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Assessing the viability of treatment rights for prisoners with personality disorder: Substance or substantive?

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ABSTRACT

Personality disorder (PD) has long been criticized as a diagnosis, not least for the issue of its supposed untreatability. This has precluded many offenders with PD from receiving treatment for their disorder in a secure hospital, with detention in the potentially deleterious penal environment the result. However, transfers for public protection continue to occur. A further problematic issue for treatment considerations when diversion from prison hangs in the balance is the removal of the need for proposed treatment to provide a therapeutic benefit under the recently amended Mental Health Act 1983. In light of these developments, this paper considers the significance of human rights instruments, such as the European Prison Rules 2006, which aim to offer rights to treatment, giving the offender with a diagnosis of PD access to adequate and sustaining treatment, both in prison and secure hospitals. Copyright © 2009 John Wiley & Sons, Ltd.

Introduction: Treatment and international human rights instruments

Personality disorder: Therapeutic ambivalence precursory to inadequate medical care

After half a century of legal developments, 'rights' to treatment in prisons have been given a fresh outlook in the form of the European Prison Rules (EPR; Council of Europe, Recommendation Rec, 2006), Article 10(3) of which states: 'The penitentiary system shall comprise treatment of prisoners the essential aim of which shall be their reformation and social rehabilitation...'. In 1990, the Home Office (1990), previously opposed to the idea, gave a voice to this ideal by contracting in the National Health Service into prisons. Furthermore, with the aim of giving

prisoners access to the equivalent quality and range of services received by the public, in April 2003, budgets for funding prison health services shifted from the Home Office to the Department of Health. And from April 2006, prison health, including mental health, care was transferred to the NHS (Department for Health, 2003). One ought to question whether these positive moves have resulted in improved access to medical care. With continuing gaps in service provision and overcrowding¹, it is clear that an observation of the Department of Health and Social Security & the Home Office in 1987 remains pertinent: 'The degree of overcrowding and pressure of facilities

¹As of February 2008, the total prison population had reached 82 283–311 over 'operational capacity' (HM Prison Service, 2008).

in the local prisons...is at a level which militates against the promotion of health-care, both physical and mental².

The implications of this shortfall must not be underestimated. Whilst studies often proffer little differentiation between mental disorders when examining suicide, Dooley (1990) revealed that the diagnosis of personality disorder (PD) was implicated in 26% of cases. Recently, Jenkins et al. (2005) found 57% of those who had made suicide attempts had antisocial or other PD. Already significant, with ongoing problems in screening for the disorder, the true percentage is likely to be higher. Liebling (2006) takes a different approach, proposing that 'relational or moral aspects' of prisoners' treatment are linked to levels of distress, which in turn increases institutional suicide rates³. But, if despair is a product of mental disorders⁴, and mental disorders lead to an increased risk of suicide⁵, it must be questioned whether the consequences of inadequate treatment have been overlooked in the prevention of prison suicide.

The absence of a right to proper rehabilitation was first realized in 1990, in the case of *Knight v Home Office*, in which the violent disposition of a mentally disordered offender prevented his receiving treatment in a hospital ward. Instead, he received treatment in prison, where he subsequently committed suicide following inadequate supervision. Asked to find a ruling of negligence, however, the court declined:

'The prison's central function is to detain persons deprived of their liberty by operation of law. The prison authorities have a duty to provide medical care where physical or mental illness is present. But the law should not and does not expect the same stan-

dard across the entire spectrum of possible situations, including the possibility of suicide, as it would in a psychiatric hospital outside prison.⁶

Only a decade on, as a reaction to concerns expressed by the then HM Inspectorate of Prisons, Sir David Ramsbotham (1996), on poor treatment standards in prison, The National Service Framework for Mental Health recognized that prisoners should expect the same quality of care as others⁷. This sentiment appears in Rule 47.2 of the EPR 2006, which provides that: 'The prison medical service shall provide for the psychiatric treatment of all prisoners who are in need of such treatment and pay particular attention to suicide prevention'. Yet, incompatibly, the commentary to Rule 47 says that: 'Appropriate therapeutic options should be available for persons with mental disorders detained in penal institutions.' Besides the lack of clarification as to the meaning of 'appropriate'⁸, when read in light of Rule 47.2 above, 'shall provide' runs counter to 'appropriate therapeutic options' in respect of prisoners' 'rights'. Taken together, they could sanction the provision of only that treatment which an authority considers appropriate. If this is a correct reading of the EPR 2006, the provisions are self-defeating. The practical result would be remarkably similar to principle 20(2) of the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, which, extending its rights to treatment to criminal offenders, states that this need only be 'to the fullest extent possible'⁹.

