

The Other Side of the Table?

Mental Health Tribunal Members' Association 2014

17 October 2014

Lady Hale, Deputy President of the Supreme Court

Children usually want to be seen as normal and ordinary, not to stand out in the crowd, and I suspect that most adults, even the most extraordinary adults, feel the same. But even if we do not want to be seen as the same as other people, because we are all different individuals, we want to be treated in the same way as other people are treated. “Normalisation” has been the great goal of the mental health world for more than half a century. But over the last fifty years we seem to have completely changed our minds about what normalisation might mean.

I first encountered mental health law in 1970, when the advent of generic social work meant that the course in law for child care officers which I had been teaching at Manchester University had to broaden into other areas including mental health. This was only ten years after the Mental Health Act 1959 had come into force. That Act was based on normalisation principles which will have seemed revolutionary then. People with mental disorders and disabilities should be treated in the same way as people with physical illnesses and disabilities. So:

- (1) The facilities where they were looked after should be part of the mainstream health and social services, not segregated into a separate service where special

rules and regulation applied. Warehousing them in large institutions, originally on the outskirts of town or in the countryside, was to be phased out.

(2) They should be admitted to those facilities in the same way as any other patient or resident, without special judicial formalities. What lawyers might call “safeguards” were now called “formalities” and were to be avoided wherever possible.

(3) Those very few who could not be looked after in the normal way might be subjected to compulsory procedures but these should be as “light touch” as possible, decided upon by professional consensus and subject to independent specialist review, rather than the ordinary judicial process (that was only thought necessary where property – usually large amount of property – was involved). Anything else was “legalism”, which was a dirty word.

All of this was indeed a great improvement on what had gone before. At first, it meant that there was almost no such thing as “mental health law”. Lawyers were not involved in the compulsory processes and were hardly ever seen in mental health review tribunals. Then two things happened. A young Larry Gostin became legal officer of MIND and set about subjecting the English law to an American constitutionalist scrutiny. And a young solicitor called Michael Napier encountered the case of Mr X, recalled to Broadmoor after some years of freedom with absolutely no way of challenging the reasons for this. Their separate efforts led to some important reforms which tightened the legal safeguards for compulsory patients. Public funding became available to represent patients before

tribunals and so lawyers became increasingly involved. Case law, which had been virtually non-existent in the 1960s and 1970s, rocketed in the 1980s and 1990s.

But all of this effort was directed towards compulsory patients. And this meant compulsory hospital patients. Such fragmentary procedures as there were for compulsion outside hospital were scarcely ever used. Most compulsory patients were “sectioned” under the compulsory procedures for non-offenders, and in practice these were only invoked for patients who actively objected to their admission, detention or treatment. Hence the great majority were cared for, whether in hospital or at home or somewhere in between, without formalities. We all thought that this was a good thing.

There was, of course, a worry that some people might agree to their admission and treatment, knowing that there was a real risk that they would be “sectioned” if they did not. But on the whole there was much less worry about people who were unable to make decisions for themselves, but were compliant with whatever the professionals thought best for them. It was only during the 1980s that some began to worry about the juridical basis for looking after people who lacked the capacity to agree to their own treatment or care.

The people concerned fell into two main categories. There were older people with some form of dementia and there were younger people with mental disabilities or brain damage. Most of the people in either group were no longer looked after in hospitals, but in care homes or other placements or their own homes. Most of them were not seen as

candidates for compulsory psychiatric treatment, although some might still fall within the definition of mentally disordered for the purpose of the Mental Health Act. Most mentally disabled people, however, were taken out of the scope of the long term compulsory procedures by the 1982 amendments. The issues were not with compulsory psychiatric treatment but with their living arrangements and with ordinary medical treatment for physical disorders and diseases.

In the late 1980s, encouraged by The Law Society, the relevant voluntary organisations, parents and carers, the Law Commission began a project on mentally incapacitated adults to examine whether there was a need to clarify and reform the law. Then along came *Re F (Mental Patient: Sterilisation)*¹, which clarified several things. (1) There was no process for appointing some-one to take decisions on behalf of an adult person who was unable to take them for herself; but (2) it was lawful under the doctrine of necessity to take decisions for her provided that this was in her best interests; and (3) in cases of doubt or difficulty the High Court could declare whether a proposed course of action would, or would not, be lawful.

