THE CONCEPT OF 'BEST INTERESTS' IN THE TREATMENT OF MENTALLY DISORDERED PATIENTS IN THE UNITED KINGDOM: A LEGAL ANATOMY*

Abstract
Mental disorder is simply any disorder or disability of the mind. The concept of best interests requires that a decision maker should make decisions which will be in the overall best interests of the incapacitated person. Until the coming into existence of the Mental Capacity Act (MCA), there was no statutory framework for making decisions for persons who lack capacity especially the mentally disordered persons. However, the concept of best interests has no place in the MHA as patients may be detained, assessed and treated without consent and certification. This research considered the concept of best interests in the treatment of mentally disordered patients in the United Kingdom by reviewing the Mental Health Act and the Mental Capacity Act as well as the provisions of the European Convention on Human Rights. The writer found as its key recommendations that Section 131 of the Mental Health Act be amended to incorporate the best interests reasoning and that both the Mental Health Act and the Mental Capacity Act (MCA) should be amended to contain an appraisal of the eminence of the European Convention on Human Rights especially Articles 5 and 8 of the Convention.

Keywords: Best Interests, Mental Disorder, Mental Health, Mental Capacity, Patients.

1. Introduction

Until the coming into existence of the Mental Capacity Act[1] (MCA), there was no statutory framework for making decisions for persons who lack capacity especially the mentally disordered persons. The mentally disordered patients are usually detained, assessed, treated or placed under the Mental Health Act (MHA)[2]. The detention, assessment, treatment and placement are usually done without consent and based mainly on the medical practitioners' or local authorities' sole decisions and discretions; the only qualification being to safeguard the life or health of the patient or that of the others. This qualification more often leaves the medical practitioners, local authorities as well as carers on a blink because of lack of clarity as to what decision was or was not carefully taken. The treatment and placement without consent under the Mental Health Act[3] has resulted in a lot of court cases and has created a great degree of divergence more especially with the provisions of the European Convention on Human Rights (ECHR)[4] which enshrined the Universal Human Rights. Those universal rights enshrined under the Convention include the right to physical liberty, security and autonomy[5] of which the courts have in several decided cases ruled in favour of. There also abound a huge divergence in treatment without consent under the Mental Health Act[6] and treatment after consideration of the patient's best interests under the Mental Capacity Act.[7] Under the MCA, patients must be treated in their best interests.[8] However, the concept of best interests has no place in the MHA as patients may be detained, assessed and treated without consent and certification.[9] To the strict adherents of the MHA, bringing in the best interests decisions and guidelines as contained in the MCA will warrant an unnecessary legal impediment to medical practitioners, carers and other health professionals in carrying out their routine and strictly necessary activities and would also more likely than not be antagonistic or injurious to the patient's own medical interests. On the other hand, the adherents of the concept of best interest under the MCA have argued that the incorporation of the broader best interests' guidelines and decisions will be necessary to protect patients' universal human rights enshrined in the ECHR and as well, promote the social and cultural values of the society.

This study will x-ray the extent of divergence in the treatment without consent under the MHA and the treatment in the patient's best interests under the MCA as well as the eminence of the universal rights of every individual to physical liberty and autonomy enshrined under the ECHR - noting the inherent flaws occasioned by the divergence in the application of the provisions of the above-mentioned legislations, case laws and policies.

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[1] 2005, c.9.
[2] c.20.
[3] 1983, c.20.
[4] 1953.
[5] Articles 5 & 8 of the ECHR.
[6] 1983, c.20.
[7] 2005, c.9.
[8] Sections 1 (5), 4 (1-11) of the MCA, 2005.
[9] Parts II and IV of the Mental Health Act, 1983.