⁶(1990) 3 All ER 237, per Pill, J, paragraph 38.

⁷DOH (1999, p. 9).

⁸In terms of physical health, Rule 41.1 suggests this involves access to 'at least one qualified general practitioner'; and in accordance with Rule 41.3, if deemed 'appropriate', on a part-time basis.

⁹This conclusion would provide for interesting re-reading of the quote provided by the then Home Secretary, John Read, when asked whether he thought prisons worked, to which he replied: they allow 'the full possibility of rehabilitation' (Reid, 2006).

²DHSS/HO (1987, paragraph 5.1).

³In addition, in 2003, there were 17 294 cases of attempted suicide and cases of self-harm (Lead Article, 2006).

⁴In accordance with Section 1(2) of the MHA 1983 (as amended), the term 'mental disorder' now encompasses PD.

⁵Shaw, Baker, Hunt, Moloney, and Appleby (2004) identified that 72% of those who committed suicide had a mental disorder.

In reality, to 'the fullest extent possible' may in fact be substituted for 'the extent deemed *worthy*'. For one Institute of Psychiatry discussion paper (Moran, 1999) suggests that psychiatrists generally dislike the diagnosis of PD¹⁰. According to Lewis and Appleby (1988), the prevailing view is that sufferers are less deserving of treatment than those with other disorders of mind. As evidence of this, Bateman and Tyrer (2004) more recently provide that assertive outreach teams, and within the forensic system, regional medium secure units often exclude patients with PD. Others reveal that many doctors are concerned that they have neither 'the skills, training, nor resources to provide adequate services' (NIMHE, 2003). These hurdles are surely not envisaged by Rule 40.3, which states: 'Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation'. In sum, Rules 40.3 and 47.2 are substantively clear on the level of care to be expected, but are clouded by practical factors such as resource provision and the unwillingness of some professionals to engage with the disorder.

Recourse to convention rights for prisoners seeking treatment?

The Human Rights Act 1998 became a binding legal instrument in 2000; it seeks to protect certain rights and freedoms guaranteed under the European Convention on Human Rights. The principle articles aiming to guard against the infringement of treatment rights are Article 3 (the prohibition of torture or inhuman or degrading treatment or punishment) and Article 2 (the right to life protected by law).

¹⁰In light of the qualification 'generally', one ought to note the drive in some quarters to increase knowledge regarding the efficacy of treatments offered in secure units. Notably, Duggan et al. (2006) recently conducted a review of all randomized controlled trials of psychological interventions for participants with a recognized PD.

Article 3

Inadequate psychiatric care could potentially amount to inhuman and degrading treatment. Article 3, however, poses an onerous duty on a potential applicant hoping to prove a breach, for one must demonstrate, in the words of *Kudla v Poland* (a case concerning a prisoner with a PD), that:

'the manner and method of the execution of the measure do not subject him to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, his health and well-being are adequately secured by, among other things, providing him with the requisite medical assistance'¹¹.

Theoretically, imprisonment should entail only a deprivation of liberty. WHO embodies this standard stating that imprisonment should not result in the depriving of other human rights, including 'exposure to greater risks to their health than they would face in the community'¹². This was exemplified in *Keenan v United Kingdom*, in which Article 3 was engaged after an at-risk mentally ill prisoner who subsequently committed suicide after being placed in a segregation block for punishment. It was found that an absence of appropriate supervision and psychiatric input into his treatment culminated in the inability of the prisoner to withstand the stress of prison life¹³.

The case of *Keenan* compliments the duty to prevent prisoner suicide through reasonable care in the House of Lords case of *Reeves v Commissioner of Police for the Metropolis*¹⁴. It contrasts with the earlier dicta of *R v North Humberside and Scunthorpe Coroner, ex p Jamieson*¹⁵, in which the verdict of

¹¹(2002) 35 EHRR 11, paragraph 94.

¹²WHO (2002, p. 13).