Nevertheless, the Commission thought that there was still a need for law reform and pressed on with the project, which reported in 1995.² The main aims were: (1) to emphasise the presumption of capacity; (2) to provide a principled but workable definition of incapacity, which would be decision-specific and might fluctuate from time to time; (3) to preserve but clarify the necessity principle as a reassurance to carers and

¹ [1990] 2 AC 1.

² Law Com No 231, *Mentally Incapacitated Adults*.

health workers; (4) to preserve but clarify the “best interests” principle, emphasising that even if a person lacked the capacity to decide for herself, she was still an individual with her own wishes and feelings which should be carefully considered when deciding what was best for her (it is not in the best interests of anyone to make them eat food, however nutritious, which they do not like); (5) to allow people who had capacity to provide for their own future incapacity by appointing proxy decision makers and/or making advance decisions about their medical treatment; and (6) providing a jurisdiction to resolve issues about a person’s care and welfare as well as her property and affairs.

The Commission’s proposals were generally welcomed but it took the government a long time to decide what to do with them. In the meantime the Family Division had developed the declaratory jurisdiction recognised in *Re F* into something very like a full-blown welfare jurisdiction – so perhaps it did not look so revolutionary to implement our proposals. Ten years after our report, the Mental Capacity Act 2005 was passed. (This is not quite a record from report to implementation: our 1985 report recommending the abolition of blasphemy was implemented in 2008.) Commentators were generally complimentary about the underlying principles, the emphasis on autonomy and normality wherever possible, and the simplicity of its language and structure. Paul Bowen has kindly described it as “an elegant piece of legal architecture”.

Even as the Act was passed, however, we knew that it was incomplete. In *HL v United Kingdom*³, the European Court of Human Rights had decided that the necessity principle

³ (2004) 40 EHRR 761.

did not provide enough (indeed any) safeguards for people who were deprived of their liberty within the meaning of article 5 of the European Convention. The lack of procedural safeguards meant that their detention could not qualify as the “lawful” detention of persons of unsound mind for the purpose of article 5(1)(e); and they were also entitled to the benefit of regular reviews of the continued lawfulness of their detention.

HL, you will remember, had spent many years living in a hospital but had then been placed with professional foster parents. A head-banging episode at his day centre had led to his being sedated and taken to hospital where he was kept for several weeks and at first not allowed to see his foster parents in case he wanted to leave with them. So they brought habeas corpus proceedings. A majority of the House of Lords held that he was not even detained, which Lord Steyn described as a “fairy tale”. But they all agreed that his stay in hospital was justified at common law by the doctrine of necessity.⁴ This was before the Human Rights Act, so their lordships did not have to grapple with article 5 (I don’t think that it was even mentioned).

No doubt the Department of Health hoped that the UK would win in Strasbourg – I confess to having had mixed feelings about it, because I had been brought up to believe that the lack of stigmatising and bureaucratic formalities for treating people who were unable to make their own decisions was a good thing rather than a bad thing. When the UK lost the case, the government had to decide upon a policy to put things right, but did

⁴ *R v Bournewood Community and Mental Health NHS Trust, ex parte L* [1999] 1 AC 458.

not want to hold up the Mental Capacity Bill while it did so. So the original version of the Act merely made it clear that the necessity principle codified in section 5 of the Act did not authorise a deprivation of liberty within the meaning of article 5 (at least I think that that was what section 6(5) meant). As amended by the Mental Health Act 2007, the 2005 Act now provides that a person may only be deprived of her liberty by an order of the Court of Protection or in accordance with the deprivation of liberty safeguards (the DoLS) provided for in Schedule A1 to the Act (section 4A).

For reasons which I do not know, the DoLS are only able to authorise the deprivation of liberty in a hospital or registered care home. Deprivation in any other setting can only be authorised by the Court of Protection. It may be that the government thought that keeping a person in some other setting would not amount to a deprivation of liberty for which the State would be held responsible. It may indicate an understandable assumption that keeping someone in a “normal” setting does not deprive her of her liberty. Until March this year they had some justification for that assumption. But in *Surrey County Council v P; Cheshire West and Chester Council v P*,⁵ the Supreme Court, by a majority of four to three, held otherwise.