Against this background, the writer proposes to drive home the contents of this essay under the following headings:

i. Definition of key terms;
ii. Different ways of making decisions for others;
iii. Best interests concept under the MCA;
iv. Treatment under the MHA and the concept of best interests;
v. The rights of mentally disordered or incapacitated persons under the ECHR;
vi. Areas of divergence between the MHA and the MCA in the treatment of mentally disordered or incapacitated persons and the flaws inherent; and
vii. Conclusion and Recommendations.

2. Mental Disorder

Defining mental disorder is difficult because it has no unitary condition. The definition of mental disorder adopted by any national legislation depends on many factors which may include the purpose of the legislation, the social, cultural, economic and legal context in different societies. Mental disorder can cover mental illness, mental retardation, personality disorders or even substance dependence. The Mental Health Act[10] defined mental disorder as: 'any disorder or disability of the mind….'[11] The Mental Capacity Act[12] did not define mental disorder but dwelt more on persons who lack capacity and treatment in their best interests.[13] Thus, the treatment in the patients' best interests envisaged under the MCA goes beyond treatment of patients suffering from mental disorder as defined under Section 1(2) of the Mental Health Act[14] but to any patient suffering any mental disability which prevents him or her from taking relevant decisions for his or herself. The MCA envisages for an alternative concept wider than the definition of mental disorder under the MHA. It brings into the realm, the 'concept of mental disability' which prevents a person from taking relevant decisions for his or herself. Bertolote and Sartorius define the concept 'disability' as: 'that which refers directly to peoples' immediate perception of their lives, their environment and their needs and limitations'.[15]

3. Incapable Patients

A person must be assumed to have capacity unless it is established that he lacks capacity.[16] The MCA states that: '…a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of or disturbance in the functioning of the mind or brain'.[17] The Act went further to buttress that it does not matter whether the impairment or disturbance is permanent or temporary.[18] Against the foregoing background, incapable patients are persons who lack capacity to, or are at one time or another unable to make relevant decisions for themselves because of an impairment or disturbance of the mind or brain. However, lack of capacity must be expressly established before the law is allowed to intervene in the person's life.[19]

4. Different Ways of Making Decisions for Others

There are three main ways of making decisions for others namely: advance decisions, substituted judgments and best interests.[20]

Advance Decisions

A person with a mental disorder or who lacks capacity may during periods when he/she is well or sound, determine what he/she finds acceptable and unacceptable. Thus, one way of making decisions for people who lack capacity is to abide by the wishes they made when they are well and had capacity. This method is referred to as 'advance

[10] 1983, c.20.
[11] Section 1(2) of the Mental Health Act, 1983, c.20 – This definition was as a result of the 2007 MHA (c.12) which amended the MHA 1983.
[12] 2005, c.9.
[13] Sections 1,2,3 & 4 of the Mental Capacity Act, 2005.
[14] 1983, c.20.
[15] Bertolote J M, Sartorius N (1996) WHO initiative of Support to people disabled by mental illness, some issues and concepts related to rehabilitation, European Psychiatry 11 (Suppl. 2) p. 565.
[16] Section 1 (2) of the Mental Capacity Act, 2005, c.9.
[17] Ibid., s. 2 (1) d.
[18] Ibid., s.2 (2).
[19] Ibid., s.1 (2) (3).
[20] Buchana, A. & Brock, D. 1990 'Deciding for Others'. Cambridge University Press, Annon.

decisions method' or 'advance directives'. For instance, Sections 24 and 25 of the MCA[21] give persons who lack capacity right to make advance decision to refuse treatment.[22]

Substituted Judgment
This method of making decisions for others entails that someone making decision for another should make the decision they believe the incapacitated person would have made if that person had the capacity to make the decision.

Best Interests
This requires that a decision maker should make decisions which will be in the overall best interests of the incapacitated person. To do so, what will be in the best interests for the incapacitated person both now and in the future will be considered.[23] Finally, the MCA incorporates the elements of these three ways of making decisions in the checklists provided for under Sections 4, 24 and 25 of the Act.[24] However, the overriding factor is that of best interests which is in the form of statutory safeguards to the procedure for deprivation of liberty of mentally incapacitated persons.