¹³(1998) 26 EHRR CD64, paragraphs 113–115.

¹⁴(1999) QB 169, at 379.

¹⁵(1994) 3 All ER 972.

lack of care was available only in cases where there had been 'gross neglect' directly connected with the suicide. This is to be welcomed: if 'gross neglect' were the standard to engage Article 3 where the possibility of inadequate treatment is raised in respect of prison suicide, given that one ought to expect an 'unavoidable level of suffering inherent in detention' following *Kudla*, proving that suicide resulted from inadequate treatment would be an impossible burden, providing *some* 'medical assistance' was received by the prisoner. Yet, this result is conceivable even disregarding *Reeves v Commissioner of Police for the Metropolis*. For, if the 'manner' of imprisonment described in *Kudla* is taken to mean overcrowded conditions, proving that 'health and well-being' were not adequately secured and that this resulted in 'unavoidable' suffering, will be more burdensome given the court's willingness to take into consideration the 'practical demands of prison'. Evidently, in legal terms, the fact of overcrowded conditions in the penal system would suggest that it is currently permissible to provide substandard treatment within them.

Article 2

The right to life is enshrined in Article 2 of the ECHR¹⁶. In *Keenan*, the court held that the authorities had a positive duty to prevent self-inflicted deaths when the authorities were on notice of a 'real and immediate risk' to life, therefore extending the dicta of *Osman v United Kingdom* to outside third-party danger¹⁷. Specifically, at paragraphs 89–92, the positive duty under Article 2 was extended to 'where the risk to a person derives from self-harm'. However, it was said that there being no way of knowing that the deceased posed an immediate risk to himself, coupled with the existence of daily medical supervision and a lack of evidence otherwise

indicating failure to provide care which would have averted his suicide, meant that the authorities had done all that was required of them¹⁸. The case of *Keenan* would appear to put out of reach Article 2 rights if it could not be proven that the authorities were aware of the risk of the prisoner self-harming¹⁹. Moreover, achieving this high threshold continues to be compromised by the fact that obligatory screening for mental health conditions is not a legal requirement during imprisonment.

Diversion of Article 5 convention rights

Hospital orders and falling foul of criminal responsibility

The issue of treatment rights for the offender with PD is felt most forcefully in respect of diversionary practices. For the mentally disordered offender, diversion embodies the principle of treatment over punishment (Department of Health and Home Office, 1992). Section 37 of the Mental Health Act 1983 states that one option open to the court on sentencing is a 'hospital order'. In *R v Birch*, it was said that this entails removing the offender from the penal process and placing the patient 'in the hands of the doctors', in so doing, dispensing with retributive and deterrent aims of imprisonment²⁰.

Whilst fortifying therapeutic rather than punitive ideals, the appropriateness of any deprivation of liberty, by way of hospital order or otherwise, is policed by Article 5(1) of the ECHR. Under subsection (e), it is lawful to deprive an individual of 'unsound mind' of their liberty, and remains so in the presence of a continued mental disorder, as

¹⁸At paragraphs 93–101.

¹⁹Its scope is further limited by allowing only the deceased's next-of-kin to present an Article 2 case.

²⁰(1989) 11 Cr App R(S) 202 (CA), Mustill LJ, at 210. An exception exists where it is necessary to mark the gravity of the offence with punishment (*R v Morris* (1961) 45 Cr App R 185; *R v Birch*, at 215, *per* Mustill LJ), or there is no reasonable prospect of treatment (*R v Birch*, at 215, *per* Mustill LJ).

¹⁶See *McFeeley v UK* (1980) 3 EHRR 161.

¹⁷(2000) 29 EHRR 245.

shown by objective medical evidence²¹. Article 5(1)(e) was applied, successfully, in *Aerts v Belgium* (a case involving a diagnosis of borderline PD), in which it was adjudged unlawful to have held on remand a mentally disordered offender for 7 months while a hospital bed was sought in accordance with the directions of the court²².

Article 8 of the Council of Europe's 'Recommendation Rec (2004)' 10 of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder' suggests that the mentally disordered offender be cared for in 'the least restrictive environment available'. The result is that *Aerts* appears to have gone one step farther than Article 8. The decision runs closer to Article 4 of the EPR 2006, which provides that: 'Prison conditions that infringe prisoners' human rights are not justified by a lack of resources.' And though *Aerts* was a prisoner on remand, since s.37(4) specifies that a prisoner may be conveyed to and detained in a place of safety, defined in Section 55(1) to include a prison or remand centre, it is relevant by analogy²³.