The Surrey case concerned two sisters, whose initials were MIG and MEG, both with severe learning disabilities. They were removed from their abusive family in care proceedings while they were still children. One was placed in a foster home, where she was provided with support in most aspects of her daily life. She was happy there and

⁵ [2014] UKSC 19, [2014] AC 896.

showed no inclination to leave but had she done so she would have been prevented. The other sister was less happily placed in a small specialist home for adolescents. She required continuous supervision and control. She too showed no wish to go out on her own but would have been prevented if she did. Both attended the same education unit. In other words, their living arrangements were as close to normal home life as they could be, consistent with catering for their needs. The case was in court because of the care proceedings but was transferred from the Family Division to the Court of Protection when the sisters reached the ages of 17 and 16. Parker J held that the arrangements were in the sisters' best interests and did not constitute a deprivation of liberty.⁶ The Court of Appeal agreed.⁷

The Cheshire case concerned a 39 year old man, with cerebral palsy and Down's syndrome. He was placed in a bungalow near his mother's home which he shared with two other residents and members of staff. He was taken out to a day centre and other social activities and to see his mother. But he did from time to time have to be restrained, or otherwise managed, to prevent him eating his incontinence pads. So his living arrangements were probably also as close to normal home life as they could be, consistent with catering for his needs. His case was in court because the local authority and his mother disagreed about what was in his best interests. Baker J held that the arrangements were a deprivation of P's liberty, but that they were in his best interests.⁸ The Court of Appeal held that they were not a deprivation of liberty.⁹

⁶ [2011] Family Law 29.

⁷ [2011] EWCA Civ 190, [2012] Fam 170).

⁸ [2011] EWHC 1330 (Fam).

⁹ [2011] EWCA Civ 1257, [2012] PTSR 1447.

The issue was by what test do you measure a deprivation of liberty? Section 64(5) of the 2005 Act says that it means the same as it means in article 5 of the European Convention. We therefore had to look to the Strasbourg jurisprudence for the answer. But Strasbourg had never had a case involving placements in such near-normal settings where the residents had not shown any dissatisfaction or desire to leave. So what could we deduce from the cases which they had had?

Every statement of the general principles in the Strasbourg cases starts with *Guzzardi v Italy*.¹⁰ Read as a whole, the Convention distinguishes between deprivation of liberty (article 5) and restrictions on freedom of movement (article 2 of Protocol 4, not ratified by the UK). The difference is “one of degree or intensity, and not one of nature or substance”. So the starting point is the “concrete situation” of the person concerned and a whole range of factors has to be taken into account – type, duration, effects and manner of implementation. However, although this statement features in all the cases, the Equality and Human Rights Commission pointed out that the difference between deprivation and restriction only really becomes important when the situation falls outside the list where deprivation may be permitted under article 5(1): *Guzzardi* itself was a case of preventive banishment of a suspected mafioso to a small island; *Austin v United Kingdom*¹¹ was about kettling demonstrators (and hapless bystanders) at Oxford Circus for hours; our own control order cases¹² were about preventive controls over suspected

¹⁰ (1980) 3 EHRR 333.

¹¹ (2012) 55 EHRR 359.

¹² Such as *Secretary of State for the Home Department v JJ* [2007] UKHL 45, [2008] AC 385.

terrorists. In none of these situations does article 5 permit the state to deprive people of their liberty, so Strasbourg has tended to adopt a more discriminating approach than it has in cases which are covered by article 5, such as “lawful detention of persons of unsound mind”.

In that situation, the acid test revealed in the line of cases which began with *HL v United Kingdom* was whether the person concerned was under the complete supervision and control of the staff and not free to leave. That, said the majority in the Supreme Court, is the test which should apply under the 2005 Act. Lord Neuberger was the swing vote and so he helpfully addressed the four factors which persuaded the minority, Lord Carnwath, Lord Hodge and Lord Clarke, to the contrary view.

- (1) The person concerned lacked the capacity to decide for herself where to live but had not shown any objection to her placement. But it would be wrong in principle to distinguish between the compliant and the objecting. While consent can authorise what would otherwise be a deprivation, the reverse does not follow. It would of course be contrary to *HL v United Kingdom*, where the whole point was that the patient was compliant.
- (2) The placement was in a small group home or domestic setting which is as close as possible to normal home life. Lord Neuberger could see no good reason to distinguish according to the place of confinement. (Children were different, either because they were not in fact deprived or because it was done by their parents and not by the state or if they were it was justifiable under article 5(1)). This is the “gilded cage is still a cage” point.