5. The Best Interests Concept under the Mental Capacity Act
The overriding model for taking decisions for incapacitated persons under the MCA is that of best interests.[25] This said model envisages that any act done on behalf of any persons who lacks capacity must be done in the person's best interests. The MCA defines the legal framework for making best interests decisions for persons who lack capacity - either to make such decision or consent to same. Although there is no definition of best interests under the MCA, it however, outlines some statutory checklists in the form of factors to be considered when making decisions on behalf of a person who lacks capacity to do same.[26] The MCA[27] requires carers and professionals to first of all ascertain and ensure that a person actually lacks capacity to make decisions for himself/herself before making any decision on his/her behalf.[28] The next step would be to follow the process of decision making as laid down in Section 4 of the Act.[29] The statutory checklist provided for under Section 4 of the MCA is overly premised on many viable principles to wit:

i. A presumption that every person has the capacity and right to make relevant decisions for his or herself;[30]
ii. The right of individuals to be supported to make their own decision;[31]
iii. The right of an individual to make decisions for his or herself even if the decision is seen as unwise;[32]
iv. Any act or decision on behalf of people that lack capacity must be in their own best interests;[33] and
v. The right of every individual to physical liberty, autonomy and the right to less restrictive decisions.[34]

6. Treatment under the Mental Health Act (MHA) and Concept of Best Interests
Under the Mental Health Act,[35] a person with mental disorder or who is mentally incapacitated may be admitted or detained in a hospital for a period of time without his own consent for the reasons of his own health, safety and protection of other persons.[36] Moreover, Part IV of the Act[37] provides that treatments may be given without the detained patient's consent, whether in emergency situations, or in any other situation(s) in order to safeguard the patient's life or health, or that of other persons.[38] The legal/legislative basis for the above informal detention, admission, assessment and treatment are also provided for in the MHA to wit:

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[21] 2005, c.9.
[22] See also Section 4(6) of the Mental Capacity Act which requires decision makers to consider both the present and past wishes of the person who lacks capacity.
[23]See Section 4 of the Mental Capacity Act which provides statutory checklists to be considered before ascertaining the best interest choice.
[24] MCA, 2005, c.9 - See also its Section 4(1-7).
[25] Ibid., s.1(5).
[26] Ibid., s.4.
[27] 2005, c.9.
[28] MCA, 2005, c.9, s.1 (2-4).
[29] Ibid.
[30] Ibid., s.1(2).
[31]Ibid., s.1(3).
[32]Ibid., s.1(4).
[33]Ibid., s.1(5) .
[34]This reasoning is imported from the provisions of Articles 5 & 8 of the ECHR which enshrine the universal right to physical liberty and autonomy.
[35] 1983, c.20.
[36] MHA, 1983, c.20, ss.2 & 3.
[37] MHA, 1983, c.20.
[38]MHA, 1983, c.20, ss. 58, 62 & 63.

> Nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or registered establishment in pursuance of arrangements made in that behalf and without an application, order or direction rendering him liable to be detained under this Act…[39]

Notwithstanding that the MHA provides that the legal basis for informal admission, detention and treatment of a person with mental disorder would be to preserve and safeguard the life and health of the patient and that of other persons, it did not provide the legal tests or guidelines for making such decisions.[40] The question then to be asked is: *'*what is the legal test for justifying treatment of mentally disordered persons without consent under the Mental Health Act?'