Aerts may be contrasted with *Bizzotto v Greece*²⁴, concerning Article 5(1)(a). This Section provides

²¹This formed part of a three-pronged test in *Winterwerp v The Netherlands* (1979) 2 EHRR 387. Starkly, art 14(1) of the 2006 UN Convention on the Rights of Persons with Disabilities provides that 'States Parties shall ensure that persons with disabilities, on an equal basis with others...' (b) 'Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify the deprivation of liberty.' Whether for treatment or otherwise, the idea that no mentally disordered offender should be detained for treatment can surely not have been the intention of the UN. Arguably, this merely recognizes the 'Bournewood' litigation, which exposed the dangers of exercising 'complete and effective control' over a patient, absent legal safeguards upon which a patient could challenge the lawfulness of their detention. See *HL v United Kingdom* (2005) 40 EHRR 32, paragraph 91.

²²(2000) 29 EHRR 50, paragraph 54.

²³*Contra.*, one could conceivably argue that this case concerns only transfer decisions and not detention *per se*.

²⁴(1996) ECHR 50.

for the 'lawful detention of a person after conviction by a competent court'. In this case, a non-mentally disordered offender was convicted of drug charges, and was handed drug rehabilitation rather than a penal sentence. The Greek authorities could not provide Bizzotto with the necessary facilities, however, and he was instead remanded in prison until such time as those facilities became available. Under Greek law, an offender sentenced to drug rehabilitation is subject to periodic review following 1 year's detention to determine the appropriateness of continued detention. Despite the ruling in *Ashingdane v United Kingdom* that there must be some relationship between the grounds of permitted deprivation of liberty and the place and conditions of detention²⁵, the court held that a period of detention was passed for the purposes of punishment, and so the decision to place Bizzotto in prison did not affect the main grounds of his detention²⁶.

The dichotomy of approaches in Bizzotto and *Aerts* encapsulates the problem of criminal responsibility determining treatment conditions. As Mr Bizzotto found out to his detriment, the absence of criminal responsibility appears to provide a turnkey to accessing adequate treatment. Put another way, if one is not found to have a mental disorder, then the Convention would not seem to require that a prisoner receive adequate care. The danger here is that PD is identified only sparingly in prisons. Factors limiting diagnosis were recently identified by Salize, Dreßing, and Kief (2007) in their evaluation of the practices of 24 European countries. They suggest that at a national level, common standards 'hardly exist' with regards the quality of screenings. Even within countries, routine practices often differ from region to region, possibly due to the 'lack of adequately trained staff, scarce financial resources or other causes'. 'Other causes' must certainly take account of the infancy of clinical assessments for diagnosing PD. The reliability of assessments is hampered, not merely by

²⁵(1985) 7 EHRR 528, paragraph 44.

²⁶At paragraph 32.

a lack of validity amongst the different instruments used, but by formal diagnostic criteria, such as the DSM-IV, which covers both personality traits and social deviance as markers. Therefore, unless one is suffering from PD *and* an attendant Axis I disorder, such as the more easily diagnosable depression or schizophrenia, those with undiagnosed PD are more likely to be housed in a penal environment, deleterious to their health²⁷.

Whilst theoretically correct, Peay (1997) reminds us that ‘many, if not most, “disordered” offenders do not receive the therapeutic “hospital order” disposal, even though their culpability may be mitigated...’. In this regard, satisfied those would be who argue that treatment for mental disorders should, as with physical ailments, be treated in prison. Bean (2001), indeed, opines that psychiatry is concerned with treating mentally ill persons, and prison with ‘inflicting suffering according to principles of retribution or deterrence’, making prison an inappropriate institution for care of those with mental disorders.