- (3) A court had authorised the placements in the best interests of the persons concerned. But the question was whether that authorisation was good for all time, or whether it had to be periodically reviewed to ensure that the deprivation continued to be lawful.¹³
- (4) The regimes were no more intrusive or confining than was necessary for the protection and well-being of the person concerned. That, combined with the normality of the arrangements, is probably what makes the idea that this is a deprivation of liberty counter-intuitive. But the Grand Chamber has now made it clear (principally in *Austin v United Kingdom*¹⁴, but also *Creanga v Romania*¹⁵ that the fact that the object is to protect, treat or care for the person confined has no bearing on whether that person has been deprived of liberty, although it may be relevant to the later question of justification. (This has put to rest the suggestion to the contrary in the much earlier chamber decision of *HM v Switzerland*,¹⁶ about the placement of an elderly lady in a nursing home for her own good. The recent cases either distinguish this on the basis that she had agreed to be there or do not refer to it at all.)

The underlying point, of course, is whether people with mental disabilities are entitled to the same freedom as the rest of us: whether, therefore, their situation should be compared with the situation of an ordinary person without their disabilities or whether, as the Court of Appeal had thought in the *Cheshire* case, it should be compared with that

¹³ The necessity for periodic reviews of article 5(1)(e) detentions has been established since *Winterwerp v The Netherlands* (1979-80) 2 EHRR 387.

¹⁴ (2012) 55 EHRR 359.

¹⁵ (2012) 56 EHRR 361.

¹⁶ (2002) 38 EHRR 314.

of someone with the same disabilities. The majority in the Supreme Court were quite clear that they had the same rights as anyone else. The whole point of human rights is that they are universal and enjoyed by everyone, founded as they are on the ringing declaration in article 1 of the Universal Declaration of Human Rights, “All human beings are born free and equal in dignity and rights”.

This is now reinforced by the United Nations Convention on the Rights of Persons with Disabilities, ratified by the UK in 2009. The recitals reaffirm the principle of universality of human rights and fundamental freedoms and the “need for persons with disabilities to be guaranteed their full enjoyment without discrimination” (recital (c)). The definition of persons with disabilities includes people who have “long term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (article 1), so there is no doubt that mentally disabled people are included. The UK has not incorporated the Convention into domestic law, but Strasbourg takes into account relevant international norms when interpreting the European Convention (and there is at least one case where it has referred to the CRPD: see *Glor v Switzerland*, App no 13444/04, 30 April 2009).

The UN Convention does present a problem with which we did not need to grapple in the *Surrey* and *Cheshire* cases. Article 14.1 provides:

“States Parties shall ensure that person with disabilities, on an equal basis with others:

- (a) Enjoy the right to liberty and security of person;
- (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 a deprivation of liberty.*”

Taken literally, those last words might suggest that both the Mental Health Act and the Mental Capacity Act are in breach of the Convention by providing for people with mental disorders and disabilities to be deprived of their liberty. There may be ways of reconciling them, for example, by suggesting that disability alone is not a sufficient justification. But for us the law is clear: those statutes do authorise it, but public authorities, including courts and tribunals, must operate them compatibly with the European Convention, which also authorises it in certain circumstances.

The impact of the *Surrey* and *Cheshire* cases has, of course, been dramatic. It was always difficult to understand how the government arrived at its initial predictions of the use of the DoLS. In 2009, they thought that there were roughly 500,000 people in England and Wales who had a mental disorder, lacked capacity and lived in a hospital or care home. These included over 190,000 with severe learning disability and 230,000 older people with dementia. Department of Health analysts thought that around 10% of these, or 50,000 people, might need additional restrictions which might involve deprivation of liberty. Then for some reason they predicted that there would be 21,000 assessments in 2009/2010, of which only 25%, or 5250, would result in authorisations. The Ministry of Justice then predicted that only 2.5% of authorisations would trouble the Court of

Protection, making around 130 cases in court. Both predicted that assessments would rapidly decline, as practice improved, until 2015/16, when there would be only 6,600, although 25%, or 1700, would still result in authorisations and 42 cases would go to court.

In fact, the early figures were much lower than that, but instead of falling, they have been rising for the last four years. In 2013-14, there were 13,000 applications in England, a 10% increase from 2012-13. But the government are now predicting a much larger figure for this year because of our decision. Figures from 130 out of the 152 local authorities show a leap from 12,400 applications in the whole of 2013-14 to 21,600 in the first quarter of 2014-15.¹⁷ Despite this, the Department of Health's response to our decision has been positive. They have set in train various initiatives to improve the operation of the DoLS. In a recent letter to DoLS leads in Local Authorities and the NHS,¹⁸ they have said that:

“DoLS is about the individual and ensuring that a light is shone on the conditions of their care; maximising their empowerment and human rights. There are countless examples of how DoLS has led to a real improvement in the care individuals receive.”