7. The Rights of the Mentally Disordered or Incapacitated Persons under the European Convention of Human Rights (ECHR)

In the case of *Surrey County Council v P & Ors Cheshire West and Chester Council VP & Another*[41] the Supreme Court per Baroness Hale of Richmond DPSC affirmed that: 'The whole point about human rights is their universal character. The rights set out in the European Convention are to be guaranteed to 'everyone': Article 1. They are premised on the inherent dignity of all human beings whatever their frailty or flaws….' The purport of the above statement is that rights set out in the ECHR are the same for everyone (i.e. inalienable), regardless of whether or not they are mentally or physically disabled. In line with the above affirmation, Article 14 of the ECHR[42] provides thus: '...the enjoyment of the rights and freedoms set forth in this convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status'. Mentally disabled persons therefore, are entitled to the fundamental rights guaranteed under the Convention. These rights include right not to be subjected to torture or inhuman treatment[43] and right to physical liberty and security.[44] Throughout the 19th century till date, the right to physical liberty and autonomy of people with disabilities (for example, people with mental disorder) has constantly been breached by countries, medical practitioners, carers, professionals and individuals but it is worthy to note, however, that courts have thus in many decided cases in line with the provisions of the Convention forestalled the rights to physical liberty of persons with disabilities as well as heralded the concept of best interests.[45]

8. Areas of Divergence between the Mental Health Act and the Mental Capacity Act in the Treatment of Mentally Disordered or Incapacitated Persons and the Inherent Flaws

There exist wide divergences between the provisions of the Mental Capacity Act[46] and that of the Mental Health Act[47] in relation to treatment of mentally disordered or incapacitated persons. Under the MHA, a person with mental incapacity may be detained, assessed and treated in a hospital without the person's consent for reasons of his own life, health, safety and that of the other persons.[48] Part IV of the Mental Health Act[49] provides that a detained patient may be treated without consent on several instances which include: (i) urgent treatment;[50] and (ii) mental disorder.[51]

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[39] Ibid., s.131(1).

[40] This explains why the Government's White Paper on Reforming the Mental Health Act proposes a single framework for the application of compulsory powers of care and treatment.
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4058916.pdf [accessed on the 3rd of May, 2015].

[41] [2014] UKSC 19 paragraph 36.

[42] 1953.

[43] ECHR, 1953, Art. 3.

[44] Ibid., Art. 5 (1).

[45] See the cases of *Re F ((Mental Sterilization)* [1990] 2 AC 1; *HL v United Kingdom* [2004] 40 EHRR 471; *Stanev v Bulgaria* [2012] 55 EHRR 696 para 118, where the court held that there was deprivation of liberty 'where the applicant was an adult incapable of giving his consent to admission to a psychiatric institution which, nonetheless, he had never attempted to leave'; *Re Y (Mental Incapacity: Bone Marrow Transplant)* [1996] 2 FLR 787; *Re A (Male Sterilization)* [2000] 1 FLR 549 CA; *Burke v The General Medical Council* [2004] EWHC 1879 (admin); *Surrey County Council v P & Ors and Cheshire West & Chester Council VP & Another* [2014] 19 UKSC 896.

[46] 2005, c.9.

[47] 1983, c.20.

[48]Mental Health Act, 1983, c.20, ss. 2 and 3.

[49] Ibid..

[50] Ibid., s. 62.

[51] Ibid., s. 63.

Moreover, under the MHA, persons with mental disabilities can be informally placed into the care of local authorities or guardians.[52] Coincidentally, just as the hospitals could admit and treat persons with mental disorder informally, the local authorities and the other registered establishments can also admit patients with mental disorder without certification. The legal basis for such admissions is found from the provision of Section 131(1) of the Mental Health Act.[53]

The underlying question which arises from treatment of mentally disordered persons under the MHA is: 'What is the legal basis or test for the justification of the informal detention, assessment, treatment or confinement or placement of mentally disordered persons under the Mental Health Act?' The developing case laws, policies and the Mental Capacity Act have provided the answers to the above question. Initially, the developing case laws involved the courts in deciding whether a medical treatment was in the best interests of the mentally incapacitated patient. Another area where there has been series of controversies and flaws with regards to treatment of mentally incapacitated persons is in the area of living arrangements and care made on behalf of mentally incapacitated persons. The question has always been about the criteria for judging whether the living arrangements and care made for mentally incapacitated persons amount to deprivation of their liberty? Before the introduction of the deprivation of liberty safeguards or checklists into the Mental Capacity Act,[54] there was no formal criterion for checking whether the living arrangements made on behalf of the mentally incapacitated person are in their best interests. Apart from the court authorizing the living arrangements, the Mental Health Act[55] did not provide any criteria. Carers, institutions and local authorities who make those living arrangements for mentally incapacitated persons with hope and belief that the arrangements they have made were indeed the best were more often dragged to court.

