Contracting Out, Opting Out: Does the Mental Health Act 2025 Address the Human Rights Protection Gap in Commissioned Mental Health Care?

About the Author:

Dr Thomas J W Peck is a Lecturer in Law at the School of Law, Lancaster University.

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ABSTRACT

The growth in commissioned mental health services from private providers presents a significant challenge for the protection of human rights in the UK. Restrictive legislative protections and the unpredictable judicial application of section 6 of the Human Rights Act 1998 lead to the denial of justice for those whose rights may have been violated by a private mental health provider commissioned by the state. This 'protection gap' was demonstrated in the recent case of *Sammut v Next Steps,* where the case was summarily dismissed on the grounds that a private mental health provider, commissioned by the local authority, was not a 'public body' for the purposes of section 6(3). Seemingly in response to injustices such as this, section 51 of the Mental Health Act 2025 seeks to address this issue, by providing for the automatic application of section 6 to private providers where they have been commissioned for aftercare services by a local authority, or where care is otherwise contracted out by the NHS. Whilst taking steps in the right direction, I argue that this reform does not go far enough and leaves significant gaps in protection remaining for vulnerable patients outside of the narrowly defined categories proposed under the Act. Of particular concern are those in receipt of private mental health care in detention settings, such as prisons or immigration detention centres. I argue that legislative reform is required to ensure that all private mental health care, commissioned by the state is considered a public function for the

purposes of the Human Rights Act, ensuring access to justice for those whose rights may have been infringed in these contexts.

Introduction

Writing in 1990, Birkenshaw, Harden and Lewis opined that:

> "It would be a fine irony if British citizens were to get a bill of rights only to find that the 'public' authorities against which the right might be impleaded had largely been replaced by 'private' bodies, which could be rendered accountable only through private law"[1]

It seems such irony may have come to pass. The outsourcing of public services such as health and social care has seen a stark rise over the past decade. Reasons for this shift are unclear and multifaceted, ranging from funding concerns, ideological commitments to 'consumer choice', and a method of addressing unmet demands.[2] Yet privatisation has not necessarily resulted in the improvements in service provision that were expected.[3] Regardless, within the mental health sector, the increase in private provision presents a significant challenge for the protection of human rights in the UK, for a distinctly vulnerable population. This challenge was put on full display by the recent case of *Sammut v Next Steps Mental Healthcare Ltd*[4] which reignited concerns of a 'protection gap' for patients placed in outsourced mental health facilities. Despite being unlawfully detained and dying under the care of a private mental health provider, the claim was dismissed by the High Court, as the provider was not considered a public body under section 6 of the Human Rights Act 1998. *Sammut* highlights that victims of potential rights infringement may be denied access to justice and remedies where care is outsourced to private actors. The inherent vulnerability of patients in the mental health care sector, alongside the growing role played by private actors, creates a pressing issue for human rights protection.

The Mental Health Act 2025, aims to remedy injustices such as in *Sammut,* purporting to close this 'protection gap' in England and Wales. Section 51 of the Act expands the automatic application of s.6 HRA, to include s.177 MHA aftercare services, as well as any commissioned private care funded by the NHS.[5] In light of this development, I evaluate whether the Act is successful in its

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[1] Patrick Birkenshaw, Ian Harden and Norman Lewis, *Government by Moonlight: The Hybrid Parts of the State*, (Unwin Hyman 1990), 291.
[2] B. Goodair, "Accident and emergency'? Exploring the reasons for increased privatisation in England's NHS' (2023) 138 HP 104941.
[3] A. Bach-Mortensen, B. Goodair and C. Corlet Walker, 'A decade of outsourcing in health and social care in England: What was it meant to achieve?' (2024) 58 SPA 938.
[4] [2024] EWHC 2265 (KB).
[5] Mental Health Act 2025, s.51

aim. In doing so, I explore the existing protection gap, highlighting deficiencies in the current statutory regime and its judicial interpretation. I explore how s.6(3) of the Human Rights Act has been inconsistently interpreted and applied by the Courts, resulting in a lack of legal certainty and potential denials of justice for victims of private-sector human rights abuses. Following this, I then evaluate whether the reforms address the protection gap. I argue that the Mental Health Act goes some way to closing the gap, particularly in cases such as Mr Sammut's, where funding under s.117 of the Mental Health Act 1983, which relates to the provision of aftercare following compulsory detention in hospital, excluded review. However, it is evident that the Act does not fully close the protection gap, as it fails to provide for the automatic application of section 6 HRA, for those whose care is commissioned by public bodies other than local authorities or the NHS. I argue that the protection gap exists in contexts far beyond traditional healthcare settings, impacting particularly vulnerable groups such as prisoners and those held in immigration detention centres where mental health services are commissioned to private providers.