It concludes:

¹⁷ www.hscic.gov.uk/pubs/mentcap1314annual; and catalogue/PUB/15475.

¹⁸ Niall Fry, Update following 19 March 2014 Supreme Court judgment, 8 September 2014.

“Handled in a manner that puts individuals first and foremost, [the judgment] provides a real opportunity to provide real benefits to some of the most vulnerable individuals in our society”

The Court of Protection response has been a little different. Anticipating a huge rise in applications, the President of the Court of Protection set up a big case, in which the Official Solicitor as advocate to the court, the Secretaries of State, the Law Society, the Association of Directors of Social Services, eight local authorities, two clinical commissioning groups, one NHS Trust, four patients, and MIND took part in answering a questionnaire devised with a view to sorting out the principles which would govern a stream-lined procedure for authorising deprivations. This is a novel and interesting way to conduct procedural reform. Most, but not all of the questions are answered in a judgment handed down on 7 August 2014.¹⁹ Controversially, these would mean that the person concerned need not always be a party to the proceedings, and so would not need to be represented; that even if she was a party, her litigation friend would not need to act through a solicitor; and an oral hearing would not always be required. Permission to appeal is being sought on those issues.

Co-incidentally, just before our decision was published on 19 March, the House of Lords Select Committee on the Mental Capacity Act 2005 published its report, *Mental Capacity Act 2005: post-legislative scrutiny*²⁰ on 13 March. This had a great many interesting things to say about the DoLS. Even before our definition of a deprivation, their evidence was that

¹⁹ *Re X and Others (Deprivation of Liberty)* [2014] EWCOP 25.

²⁰ 2013-2014, HL Paper 139.

the safeguards were not being used when they should be. There were the usual inexplicable regional variations. Above all, witnesses suggested that compliant people without capacity were rarely considered potential candidates for the DoLS or for court applications, thus negating the very purpose for which they were introduced (para 266). The committee instanced a request for guidance from a local authority team in a case which was “strikingly similar” to *HL* (para 268).

At the same time, there was support for the purpose underlying the DoLS, but the DoLS themselves were criticised as “hugely complex, voluminous, overly bureaucratic, difficult to understand and yet [providing only] minimum safeguards” (para 271, quoting Richard Jones). Anyone who has tried to read the two schedules to the 2005 Act will have every sympathy with that. They look much more complicated than the processes for sectioning a patient under the Mental Health Act. I suspect that they also take a great deal more time.

Another difference between sectioning and the DoLS may be worth thinking about. The social worker (or other approved mental health professional) and doctors who do the sectioning are usually directly involved in the patient’s care: the sectioning process, though it has some additional burdens, is part of the process of deciding upon the patient’s clinical and care needs. The independent check comes from the hospital managers and the tribunal. Under the DoLS, the hospital or care home looking after the person concerned makes the application, but the best interests assessment is done by someone from the supervisory body. However, the supervisory body will often be the

body which commissions the very care which will result in the deprivation of liberty. So the committee were told that “some cases indicate that DoLS has been used as an instrument of oppression, where local authorities acting as supervisory bodies have used DoLS to get their way” (para 289, Richard Jones). This was certainly the perception of Stephen Neary’s father.

The Committee also identified the gap which our case has turned into a glaring hole – that the DoLS do not apply to supported living arrangements. Many witnesses pointed out that people living in such arrangements were just as vulnerable to being deprived of their liberty, and to inadequate or abusive care, as were people in hospitals and care homes, perhaps more so as these were not inspected by the Care Quality Commission (para 294). (I will not go into the knotty question of how for these arrangements are covered by the Human Rights Act.) The government was content that local authorities should go to the Court of Protection for authorisation, but the Committee had evidence that they did not do this when they should (para 296). I suspect that, just as the DoLS tend only to get used where the person concerned is resistant to the placement, cases only get taken to court when the person concerned is resistant or there is a dispute with relatives.

Another problem with the DoLS is the interface with the Mental Health Act. The idea was to keep the two regimes separate, so that the 2005 Act could not be used where patient was or ought to be sectioned under the Mental Health Act. In summary, therefore, a person is ineligible for the DoLS: (1) if he is actually detained under the

Mental Health Act (sched 1A, para 2, case A); (2) if he is on leave of absence, under a CTO or conditionally discharged, and the object is to return them to hospital for treatment for mental disorder (cases B and C); or (3) if he is under guardianship or “within the scope of the Mental Health Act”; ie he could be sectioned if the required medical recommendations had been given (cases D and E); where the object is for him to be accommodated in hospital in order to be given medical treatment for mental disorder (sched 1A, paras 5(3) and 16(1); and he objects to this or to some or all of the mental health treatment proposed (sched 1A, para 5(4), 5(5)). Thus, because he was not objecting, HL would have been eligible for the DoLS even though he was in hospital and both could and would have been sectioned had he tried to leave.