Ever since the coming into force of the European Convention on Human rights,[56] many cases have come to the court either for the court to decide whether the living arrangements made on behalf of a mentally incapacitated person by the local authorities or other institutions amount to deprivation of liberty or whether such deprivation of liberty can **be** justified. Before the introduction of the statutory checklists in the form of factors to be considered before taking a decision on behalf of an incapacitated person under the *Mental Capacity Act,*[57] the Court had in deciding the cases brought before it, either held that:

i. Incapacitated persons must be treated in their best interests;
ii. A living arrangement made on behalf of a mentally incapacitated person where her/he is under continuous supervision and control and is 'not free to leave' amounts to deprivation of right and liberty;[58] and
iii. The rights set out in the ECHR are for everyone.

In *Re D-R (Contact: Mentally Incapacitated Adult),*[59] the court held that it will be in the best interests of a young woman with a learning disability not to have contact with her father, who she had not seen for some time as that would not be meaningful to her; would confuse her and would cause conflict with other family members. In *Re F (Adult: Court's Jurisdiction),*[60] the court held that it was in the best interests of an 18 year old learning disabled woman to be placed by the local authority, rather than staying with her mother who usually neglects and abuses her.[61] In *HL v United Kingdom,*[62] the European Court of Human Rights held that HL, an autistic and profoundly mentally disabled who was sedated and taken away from his foster carers to a psychiatric hospital on the call of a social worker and was restricted had been deprived of his Convention right to liberty. Both in the HL case above and other decided cases, the courts have held that the criteria for ascertaining whether a mentally incapacitated person's right to liberty as enshrined under the Convention has been breached would be: 'whether the mentally incapacitated person is 'free to leave' the care placement'.[63] The court in *JE v DE*[64] explained what 'free to leave' means thus:

[52] Ibid., ss. 7 and 13.
[53] 1983, c.20.
[54] 2005, c.9.
[55] 1983, c.20.
[56] 1953.
[57] 2005, c.9.
[58] *Cheshire West and Chester Council VP v Surrey County Council V P* [2014] UKSC 19, Mental Capacity Act 2005, c.9, s.4.
[59] [1999] CA 2 FCR 49).
[60] [2001] Fam 38.
[61] See also *Re S (Adults lack of capacity: Carer and residence)* [2003] EWHC 1909 (fam).
[62]. [2004] 40 EHRR 761.
[63] See the cases of: *HL v United Kingdom* [2004] 40 EHRR 761, para 91; *Austine and Others V. United Kingdom* [2012] 5 EHRR 359 *Stanev v Bulgaria* [2012] 55 EHRR 962.
[64][2007]2 FLR 1150 para 115.

> …the fundamental issue in this case… is whether De was deprived of his liberty to leave the X home and whether De has been and is deprived of his liberty to leave the Y home. And when I refer to leaving the X home and the Y home, I do not mean leaving for the purpose of some trip or outing approved by SCC or by those managing the institution; I mean leaving in the sense of removing himself permanently in order to live where and with whom he chooses….

Against this backdrop, it can be seen that the human rights set out in the European Convention are for everyone whether or not they are mentally or physically disabled. The rights include the rights enshrined by Article 5 (right to physical liberty)[65] and Article 8 (right to respect for private and family life and the home).[66] As a result, the courts have given guidance that where a mentally incapacitated persons is to be deprived of his liberty either by placement in a hospital or a registered care home or in another living arranged home, such deprivation must be authorized by the court or after a diligent consideration of the deprivation of liberty safeguards set out in the *Mental Capacity Act*[67] in order to ensure that the affected person's best interests is achieved.