Given this, I argue for a broadening of the reforms in the Mental Health Act 2025 to remedy the protection gaps for commissioned and private mental health patients who sit outside the scope of the current proposals. I argue that any mental health service commissioned by the state and provided by a private body should be captured by section 6(3). Against the backdrop of inconsistent judicial interpretation, more direct action is required to ensure focus rests upon function, rather than funding. Given this, I argue that closing the protection gap requires explicit legislative intervention to ensure that provision of mental health care is treated as a public function regardless of the funding sources of the provider and should therefore fall automatically within the scope of s.6(3).

Section 6 of the Human Rights Act 1998

Section 6 of the Human Rights Act 1998 makes it unlawful for a public authority act in a manner which infringes upon or is incompatible with convention rights.[6] The term 'public authority' is defined as "any person certain of whose functions are functions of a public nature".[7] Under section 6(3) the Act provides for bodies which are in some ways private in nature and in other ways public. There is thus a distinction between a *core* public authority under s.6(1) and a *hybrid* public authority under s.6(3). As Lady Hale notes in *YL v Birmingham City Council*[8] such bodies reviewable under the

[6] Human Rights Act 1998, s.6(1).
[7] Human Rights Act 1996, s.6(3)(b).
[8] [2007] UKHL 27.

Act are "…bodies, only certain of whose functions are 'of a public nature' have to act compatibly with the Convention, unless the nature of the particular act complained of is private."[9] The Act provides no further guidance on how the applicability of this section is to be determined. The courts have therefore been required to develop case law to allow them to determine whether the unlawful act is public or private.[10]

Given the loose statutory construction, the question of when an otherwise private body constitutes a public body for the purposes of the Human Rights Act has been subject to extensive judicial interpretation. Such interpretation of section 6 finds its roots in analogous approaches to the question of 'public bodies' for the purposes of Judicial Review, such as the seminal case of *ex parte Datafin*[11] which was drawn upon by Lord Woolf CJ in *Poplar Housing v Donoghue,*[12] one of the first cases to consider the meaning of s.6(3). In doing so, Lord Woolf opined that the provision by the private sector, of services normally provided by the public sector, should not mean that the provision of such services is to be automatically deemed public in nature.[13] Lord Woolf's explicit reference to *Datafin* strikes as ironic. Lloyd LJ focused closely on the "nature of the power"[14] in relation to the function being performed. This function-centred approach appears distant in the judgment in *Poplar,* where Lord Woolf's focus appears targeted upon the nature of the body itself, rather than the function performed.[15] This, Lord Woolf argued, was to prevent private bodies from being caught within the purview of the Human Rights Act "merely because it performs acts on behalf of a public body which would constitute public functions were such acts to be performed by the public body itself".[16] Such a position, in tandem with highly broad and uncertain judicial approach to section 6 (explored in detail in the following section), has led to cases which ultimately fail to uphold the purpose of Human Rights Act, to 'bring rights home'[17] and protect against violations of fundamental rights by allowing private actors to infringe with relative immunity from judicial intervention.

[9] [2007] UKHL 27, at [37]. It is worth noting that Lady Hale was speaking here in the minority. Nevertheless, her perspective appears to have won out in terms of judicial acceptance and later statutory reform through the Care Act 2014.
[10] Human Rights Act 1996, s.6(5).
[11] *R v Panel of Take-overs and Mergers, ex parte Datafin plc* [1987] QB 815.
[12] *Poplar Housing and Regeneration Community Association Limited and Another v Donoghue* [2001] EWCA Civ 595, [65].
[13] [2001] EWCA Civ 595, [58].
[14] [1987] QB 815, 847.
[15] Thomas Webb, 'Donoghue v Poplar Housing and Regeneration Community Association Limited and another [2001] EWCA Civ 595, Court of Appeal' in Thomas Webb (ed), *Essential Cases: Public Law*, (6 edn, Oxford University Press 2023) .
[16] [2001] EWCA Civ 595, [59].
[17] Secretary of State for the Home Department, *Rights Brought Home: The Human Rights Bill* (White Paper, Cm 3782, 1997), Introduction.

In the context of health and social care provision, this presents a particularly pertinent injustice, given the inherent vulnerability of patients and the degree of power held by those commissioned and tasked with their care. As such, Parliament has attempted to provide some further clarity and provide statutory protection against some private actor interferences. Section 145 of the Health and Social Care Act 2008 sets out that a person providing "accommodation together with nursing or personal care, in a care home for an individual"[18] under the National Assistance Act 1948 is regarded as a public body for the purposes of s.6 HRA.[19] This measure arose partly in response to the decision in *YL* where the majority held that a private care home contracted by a local authority was not a hybrid public body for the purposes of s.6(3) HRA.[20] Similarly, section 73 of the Care Act 2014 sets out that registered care providers are considered public bodies for the purposes of section 6(3)(b) of the Human Rights Act,[21] specifically, when the care is arranged by an authority (such as an NHS Trust or Local Council)[22] and the authority arranges or pays for the care under a corresponding statutory provision (such as those under the Care Act).[23]