The committee identified a gap between the two systems, in that a person who has been sectioned under the Mental Health Act and requires treatment for a physical disorder cannot be compulsorily treated under that Act; but nor can he be deprived of his liberty for that purpose under the DoLS. The Court of Protection can, of course, fill the gap (either under the 2005 Act or under its inherent jurisdiction) but it would not normally be necessary to go to court for this purpose (paras 298-9).

The committee’s solution was a comprehensive review of the DoLS with a view to making them compatible in style and ethos with the rest of the 2005 Act, closing the gaps and addressing the specific problems they had identified (paras 271 – 277). They did not think that a definition of deprivation of liberty was needed, or even possible given that it would have to keep pace with the Strasbourg jurisprudence (paras 279 – 283). The term

itself was, of course, “unhelpful”, but perhaps unavoidable. Better understanding of the purpose behind the safeguards was urgently required (paras 284 – 285).

The government has “announced various measures to improve [the] operation” of the DoLS, but it has passed the task of comprehensive review to the Law Commission. As part of their Twelfth Programme of Law Reform, announced on 22 July, they have a project on *Mental capacity and detention*, described as follows:

“This project will consider a new legal framework to allow for the authorisation of best interests deprivations of liberty in supported living and other community care settings, in accordance with the select committee’s recommendations. We will also consider changes that will have to be made to DOLS to take account of the outcome of our work.”

The website puts it rather differently:

“Our project considers how deprivation of liberty should be authorised and supervised in hospitals, care homes and community settings, where it is possible that Article 5 rights would otherwise be infringed. This includes considering the legislation underpinning DoLS in its entirety”.

I do not think that this means that they are going to review the fundamental principles upon which the 2005 Act is based. They may look at the very recent Report of the

Scottish Law Commission dealing with this subject,²¹ which suggests a process for authorising “significant restriction of liberty” to get round the demarcation problems.

On the other hand, I hope that it does mean that the Commission will consider whether the Court of Protection is the right place to decide these issues. The Select Committee heard evidence in support of a tribunal system, but others thought that there were other ways of making the Court more accessible and less costly (paras 220 – 223). Not surprisingly, the judiciary were against giving the task to a tribunal, but it is difficult to see why your chamber is not the obvious place. You have the expertise in dealing with mental health and disability issues, you know something about health and social care, you are much cheaper and more accessible than the courts, you could learn how to deal with all the issues or leave those which were unsuitable (in practice, probably only property issues) to the courts, you are used to dealing direct with people without the intervention of the Official Solicitor, you are so much more flexible in your procedures and you could recruit the specialist district judges to your ranks.

In fact, it has long struck me that we would have a much more coherent and comprehensible system if we adopted the principles of the Mental Capacity Act for all kinds of mental disorder and disability. They would go something like this:

- (1) Everyone should be assumed to have the capacity to decide for themselves whether to accept the treatment or care that others think they need. A person’s

²¹ Scot Law Com No 240, *Adults with Incapacity* (1 October 2014).

right to choose what may be done with his body or his mind should only be taken away if he lacks the capacity to make the decision for himself.

- (2) Any restriction on this right should be kept to a minimum. If it is taken away in important respects, for example by depriving him of liberty or obliging him to accept treatment which he does not want, there should be effective safeguards against abuse, regular reviews and the opportunity to challenge the decision before an independent tribunal.
- (3) There must always be the appropriate care and treatment in return, but it is possible that a person may need care and accommodation without needing psychiatric treatment.
- (4) The guiding principle in deciding what to do should be the best interests of the person concerned, but his own personality, wishes, feelings and values are an important part in deciding what will be best for him.
- (5) Underlying and overriding all of these principles is respect for the dignity and humanity of all people, however disabled or disordered in body or in mind or both.

These are undoubtedly the values underlying the Mental Capacity Act 2005. They are less obviously the values underlying or reflected in the Mental Health Act 1983 (as amended in 2007), which has always been concerned to protect the public as well as the patient. So it will never happen. But I find it fascinating that the normalisation and non-discrimination principles of 50 years ago should have led the law to abandon formal

procedures whereas the normalisation and non-discrimination principles of today have led us to reintroduce them.