9. The Courts on Whether a Medical Treatment was in a Patient's Best Interests

There abound lots of uncontroverted decided cases wherein the courts have confirmed and heralded the prominence of the concept of best interests in treatment of mentally disordered persons or mentally incapacitated persons. In *Re F (Mental Patient; Sterilisation),*[68] the House of the Lords affirmed that persons who lack capacity can be treated without consent but such treatment must be in their best interests. In *R (on the application of N) v Dr M,*[69] the court also held that there is an obligation placed upon medical professionals and carers to consider patient's best interests as well as medical necessity in approving treatment. The courts further expanded the concept of best interests beyond medical best interests. In *Re S (Adult Patient: Sterilization),*[70] the court affirmed that the best interests test embraces issues wider than medical. In *Re MB (Medical Treatment),*[71] the court decided that it will be in the best interests of a woman patient to undergo a caesarean section for her best interests would be served by giving birth to a baby who was alive and healthy.[72] Again, in *Re A (Male Sterilization),*[73] the court held that it is in the best interest of a 28-year-old-man with Down's syndrome not to have a vasectomy as wanted by the mother. In *Re S,*[74] the court also noted that the duty of the medical professionals was of two folds namely: (i) To act in accordance with competent, responsible and relevant medical opinion; and (ii) To act in the best interests of the patients. The court in *Re Y (Mental Incapacity: Bone Marrow Transplant)*[75] considered both social and welfare benefits as against medical and emotional non-benefits, before affirming that the patient's social and welfare benefits outweighed the medical and emotional non-benefits. The court granted the permission for severely learning disabled woman to donate her bone marrow to her seriously ill sister. Flowing from the foregoing background, it is crystal clear that the courts in dealing with the flaws inherent in the treatment of mentally disordered or incapacitated persons necessitated by the divergence between the provisions of the MHA and the MCA have decided in favour of the concept of the best interests under the Mental Capacity Act.[76] The courts, in the above discussed cases, incorporated the best interests' balance sheet approach in considerations of patient's best interests taking a shift from the stricter confines of the Mental Health Act;[77] making sure that there is nothing ruled out of consideration in assessment of patients best interests. This echoes the age-long credence given by the courts in organ donation cases - even by an incompetent adult[78] wherein the Court of Appeal in Kentucky affirmed the decision of a Circuit Court based on the benefits (best Interests) that will accrue to the incompetent donor.[79] The principles laid down in the above discussed cases have now been codified in the Mental Capacity Act.[80] Section 4 of the MCA[81] provides a checklist or factors to be considered when assessing the best interests of a patient.

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[65] ECHR, 1953.
[66] ECHR, 1953.
[67] 2005, c.9.
[68] *Re F (Mental Patient: Sterilization)* [1990] 2 AC 1.
[69] *R (on application of N) v. Dr. M* [2002] EWCA Civ 1789.
[70] *Re S (Adult patient: sterilization)* [2001] Fam 15.
[71] *Re MB (medical treatment)* [1997] 2 FCR 941.
[72] The judge further stated in this case that best interests are not limited to medical best interests.
[73] [2000] 1 FLR 549 CA.
[74] *An Hospital NHS Trust v. S* [2003] EWHC 365 (Fam).
[75] [1996] 2 FLR 789.
[76] 2005, c.9.
[77] 1983, c.20.
[78] *Strunk v Strunk* [445 s.w. 2d 145] 1969.
[79] See also the case of *Little v Little* [Tex Civ 1979], 576 sw 2d.493.
[80] 2005, c.9, ss. 1(5), 2,3,4,5 and 6.
[81] MCA, 2005, c.9.