These provisions provide statutory rebuke to the exclusion of some private commissioned services from judicial review. Nevertheless, their scope is narrow and significant gaps in protection persist. For example, where a funding obligation arises under other statutes, such as s.117 of the Mental Health Act, s.73 of the Care Act is not engaged since s.117 MHA is not included within the table of statutory provisions giving rise to an obligation under s.73(3)(a)-(b) CA. As a result of this gap in the law, commissioned mental health aftercare treatment does not automatically fall under s.6 of the Human Rights Act. Courts must therefore return to s.6(3) and make a determination as to the nature of the body. As noted, s.6(3) does not provide for a single, clear test.[24] This being the case, if a body is not expressly a public body (as will be the case for all private healthcare providers) then there is a real risk that the Courts may determine that the body's characteristics do not satisfy s.6, excluding human rights review for potential victims of abuse within the private sector. Such an outcome has been exemplified in the recent case of *Sammut v Next Steps*.

Sammut v Next Steps and the protection gap Paul Sammut suffered from schizophrenia. He was detained and treated at a facility operated by the National Health Service (NHS) for much of

[18] Health and Social Care Act 2008, s.145(1)
[19] Health and Social Care Act 2008, s.145(2)(a).
[20] [2007] UKHL 27.
[21] Care Act 2014, s.73.
[22] Care Act 2014, s.73(3)(a).
[23] Care Act 2014, s.73(3)(b).
[24] *Aston Cantlow PCC v Wallbank* [2003] UKHL 37.

his life. In 2018 he was transferred to an outsourced private facility operated by Next Steps Mental Healthcare Ltd. The exact nature and quality of his care whilst receiving treatment at this facility are not a matter of public record, however, it is clear that whilst under the commissioned care of Next Steps, Mr Sammut was subject to deprivation of liberty safeguards, without the necessary authorisation. Perhaps more significantly, Mr Sammut died whilst under Next Steps care, due to bronchopneumonia, intestinal obstruction and faecal impaction, caused by side-effects of the medicine Clozapine. Those being treated with this medication require frequent monitoring to mitigate the risks of developing such severe side effects.Believing that Next Steps to be responsible for his suffering and death, Mr Sammut's estate sought to bring a claim against Next Steps and the NHS Trust under the Human Rights Act 1998. Claims were brought for alleged breaches of Articles 2 (Right to Life), 3 (Prohibition of Torture), 5 (Right to Liberty and Security) and 8 (Right to Respect for Private and Family Life). In response, Next Steps applied for a summary dismissal of the case, arguing that it was not a public authority for the purposes of section 6 of the Human Rights Act and that the claim against them was therefore inadmissible.

In *Sammut,* the Court sought to determine whether Mr Sammut's estate could bring such a claim against Next Steps. In doing so, it sought to consider whether any of the current legislative provisions which provide for automatic consideration of private providers as performing a public function, applied. The Court held that s.73 of the Care Act did not apply in Mr Sammut's case, since the funding for his care was made through s.117 of the Mental Health Act 1983,[25] which did not provide for automatic s.6 HRA application. If Mr Sammut's treatment had been funded under the Care Act, s.73 would straightforwardly apply to allow the case to proceed. By funding the commissioned aftercare under s.117 of the Mental Health Act, the local authority effectively excluded the automatic engagement of s.6 Human Rights Act.

In light of this, the claimants argued that Next Steps was performing a public function for the purposes of s.6 of the Human Rights Act. They relied on *R(A) v Partnership in Care Ltd*[26] where it was held that a private psychiatric hospital was performing functions of public nature when exercising powers of compulsory detention under the Mental Health Act. However, the Court held that this did not apply to Mr Sammut's case since their primary claim of rights-violation was based on Mr Sammut's unauthorised deprivation of liberty. The Court reasoned that since Next Steps did not have lawful authority to detain Mr Sammut, they could not have been exercising a 'power'

[25] [2024] EWHC 2265 (KB), at [29]-[32].
[26] [2002] EWHC 529.

required attribute a function of a public nature.[27] The estate's claim therefore failed, and the potential rights violations were never substantively examines.

Ultimately, the Court's reasoning hinged on the source of funding obligation (s.177 of the Mental Health Act) and powers possessed by Next Steps, rather than assessing the functions the private provider performed. Whilst the Courts have long considered statutory powers a key indicator of public functions, the absence of a statutory basis is not exclusionary, provided the function is public in nature.[28] The line of reasoning in *Sammut* is also particularly worrying from a human rights perspective, since accountability is denied based on the rights violation itself – the absence of a formal power to detain, meaning that rights infringed through unlawful detention cannot not be examined. This result fundamentally undermines the core principle of human rights law – to protect against rights violations.

