Marry

Article 12 of the Convention states:

> Men and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right.

The case of **Mellor**[185] regarding conjugal rights and artificial insemination, as discussed under **Article 8**, is quite significant in clarifying the limitations that can be applied 'according to the National laws'. In this case it was found that the right to found a family was not absolute and that the State was able to restrict it.

The European Court has also ruled that the refusal to accept the marriage of same sex partners is also allowable.[186]

In general as long as the current laws are upheld[187], and assuming that there is mental capacity, then there is little that can be done to prevent the marriage of a person detained under the Mental Health Act.

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185 op cit

186 See for example, *X and Y v Switzerland*

187 Marriage Act 1983

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Conclusion / Summary

It is in the area of provision of services to mentally disordered offenders that the private sector has developed rapidly and is likely to continue to do so, due to the easier availability of capital funds, over their NHS counterparts, for the building of projects and the ever increasing need for the service. There are prospectively very high returns on this investment and this is also likely to continue for the foreseeable future, given the ever increasing prison population and that no realistically viable alternatives being currently proposed.

The reception of the European Convention on Human Rights into the legal systems of the United Kingdom by means of The Human Rights Act 1998, has had a quite profound effect on a variety of areas related to healthcare, particularly in the field of mental health. This has required professionals from both State and private sectors to reevaluate their policies, practices and procedures.

There has been very little by way litigation against the private/independent sector providing healthcare to mentally disordered offenders, with the notable exception of the

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Partnerships in Care[188] case. This clearly established that those private organisations, especially where powers are exercised relating to compulsory detention, fall within the auspices of the Human Rights Act by virtue of their fulfillment of public functions.

The entire range of activity related to any private healthcare organisations' activities in relation to detained patients is therefore liable to challenge under the Human Rights Act.

This impresses the need to ensure that best clinical and legal practice is followed at all times, both to protect the rights of those in their care and to protect the companies' investment.

By way of final summary, the areas that are worthy of the attention of the private healthcare organisation, and that have been discussed in this dissertation are, not in any specific order:

a) Effective and accurate pre-admission assessment and screening,
b) scrutiny of admission documentation,
c) risk assessment,
d) informing patients of their rights,
e) providing facilities for, and supporting rights of, patients to challenge their detention,

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188 op cit

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f) investigation of the therapeutic necessity of interventions such as seclusion and physical restraint and any treatments prescribed,

g) ensuring issues related to treatment without consent are strictly in accordance with the law,

h) acceptance of the duty to prevent self harm,

i) acceptance of the duty to protect the right to life of third parties against homicidal assaults by psychiatric patients,

j) minimisation of the risk of death from psychiatric treatment,

k) provision of suitably qualified and experienced staff,

l) provision of adequate healthcare and appropriate conditions of detention,

m) ensuring that issues related to renewal of detention, especially production of medical reports, are effectively dealt with,

n) ensuring that effective investigations are carried out, should any untoward incidents occur,

It is worth reiterating that the European Convention on Human Rights is a living instrument, and remembering that acts carried out and deemed acceptable previously may not be acceptable presently or in the future.

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