10. The Impact of the Express Exclusion of Mental Capacity Act in Mental Health Act Cases

By virtue of *Section 28 of the Mental Capacity Act*,[82] the MCA is expressly excluded from consideration when a patient is detained and to be treated under *Part IV of the MHA.* The question which will come to the mind of any individual who has gone through series of court decided cases in relation to treatment of mentally disordered or incapacitated patients would be: 'if the MCA is expressly excluded from being applicable to Part IV of the MHA, what is the legal basis and tests for the decisions taken on behalf of incapable patients by others without their consent?' Again, 'what is the legal test for justified treatment without consent under the MHA and the extent to which best interests reasoning under the MCA will make a negative impact in the treatment of mentally disordered or incapable patients?' Remarkably, albeit the MCA is expressly excluded from being applicable to Part IV of the MHA, the reasoning contained in the MCA has found its way into Part IV of the MHA through the back door. In order for the *Convention Rights*[83] of any incapacitated patient to be preserved in MHA detention and treatment, the best interests tests and safeguards as provided for in the MCA automatically becomes desirable and applicable and then, there becomes a convergence between both Acts – which the courts have pointed out and ruled for in several decided cases.[84]

11. Conclusion and Recommendations

The fundamental flaws witnessed in the ways we treat mentally disordered or incapacitated patients necessitated because of the divergences or incoherence between the provisions of the Mental Health Act,[85] Mental Capacity Act,[86] the European Convention on Human Rights[87] as well as the Case laws will continue to exist and form subject of court litigations unless there will be a convergence between the Mental Health Act and the Mental Capacity Act in relation to the treatment of mentally disordered or incapacitated persons subject to eminence being given to the Convention Rights which are for everybody whether incapacitated or not. There is no doubt that human rights of people with disabilities whether mental or physical might sometimes be limited or restricted and decisions either for treatment, assessment, placement or care taken by another on their behalf. However, applying the best interests' balance sheet as contained in the Mental Capacity Act and the case laws in all cases, whether for detention and treatment or for placement and care, will see to the collapse of the flaws and controversies witnessed in the way mentally disordered or incapacitated patients are being treated. In conclusion, owing to the fact that people with disabilities both mental and physical, have the same human rights as with every human being and in order to preserve the said human rights; as well as to checkmate the flaws in the way mentally disordered or incapacitated persons are being treated – due to the incoherence between the provisions of the Mental Health Act[88] and the Mental Capacity Act,[89] the writer recommends as follows:

i. That the best interests reasoning be incorporated in cases under the Mental Health Act.
ii. That Section 28 (1) of the Mental Capacity Act which excludes the Act from been applicable to Part IV of the Mental Health Act should be expunged from the MCA.
iii. That both the Mental Health Act and the Mental Capacity Act be amended to bring in provisions that would make both Acts serve as a bedrock to each other (that is, complementary to each other). This move would amount to an eclectic approach with the goal of seeking to maximise the best constituents of the two Acts.
iv. That Section 131 of the Mental Health Act be amended to incorporate the best interests reasoning.
v. That both Acts be amended to contain an appraisal of the eminence of the European Convention on Human Rights especially Articles 5 and 8 of the Convention.
vi. That Part IV of the Mental Health Act should also be amended to incorporate the best interests' safeguards.

[82] 2005, c.9.
[83] See for example Article 5 (right to personal liberty), Article 3 (prohibition of torture and degrading treatment), Article 8 (individual autonomy of personal decisions) of the European Convention on Human Rights, 1953.
[84] *Re F (mental patient: sterilization)* [1990] 2 AC 1, *HL v United Kingdom* [2004] 40 EHRR 761, *An Hospital NHS Trust v S* [2003] EWHC 365 (fam).
[85] 1983, c.20.
[86] 2005, c.9.
[87] 1953.
[88] 1983, c.20.
[89] 2005, c.9.