Sammut highlights a significant human rights accountability gap in both statute and judicial reasoning. Under current legislation, the technicality of a local authority's statutory funding obligation can be the difference between rights protection and denying access to justice. In addition, *Sammut* is a cautionary tale of the risks of leaving s.6 determinations to unpredictable judicial discretion. As Lord Nicholls made clear in *Aston Cantlow PCC v Wallbank,*[29] when determining if a private entity can be considered a hybrid public body, there is "no single test of universal application".[30] Instead the Courts have carved out a "multi-factorial"[31] test which balances a number of considerations, including, but not limited to, public funding, the use of statutory powers, substituting the function of a public authority, or providing a public service.[32] The array of discretionary considerations which judges may or may not place particular weight on is immense. As Williams notes, "it is in the nature of the multi-factorial approach that a potentially infinite number of considerations may be relevant".[33]

This vast expanse of considerations leads to inconsistencies between cases. Comparing, for example, the reasoning in *R (Weaver) v London & Quadrant Housing Trust*[34] to that of *Sammut*[35] we see a starkly different approach to s.6. In *Weaver* Lord Elias found a private landlord was a hybrid public authority due to the closeness of its operations to the local government and the significant

[27] [2024] EWHC 2265 (KB), at [48].
[28] [1987] QB 815.
[29] [2003] UKHL 37.
[30] [2003] UKHL 37, at [12].
[31] *R (Weaver) v London & Quadrant Housing Trust* [2009] EWCA 587, per Rix LJ, [119].
[32] [2003] UKHL 37, at [12] per Lord Nicholls.
[33] Alexander Williams, 'Public Authorities and the HRA 1998: Recent Trends' (2020) 25 JR 179, 180.
[34] [2009] EWCA 587.
[35] [2024] EWHC 2265 (KB).

regulation of its activities.[36] In contrast, the comparable relationship between a commissioned private mental health provider and the commissioning local authority was not even considered in *Sammut*. Commissioned mental health providers often work closely with, or even within, local authorities or the NHS and are subject to significant regulation by the regulator, the Care Quality Commission, which has oversight of both public and private healthcare provision.[37] These factors, unlike in *Weaver,* played no part in the decision in *Sammut,* evidencing inconsistency in the application of factors in determining the application of s.6. The absence of a concrete definition produced, in this instance, an unhelpful ambiguity to s.6,[38] a particularly troubling circumstance for rights-holders, who are placed in private commissioned services, creating inequality of rights-protection between those treated in public facilities and those treated in private commissioned facilities. Of course, it is a core feature of the common law that the Courts must interpret and expand upon legislative provisions. Legislation cannot possibly conceive of every possible instance and context where it may be applied. It has long been imagined that the Court's inherent sense of justice sits as the solution to the impossibility of unwaveringly comprehensive legislation.[39] Yet, as is evident from the uncertainties produced by such judicial reasoning, and the arguable injustices seen in the case of *Sammut*, the interpretation of s.6 has failed to live up to this image.

Unsurprisingly, the application of s.6 has long been subject to criticism and debate.[40] Scholars have highlighted particular concerns over judicial reasoning, which often requires ambiguously defined institutional links, rather than focusing on the nature of the functions performed.[41] This shift arguably ignores the original intent of Parliament, which emphasised the nature of the *function* over any particular link to another public institution.[42] For example, the then Lord Chancellor, Lord Irvine of Lairg, noted, in relation to section 6(3)(b) of the then Human Rights Bill, that it "asks whether the body in question has certain functions – not all – which are functions of a public nature. If it has any functions of a public nature, it qualifies as a public authority".[43] From a human

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[36] [2009] EWCA 587 at [69]-[71], per Elias LJ.
[37] The Care Quality Commission (Registration) Regulations 2009
[38] David Mead, 'The Continuing Mystery of "Publicness" Within Section 6 of the HRA' (2013) <https://ukconstitutionallaw.org/2013/10/17/david-mead-the-continuing-mystery-of-publicness-within-section-6-of-the-hra/> accessed 17.10.2013.
[39] *Omychund v Barker* (1744) 26 Eng Rep 14; see Lord Dyson 'Are the judges too powerful' (Speech as Master of the Rolls, 12th March 2014) https://www.judiciary.uk/wp-content/uploads/JCO/Documents/Speeches/mor-speech-have-judges-become-too-powerful.pdf (accessed 27.08.2025).
[40] See for example: Dawn Oliver, 'Functions of a public nature under the Human Rights Act' (2004) PL 329; Catherine M Donnelly, 'Leonard Cheshire again and beyond: private contractors, contract and s.6(3)(b) of the Human Rights Act' (2005) PL 785, S. Palmer, 'Public functions and private services: A gap in human rights protection' (2008) 6 IJCL 585.
[41] Alexander Williams, 'The Pointlessness of Section 6(5) HRA 1998' (2018) 23 JR 128; Williams, 'Public Authorities and the HRA 1998: Recent Trends'
[42] Williams, 'The Pointlessness of Section 6(5) HRA 1998', 134.
[43] *Hansard*, HOL, 24 Nov 1997, vol.583, col.796.

rights perspective, the correct focus should be upon the *function*, and not on ancillary considerations such as powers or proximity to a public body as has been developed in the case law.