It is undeniable that factors such as malnutrition²⁸, gross overcrowding, poor ventilation and the shipment of prisoners between prisons are associated with an increased risk in transmitting infectious diseases, such as tuberculosis and hepatitis B. However, in a recent qualitative study involving interviews with 111 prisoners from 12 prisons in the public sector, though occasional concern was expressed about waiting lists, initial assessment, screening during imprisonment and management of long-term conditions, such as diabetes, were generally spoken of positively (Condon et al., 2007). In contrast, those who lament the drive to increase care of those with mental disorders, and particularly PD, ought to note the specific concern expressed by the HM Chief Inspec-

tor in her annual report of 2005–2006 on general prison healthcare: ‘Mental health within prisons remains one of our major concerns. For that reason, the Inspectorate is undertaking a thematic review into mental health within prisons...’ (HM Chief Inspector of Prisons for England and Wales, 2007b). That review (HM Chief Inspector of Prisons for England and Wales, 2007) noted an over-reliance on medication and little access to psychological therapies, preventing the mitigation of *physical* side effects from psychopharmacology. Finally, in this year’s annual report on prison healthcare (HM Chief Inspector of Prisons for England and Wales, 2008), it was said that mental health services are ‘inappropriate for the level of need’, and once again poor screening was cited. Surely, the equivalence of care argument is counterfactual when the disorder in question is not conveyed in clinical practice.

(Un)Treatability and the abrogation of prisoner rights

Arguments lobbied in favour of hospital treatment for those with PD are, in some senses, superficial, in that those offenders forgoing punitive detention are often confined for longer periods than their original sentences. Historically, this was not through the operation of Section 37 of the 1983 Act, as the disorder faced the requirement, contained within Section 37(2)(a)(i), MHA 1983, that treatment would be ‘likely to alleviate or prevent a deterioration’ in condition. As has been shown, there is a pervading therapeutic ambivalence towards PD, often manifesting itself in the belief that the disordered offender is either difficult to treat or unresponsive to treatment. If it was deemed that the disorder would be responsive to treatment, this then formed the platform from which the receipt of substandard treatment in the penal institution could be justified, and rights deprived.

Later into the prison sentence, however, Section 47 sanctioned the transfer of the offender with PD to hospital if the same conditions were met. The

²⁷Co-morbid features of substance misuse has also been shown to increase the chances of acceptance into secure units (Meltzer et al., 2004).

²⁸See *Van Biljon v Minister of Correctional Services* 1997 (4) SA 441 (C), *per* Brand J (a lack of dietary vitamins contributing to contracting opportunistic infections).

injustice here is that for mental disorders other than PD, the need for hospital transfer of seriously ill prisoners is generally underestimated, and s.47 never bites on the facts (Blaauw, Roesch, & Kerkhof, 2000)²⁹. Yet, despite issues as to the amenability of the disorder to treatment, Section 47 was often invoked near to the offender's earliest release date, with the effect that sentences were extended³⁰. Whilst amenability to treatment may have been removed from sections 37 and 47 as a consequence of Section 4(7) of the MHA 2007, and replaced by the availability of 'appropriate medical treatment', without a restricted reading of the term 'appropriate', there continues to be no obstacle to prolonged detention.

Dangerousness and indeterminate detention

Indeterminate detention is foremost a concern for public protection. In the wake of high-profile murders, most notably Michael Stone, convicted of the brutal murders of Lyn and Megan Russell in 1996, the subsequent central aim of Government of 'maintaining the highest possible levels of public protection'³¹ saw the creation of the non-medical dangerous and severe PD (DSPD). The phrase DSPD describes adults with an identified PD deemed to be severe in nature and resulting in antisocial conduct, often demonstrated by the committal of serious offences. In an effort to address this issue, several Pilot Programmes have been set-up to support the 'delivery and development of new services' for those who present a 'high risk' of committing violent offences who can be 'managed and treated through the appropriate pathways of care' (Home Office, 2005a).

²⁹This is, furthermore, at odds with Rule 40.4 of the EPR, 2006 which states: 'Medical Services in prison shall seek to detect and treat physical or mental illnesses or defects from which prisoners may suffer'.

³⁰Huws et al. (1997) found that between 1984–1991, 10% of prisoners were at least as close as 6 weeks to their earliest release date, and 66% of those were suffering from PD.

³¹DOH (1998, para. 4.24).