Consideration of Parliament's original intent in developing section 6 is not forthcoming in the Courts. In *Aston Cantlow v Wallbank,*[44] Lord Nicholls held that the Court of Appeal was correct not to consider Hansard for interpretive assistance in relation to s.6,[45] despite acknowledging the "great deal of open ground"[46] left by the provisions in isolation. The introduction of parliamentary materials for the purposes of judicial statutory interpretation occurs only where legislation is ambiguous or obscure.[47] It is not within the scope of this work to delve into an argument about the legal technicalities of their inclusion or exclusion from s.6 case law. However, it is argued that the approach of the courts towards s.6 has clearly drifted away from the original intent of Parliament. Speaking in the House of Lords during the passing of the Human Rights Act, Lord Irvine stated that where a private body "has any functions of a public nature, it qualifies as a public authority".[48] The Court's approach has even been directly criticised by Parliament. In 2007, the Joint Committee on Human Rights noted that the Court's restrictive interpretation of s.6 was "potentially depriving numerous, often vulnerable people… from the human rights protection afforded by the Human Rights Act".[49] Calls for a shift in judicial perspective persist in the Committee's recent 2024 report.[50] Such statements indicate that the intention of Parliament, both at the inception of the Human Rights Act, and today, reflect a different path to that of the Courts.

Parliamentary critique of the Court's approach to s.6 arises from subsequent legislative measures (explored above) intended to remedy specific injustices borne out by the jurisprudence. Of particular significance is s.145 of the Health and Social Care Act, responding to the judgment in *YL*. Here, human rights review was denied by the Courts, who held that a privately run, publicly funded care home was not performing a public function for the purposes of section 6 HRA.[51] This, Parliament found, was antithetical to both the spirit of the Human Rights Act, and

[44] [2003] UKHL 37.
[45] [2003] UKHL 37, at [37] per Lord Nicholls.
[46] [2003] UKLH 37, at [36] per Lord Nicholls.
[47] *Pepper v Hart* [1993] AC 593.
[48] *Hansard,* HL Deb 24 November 1997, vol 583, col 796; Williams, 'The Pointlessness of Section 6(5) HRA 1998', 134.
[49] Joint Committee on Human Rights, '*The Meaning of Public Authority under the Human Rights Act'* (HL Paper 77, 28 March 2007) HC 410, at [2].
[50] Joint Committee on Human Rights, *'Legislative Scrutiny: Mental Health Bill'* (HL Paper 126, 19 May 2025), at p.46.
[51] [2007] UKHL 27.

parliaments original intention for interpretation of the nature of the functions provided by care homes in receipt of state funding.[52] As Lord Pannick notes:

> "Parliament has recognised that the provision of accommodation for the care and attention of the needy is plainly a function of a public nature, and it does not cease to be so because it is provided by the company pursuant to the statutory scheme and at public expense."[53]

A minority of justices have attempted to push back against what Williams has termed the 'institutional approach'[54] – an approach which focuses on institutional connection rather than on the nature of the function performed. Even in *YL,* the dissenting Justices voiced concern with the majority approach. Lord Bingham expressed confidence that Parliament had intended private care homes to fall within s.6(3)(b),[55] whilst Lady Hale stressed the vulnerability of patients in care settings as a factor of importance.[56]

From a human rights perspective, this reasoning presents a compelling case, as the inherent vulnerability of those under care, including mental health care, does not change when placed into a private, rather than public setting; the nature of their health condition and needs are not changed by the funding arrangements of their care. Human rights demand that rightsholders must be afforded equal protection, regardless of the circumstances of the violation. This was arguably the will of Parliament at the inception of the Human Rights Act. Such a position was, of course, vindicated by the later passing of s.175 of the Health and Social Care Act 2008, s.73 of the Care Act 2014, and most recently by the adoption of section 51 of the Mental Health Act 2025.

The case of *Sammut* highlights concerns of statutory exclusion and judicial inconsistency, resulting in a protection gap for victims of human rights violations in commissioned private mental health care settings, where their counterparts in public care would receive full protection. Restrictive legislative provisions, in tandem with unpredictable judicial decisions, deprive an acutely vulnerable section of society of full rights protection. The application of the legal framework surrounding mental health provision often entails the deprivation of liberty. Those placed in commissioned private care are therefore a distinctly vulnerable population. The exclusion of human rights review for this class of claimant is, therefore, particularly alarming.

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[52] See for example: *Hansard,* HL Deb 27 June 2007, vol 693; *Hansard,* HC Deb 18 February 2008, vol 472, cols 46-47; *Hansard,* HL Deb 6 May 2008, vol 701, cols 131GC-132GC.
[53] Lord Pannick, 'Functions of a Public Nature' (2015) 14 JR 109, 109.
[54] Williams, 'Public Authorities and the HRA 1998: Recent Trends', 181.
[55] [2007] UKHL 27*,* at [19].
[56] [2007] UKHL 27, at [67], [69-71].

It remains a positive obligation of states to provide protection to rights-holders regardless of the public or private context of the rights violation. To this end, in *Storck v Germany* the ECtHR made clear that the State's responsibility to protect against unlawful detention is not extinguished when it occurs in the context of private mental health provision.[57] On a moral level, the obligation to protect is arguably given even greater importance where vulnerable individual's rights are infringed by private actors whose services have been commissioned by the state. By contracting out, the State should not be able to opt-out of protecting fundamental rights. As Ferguson notes, the central focus of s.6(3)(b) is on the *nature* of the function, and this nature does not change when the function is outsourced to a private company.[58] Indeed, repeated Parliamentary interventions, both legislative and discursive, have made clear that the publicly funded provision of care by private providers should be considered public in nature. Nevertheless, legislative gaps and inconsistent and unpredictable judicial decisions continue to deny victims of commissioned private sector abuses access to justice. Without substantial reform, the plight of private-sector human rights victims is set to continue. Against this backdrop, the reforms under the Mental Health Act 2025 seek to address these gaps in accountability and rights protection.

Section 51 of the Mental Health Act 2025: addressing the gap?

When healthcare is outsourced to private providers, outside the remit of the exhaustive list of protected circumstances, judicial inconsistency in interpreting s.6 presents a serious issue for human rights protection. Cases such as *Sammut* demonstrate that the violation of an individual's rights will not be determinative in deciding whether a body is public or private. Private healthcare providers, deemed not to be exercising public functions, remain immune from human rights review, even where evidence suggests engagement in severe rights infringement. In a report published by the Joint Parliamentary Committee on Human Rights, it was proposed that Parliament pass legislation which provides protection under the Human Rights Act for *all* patients in receipt of publicly funded mental health treatment or after-care regardless of the status of the provider.[59] By removing the discretionary factor inherent within s.6's interpretation, all patients who are placed in outsourced private facilities by the NHS or local authorities would be equally protected by the Human Rights Act, regardless of the often Byzantine funding models.

[57] *Storck v Germany* [2005] ECHR 406.
[58] Erin Ferguson, '"Context is everything": public functions and the Human Rights Act 1998: an analysis of Sammut and Tortoise Media' (2026) PL 1, 5.
[59] Joint Committee on Human Rights, *'Legislative Scrutiny: Mental Health Bill'* at p.46.

Following the recommendations of the report, section 51 of the Mental Health Act 2025, amending the Mental Health Act 1983, extends the automatic application of s.6 of the Human Rights Act in circumstances such as Mr Sammut's. The Act makes substantial changes to the application of s.6 in the context of local authority and NHS commissioned private mental health care. Under the 2025 Act, s.117 aftercare, funded under the Mental Health Act 1983 automatically falls within the scope of s.6(3)(b).[60] Additionally, the Act seeks to ensure that any private service providing "medical treatment for mental disorder or assessment in relation to mental disorder, for an in-patient at a hospital"[61] is considered a public body under s.6 of the Human Rights Act, "where that treatment or assessment is arranged or paid for by an NHS body."[62]

These amendments make significant steps towards addressing the uncertainty faced by rights-holders transferred into NHS-commissioned private sector care. However, it only narrowly addresses the issue, expanding automatic protection only for those in care commissioned by the NHS, or s.117 aftercare. Ultimately, the reform fails to address the wider systemic injustice created by a selective and exclusionary model of justice which affords protection only to a specified class of claimant. Patients placed in private aftercare services, or NHS commissioned services, have now been added to this exclusive list of prioritised claimants, alongside those caught by s.175 of the Health and Social Care Act and s.73 of the Care Act. However, these settings are not the only areas where mental health care is commissioned by the state. For example, those placed into private care by a public body other than the NHS or a local authority are not captured by the Act's reforms. I discuss examples in more detail below, examining how the 2025 Act ultimately fails to close the protection gap in publicly commissioned private mental health care.

The human rights protection gap will remain despite the Mental Health Act 2025, in circumstances where a non-local authority, non-NHS, public body commissions private mental health services. Sections 175 of the Health and Social Care Act and s.73 of the Care Act only apply in narrow circumstances, where services are commissioned by Local Authorities and Health and Social Care trusts under provisions of the Acts.[63] Under the new Mental Health Act, this is expanded to include aftercare commissioned under s.117 of the Mental Health Act 1983, or more broadly where care is commissioned by an NHS body.[64] However, the duty to protect the mental health of individuals

[60] Mental Health Act 2025, s.51(2)(a).
[61] Mental Health Act 2025, s.51(2)(c).
[62] Mental Health Act 2025, C.52(2)(c).
[63] Health and Social Care Act 2008, s.145(1), (2)(a); Care Act 2014, s.73(3)(b).
[64] Mental Health Act 2025, s.51(2)(a)-(c).

is by no means limited to this narrow list of public bodies. Many other public bodies commission private mental health services in the pursuit of fulfilling their obligations.