The Netherlands, Sweden, Australia, the United States and Canada all have some form of indeterminate sentencing (Home Office/ Department of Health Working Group, 1999). The main precursor to the DSPD initiative, however, is the Dutch Terbesschikkingstelling (TSB) system. Under this system, a judge, in respect of an offender convicted of an offence carrying a sentence of at least 4 years and adjudged by the courts to have a serious mental illness such as PD or a learning difficulty, may pass a TSB order exclusively, or more likely, in combination with a period of imprisonment. In both cases, the order takes effect within 6 months. Subsequent treatment in a TSB clinic or secure hospital aims to reduce the chances of re-offending.

Under the Dutch system, approximately 1400 beds are allocated for TSB orders. In England, the total bed estate catering for the DSPD initiative is approximately 375 (Home Office, 2005b). In substantive terms, Section 37(4) sanctions the making of a hospital order only if the court is satisfied that an offender can be admitted within 28 days. Through the hospital's inability to provide a bed, the court is then constrained by an apparent lack of resources³². If bed space should later become available to meet the needs of Section 47 transferees, the supposed injustice in extending sentence in a category of offender who is difficult to treat would now seem redundant. It must be questioned: does such a practice not indicate a loss of proportionality to the gravity of one's sentence?

For both mentally and non-mentally disordered offenders, at a domestic level, The Powers of the Criminal Courts (Sentencing) Act 2000 engenders the principle of proportionality into sentencing practices³³. Certainly, at the European level

³²Other constraining factors that have arisen, primarily in the context of provision of medium secure psychiatric units, are the skills levels of staff within a particular unit; make-up of its current patient body (Meltzer et al., 2004); and whether successful treatment could be achieved within 2 years (Grounds et al., 2004).

³³Sections 79(2)(a), 35(1) provide that a sentence must be commensurate with the seriousness of the offence.

there is a growing recognition that prison sentences must be both humane and as short as possible. Duly noting the principles of legitimacy, legality and proportionality that underpin Article 5 of the ECHR, proportionality is explicitly referred to in Article 60.2 of the EPR 2006: 'The severity of any punishment shall be proportionate to the offence.' Incongruously, Article 3 of the 2006 Rules provides that all deprivations are to be 'the minimum necessary and proportionate to the legitimate objective for which they are imposed'. In this respect, Article 3 would appear contrary to Article 60.2 in that it permits sentences disproportionate to the gravity of a crime in diversion cases. After all, on its face, the 'legitimate objective' is to affect a cure. What is more, in terms of Article 5(1)(e) of the Convention, the offender remains lawfully detainable as a consequence of having an 'unsound mind'.

Interestingly, Part II of the Draft Treaty Establishing a Constitution for the European Union (2003) incorporates 'The Charter of Fundamental Rights of the European Union'. Article 49(3) of the Charter stipulates that 'The severity of penalties must not be disproportionate to the criminal offence'. Since the Constitution will have binding legal force, the provision would directly affect offences committed at the European level. As Ashworth and Van Zyl Smit (2004) point out: 'Article II 49(3) of the EU Charter appears to proclaim a broader and therefore more demanding standard, which raises questions about how it might be interpreted and what impact it may have,' with respect to the link between individual rights and avoiding sentences disproportionate to the crime. Currently, however, in the face of this broader standard, indeterminate sentencing cannot be considered in the context of the current human rights considerations of prison care for the mentally disabled; it is arguably a politico-legal consideration, with medico-legal terms like 'treatability' enabling purely legal decisions as to detention to be hidden behind a veil of medical objective, causing the ECHR to be satisfied that justice has been done. The implication is that political

motives, inextricably bound to those medical, are the backdrop to aims such as that expressed by the Ministry of Justice (2007), namely, to 'divert offenders with serious mental healthcare needs.' Diversion for 'healthcare needs', it appears, is subordinate to the needs of politics.

Noting the consequences of the treatability requirement with regards to PD, a recommendation of The Fallon Report in 1999 (Fallon, Blugrass, Edwards, & Daniels, 1999)—set up to investigate the alleged administrative and therapeutic failings of the PD unit at Ashworth Special Hospital³⁴, was the introduction of interim transfers. Currently, Section 38(5) of the MHA 1983 sanctions the making of an interim hospital order to access the treatability of an offender suffering from a 'mental disorder' under Section 1(2) (as amended by Section 1(4) of the 2007 Act). Providing the offender is liable for imprisonment on conviction, they may be detained in hospital for a period of 12 weeks, which may be renewed for further periods of 28 days, for up to a maximum of 6 months. The Fallon Report recommended that this period be extended to 12 months. Given that this had already been at the disposal of the court pursuant to Section 49(1) of the Crime (Sentences) Act 1997, this presumably reflects the ambition of the authors to see greater use made of the Section, rather than the establishment of new legal ground³⁵. Either way, increasing the use of such powers would appear reasonable: foremost, it could potentially assuage the injustice of transferring prisoners with determinate sentences close to their earliest release dates (ERDs): a sentence begun in a secure unit and subsequently extended would be more difficult to justify. What is more, the deleterious environment of the prison could be avoided. But, the Report conceded, the instigation of interim orders would lead to an untenable increase in prison populations³⁶. It would also be unrealistic against