Two significant examples are mental health services commissioned in the context of prisons and immigration detention centres. Each presents a pressing case study for the negative implications of the protection gap, arising from the deprivation of liberty inherent to each and the inherent vulnerability of those in receipt of mental health care whilst detained. Private services commissioned by these bodies remain outside the scope of the Health and Social Care Act, the Care Act and the new Mental Health Act and would thus be subject to judicial interpretation under s.6(3) of the Human Rights Act. Whilst this is not an automatic exclusion of review under the HRA, as I have explored above, the inconsistency of judicial interpretation of s.6(3) leads to significant uncertainty for rights-holders and may lead to injustices such as those seen in *Sammut.*

Prison services are under a duty to facilitate the wellbeing of prisoners under the Prison Act 1952.[65] In furtherance of this duty, they can commission mental health services from private providers. However, the status of these commissioned services, arising under the Prison Act, are not covered by automatic s.6 application and are therefore left to judicial determination. In this regard, there are some early indications that users of such services may succeed in s.6 cases. In *Carr v G4S Care and Justice Services (UK) Ltd,*[66] Mrs Justice Hill refused to strike out a claim brought under Article 2 of the Human Rights Act (Right to Life) on behalf of Andrew Carr, against a private healthcare provider (G4S) which had been commissioned to provide care in the prison at the time of his death. Hill J held that there was a real prospect of a court finding that the company was serving a public function for the purposes of Article 2 and s.6(3). Whilst positive news for that individual rights-holder, this ruling does little to settle the broader concerns and uncertainties associated with the application of s.6. Indeed, the reasoning in *Carr* focuses heavily on duties arising in the context of Article 2 specifically. As such, the position taken may provide little clarity to how private contractors in the context of other rights-violations may be understood. Indeed, as I have explored above, the decision in *Carr* could be overturned, distinguished, or ignored given the inconsistency between judicial opinions and methodologies in applying s.6. Incarcerated mental health patients cannot, therefore, be certain of the level of rights-protection afforded to them, since they do not benefit from the same cast-iron guarantee afforded to patients who fall within the scope of the new Mental Health Act. Rights abuse is not exclusive to detention settings, however, the absence of personal freedom, combined with the inherent vulnerability of mental health conditions situates

[65] The Prison Act 1952, s.47; The Prison Rules 1999, Rule 20(1).
[66] [2022] EWHC 3003 (KB).

it as perhaps one of the worst situations for rights deprivation to take place. It is critical therefore than any such abuses, be they from a public, or privately commissioned actor, be subject to intense scrutiny. Within the current legal framework, such scrutiny is far from guaranteed.

Immigration Detention Centres operate in a similar fashion to Prisons, where the Home Office retains the power to commission private mental health care for those held in detention.[67] Indeed, all immigration detention centres are currently commissioned to private providers, meaning that no potential rights violations occurring within these facilities are subject to automatic review under s.6. Unsurprisingly, issues related to commissioned providers and section 6 have arisen in the immigration sector. Whilst not concerning mental health provision, the case of *Ali (Iraq) v Serco Ltd*[68] illustrates the uncertainty at the heart of s.6 claims in the context of commissioned services in the immigration context. In fulfilment of the Home Secretary's obligations under section 95 of the Immigration and Asylum Act 1999 to provide accommodation to asylum seekers, a facility in Glasgow was contracted out to Serco Ltd. Mr Ali's asylum claim was rejected, and immediately following this, Serco initiated evictions proceedings without a court order. Mr Ali claimed this was in violation of Article 3 (Inhuman or degrading treatment) and 8 (Respect for Private and Family Life) of the ECHR. Intervening in the case, the Scottish Human Rights Commission made clear the negative impact of Serco's policies on a vulnerable group, leading to potential destitution and homelessness.[69] Reflecting on issues such as vulnerability, alongside the factors presented in *YL,* the lower court held that Serco was "taking the place of central government in carrying out what in essence is a humanitarian function"[70] and could therefore be considered a hybrid public body. Such a view, I argue, is clearly reflective of the intent of Parliament expressed at the passing of HRA and through subsequent discursive and legislative interventions. By focusing on the function of the body, alongside the inherent vulnerability of the claimant, the Court found a path which secured accountability for a private actor, operating within an arguably inherently public sector. Nevertheless, on appeal, Mr Ali's claim was dismissed. The Court of Appeal held that Serco was not discharging a public function but merely performing under a private contract.[71] The Supreme Court refused permission to appeal, holding that there was no arguable point of law.[72]

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[67] Immigration and Asylum Act 1999, s.153.
[68] [2019] CSIH 54.
[69] SHRC, 'Human rights arguments to be heard by court in Serco lock-change appeal' (28 August 2019) https://www.scottishhumanrights.com/news/human-rights-arguments-to-be-heard-by-court-in-serco-lock-change-appeal/
[70] *Ali (Iraq) v Serco* [2019] CSOH 34, at [31].
[71] [2019] CSIH 54.
[72] SHRC, 'Commission disappointed with Supreme Court decision on Serco appeal' (6 April 2020), https://www.scottishhumanrights.com/news/commission-disappointed-with-supreme-court-decision-on-serco-appeal/

Whilst contextually different, *Ali v Serco* illustrates the same systemic issue as *Sammut.* Each involve vulnerable individuals seeking redress for potential rights violations by a private actor commissioned by the State, and in each case, they were denied access to justice. The decision in *Ali* suggests that commissioned services within the immigration detention sector, including mental health services, may not receive protection or redress from potential rights violations. The protection of the rights of those held in detention by the state should be provided equal value, care and attention as those in traditional health and care settings, yet the disparities in application and attention speak to a neglect of certain rights-holders.

Other examples of remaining gaps in protection doubtless exist. Indeed, Baroness Keely, who proposed section 51 of the Mental Health Act, noted protection gaps in the areas of "NHS continuing healthcare and any healthcare for physical illnesses commissioned by the NHS" as well as "outsourced [child] social care and education".[73] These gaps are significant. In the context of education and mental health provision, there has been a growing recognition of the need for schools to provide mental health support to pupils.[74] Aspects of this support can be commissioned to external, private services.[75] Under the current and proposed legislative regime, it is unclear whether such commissioned services would be subject to human rights review. Arguably, some commissioned services might fall within the Care Act's 'local authority' clause[76] (although this is not a certainty), yet other school structures such as Academies, who receive funding direct from central government, would arguably sit firmly outside the automatic provisions.

The above examples serve to illustrate that private mental health care may be commissioned by a public body but fall outside the scope of the protections automatically afforded under s.6 by the s.175 of the Health and Social Care Act, s.73 of the Care Act, or section 51 of the Mental Health Act. Potential rights violations which occur under these circumstances would thus be subject to the same discretionary process as seen in *Sammut,* without being afforded the certainty of recourse, remedy or justice provided by the proposed reforms. It is impossible to describe all potential contexts where this may occur, and indeed, this is the very heart of the issue – the protection gap can only be closed by accounting for any such context by way of a blanket legislative intervention

[73] *Hansard*, HL Deb 2 April 2025, vol 845, col 335, per Baroness Keely.
[74] Department for Education, 'Mental Health and Wellbeing Provision in Schools: Review of Published Policies and Information Research Report' October 2018 https://assets.publishing.service.gov.uk/media/5bbf42ebe5274a360bba7952/Mental_health_and_wellbeing_provision_in_schools.pdf accessed 03.12.2025, 71-77.
[75] M. Garside and others, 'Mental Health Provision in UK Secondary Schools' (2021) 18 IJERPH 12222.
[76] Care Act 2014 s.73(3)(b)

which provides automatic public status to any publicly commissioned private mental health service provider.

Conclusion

The growth of private sector involvement in the provision of public services, particularly in the context of mental health services, presents significant challenges for the protection of fundamental human rights in the UK. The case of *Sammut v Next Steps Mental Healthcare Ltd* provides a lurid example of how the current statutory regime, in tandem with inconsistencies in judicial interpretations of section 6 of the Human Rights Act 1998, leave vulnerable individuals without recourse when their rights are violated by commissioned private mental health services.

In this article I have argued that the Mental Health Act 2025 represents a commendable and necessary first step towards closing the protection gap for those receiving private mental health care commissioned by the NHS or local authorities. Nevertheless, the Act fails to completely close the gap. Critically, it does not account for individuals whose care is commissioned by authorities other than those accounted for by the Health and Social Care Act 2008, the Care Act 2014 and the Mental Health Act 1983. As I have shown, these areas include particularly vulnerable groups, such as those held in immigration detention centres, prisons or even in education settings.

We must learn from the pitfalls of judicial interpretation of s.6(3) and the narrow scope of protection afforded by the new Mental Health Act. A broadening of the legislative reach of the Act is necessary to capture all commissioned private mental health providers. This framing shifts the focus away from considerations such as funding or institutional links, towards an acknowledgment of the power and control held by private actors over vulnerable populations in the provision of essential services. From a human rights perspective, such realignment better reflects the obligations held by the state towards rights-holders; significantly expanding the scope of protection for human rights by ensuring that no individual is denied access to justice simply because of how their care was funded. Ultimately, until the human rights accountability gap is closed across *all* care settings, the UK will continue to fail in its fundamental duty to protect its most vulnerable citizens.