³⁴It noted, amongst other things, poor clinical care (at 3.13.0) and widespread abuse of drugs (3.15.4).

³⁵It was suggested that this would also test offender engagement with services. See Recommendation 54, at 7.7.2.

³⁶At 7.4.5.

the backdrop of resource management within the NHS. Though financial recovery since 2006 resulted in an audited deficit of £547 million becoming a surplus of £1.789 billion at the end of the 3rd quarter of the 2007/2008 financial year (Department of Health, 2008), without significant investment, the loss will fall to the care of patients. The King's Fund (2007) is correct to suggest that 'NHS trusts must be allowed to use the surpluses to deliver new services and models of care that benefit patients'. Clearly, the conclusion of Fallon, Blugrass, Edwards, and Daniels (1999), that such a system would be 'fraught with difficulties', ought not to be ignored.

In light of these difficulties, it is inevitable that substantive changes to the law on diversion under the Mental Health Act 2007 have merely highlighted a reciprocal relationship between domestic and international legislation. It will come as no comfort to the offender with PD that this has merely been to highlight the gap between the substantive treatment rights outlined in legislation and the actual treatment they receive.

Concluding remarks

It has been shown that advocating the rights of offenders with PD is troublesome. Whilst, in substance, human rights instruments are sufficient to augment offenders' rights to psychiatric treatment, the flowing of rights is far from guaranteed. At the macro-level, many of these difficulties appear to arise due to standards being implemented with reference to the institution, rather than the needs of the offender. The EPR 2006 illustrate this: Article 12.1, for instance, is clear that those with mental disorders should be detained in an establishment 'specially designed for the purpose'; yet, Article 12.2 states that if such prisoners are 'nevertheless exceptionally held in prison there shall be special regulations that take account of their status and needs'.

It was the conclusion of the Fallon Report that what is needed is 'a radical reappraisal of the foren-

sic psychiatric services and the Criminal Justice System'³⁷. The transfer of prison care to the NHS ought to have represented a landmark in the securing of adequate treatment for the offender; but the result has not been satisfactory. In terms of fortifying treatment rights for the offender with PD, it is hoped that both screening and the drive to increase research into the treatability of the condition will be influential in remedying the potential injustices of applying preventative detention to ostensibly therapeutic diversions from prison, under section 47 of the MHA 1983.

Highlighting the poor position of current rights to treatment, however, ought not to be seen as external from the pressure on resources both in secure hospitals and in the penal system. Consequently, it may be that future litigation, coloured by Article 4 of the EPR 2006³⁸, is to be focused on Article 5 of the Convention. For, in the case of *Aerts*, one reason cited by the Government for its failure to implement the directed hospital care was overcrowding and constrained resources, yet a breach of Article 5(1)(e) was not prevented³⁹. Should the decision in *Aerts* not improve treatment rights for those in the penal system suffering from PD, a sympathetic voice concluding on the viability of treatment rights through human rights instruments would re-state principle 20(2) of the UN (1991) Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, namely, that the provision of treatment need only be 'to the fullest extent possible'.

³⁷At 7.1.3.

³⁸The ECtHR 'increasingly refers to both the existing European Prison Rules...' (Van Zyl Smit, 2006). This impliedly points out the fact that an applicant seeking to rely on Article 4 would have already raised a viable human rights point before it became relevant.

³⁹Furthermore, Article 3 of the ECHR is likely to become more influential in the future: see *Dougoz v Greece* (2001) ECHR 213; *Peers v Greece* (2001) ECHR 296; *Kalashnikov v Russia* (2002) ECHR 596. For discussion, see Snacken (2006).

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