



Involuntary mental health treatment in England and Wales: A rights-based critique of current legal frameworks and recommendations for reform

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1. Introduction

The treatment of mental disorders is in the interest of the individual as well as society with a view to reducing risk related to self-directed harm or interpersonal violence (Fazel, Zetterqvist, Larsson, Långström, & Lichtenstein, 2014; Shah, 2012; Skeem, Steadman, & Manchak, 2015) in addition to other treatment benefits (Andrews, Issakidis, Sanderson, Corry, & Lapsley, 2004; Chisholm et al., 2016). Given this situation, involuntary detention and treatment of the mentally ill represents a delicate balancing act between considerations of individual autonomy and right to liberty on the one hand, and public safety on the other (Jones, 2014; Mason & Laurie, 2013). A critical focus on treatment within the broader context of compulsory hospitalisation is warranted in view of its centrality to the whole process of non-consensual treatment for mental disorder. This essay specifically examines the legal frameworks for the treatment for mental disorder of those detained in hospital and prison by focusing on key statutory provisions in England and Wales. It will discuss these using relevant international human rights instruments and illustrative case law as well as provide relevant recommendations for legal reform.

2. Key statutes

2.1. Mental Health Act 1983 (as amended by Mental Health Act 2007) (MHA)

Under the act, a person may be compulsorily detained in hospital for assessment and/or treatment. The grounds for this detention are that the person suffers from mental disorder of a nature or degree which requires detention for assessment and it is in the interest of his health or safety or the safety of others. Furthermore, the appropriate medical treatment is available, and the treatment cannot be provided without detention. Detention under the MHA applies to mentally ill non-offenders (sections 2, 3, 4 and 5), mentally disordered offenders under hospital orders (sections 36, 37/41, 38) and mentally disordered prisoners transferred to hospital (sections 45A, 47, 48 and 49).

Mental disorder is defined in section 1 as any disorder or disability of the mind and includes learning disability only when associated with

abnormally aggressive or seriously irresponsible conduct. Treatment is defined in section 145 as 'medical treatment' encompassing nursing, psychological interventions as well as specialist mental health and other rehabilitation aimed at the alleviation or prevention of deterioration of the disorder or one or more of its symptoms. 'Appropriate medical treatment' is also defined under section 3(4) with appropriateness considering the nature and degree of the mental disorder and all other circumstances relevant to the individual.

There are important ethical and human rights considerations in the definition of mental disorder and its treatment under the act. The definition of mental disorder is regarded as being too broad with little room for restrictive interpretation (Mason & Laurie, 2013). It introduces uncertainty into mental health law (Glover-Thomas, 2011) and may be prone to arbitrary use by the state especially in relation to very few exclusions under non-consensual treatment for mental disorder (Barber, Brown, & Martin, 2017). Others argue that its broad view does not violate human rights and only indicates a need to accommodate dynamic changes in mental health diagnoses as the field evolves (*Winterwerp v Netherlands*, 1979; Leung, 2002). The act is not bound by the utopic idea of 'treatability' but rather availability of 'appropriate medical treatment'; hence, detention under the act for treatment would not be regarded as a violation of the right to liberty even when the mental condition was not wholly treatable (*A v The Scottish Ministers*, 2002). The appropriateness of the treatment is based on its purpose of alleviation or prevention of worsening of symptoms rather than likelihood of treatment success (Department of Health, 2015). In this context, the court determined in *Reid v Secretary of State for Scotland* that appropriate treatment ranged from 'cure' to 'containment'. In *MD v Nottinghamshire Healthcare NHS Trust*, it was held that detention without risk reduction in a personality-disordered patient was not mere containment and benefit derived from a ward environment represented availability of appropriate medical treatment.

The provisions for treatment under the act are in four broad categories as follows:

2.1.1. Treatment with patient's consent and a second opinion

Section 57 relates to any surgical operation for destruction of brain tissue or its functioning in the context of neurosurgery. It also covers

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<https://doi.org/10.1016/j.ijlp.2019.101451>

Received 2 September 2018; Accepted 14 May 2019

Available online 28 May 2019

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the surgical implantation of hormones to reduce male libido. As safeguards, a second opinion appointed doctor (SOAD) and two other appointed persons must provide written certification establishing the patient's capacity and consent to it. The SOAD must certify in writing that the treatment is appropriate after consulting two other persons who have been professionally involved in the patient's medical treatment. One of the two should be a nurse while the other should neither be a nurse or doctor.

2.1.2. Treatment requiring consent or a second opinion

Section 58 covers the administration of medication after 3 months of treatment during hospital detention. Medication may be administered if patient consents or the SOAD certifies the need for treatment in view of incapacity or lack of consent. As in section 57, the SOAD is expected to consult two other professionals.

Section 58A specifically deals with electro-convulsive therapy (ECT) (including ECT-related medication) and it is administered usually with consent. It may be given to non-consensual patients under the provisions of section 58. The SOAD must certify that ECT will not conflict with any valid advance decision or a decision made by a donee or the court of protection.

In recognising the fact that the presence of mental disorder does not absolutely negate capacity, these MHA sections reflect an autonomy-enabling (Bach & Kerzner, 2010) and functional view of mental capacity rather than an outcome or status approach which is unduly paternalistic (Law Commission, 1995). The sections are consistent with the right to freedom from inhuman or degrading treatment (art 3) and right to private and family life (art 8) under the European Convention on Human Rights (ECHR) (1950) enshrined in the UK's Human Rights Act (1998) (Dickens and Sugarman, 2008). They equally protect the freedom to hold opinions (art 21) and right to mental integrity (art 17) under the UN Convention on the Rights of Persons with Disabilities (CRPD) (2006) as well as principle 11(14) of the UN principles for the protection of persons with mental illness (1991) which specifically prohibits psychosurgery and irreversible treatments for involuntary patients.

2.1.3. Urgent treatment

Section 62 allows urgent treatment which is immediately necessary to save patient's life, prevent serious deterioration in his condition, alleviate serious suffering or prevent undue violence to self or others. The important protection is that the treatments must not be irreversible or hazardous although this is not explicitly stated about life-saving treatment. While 'irreversible' and 'hazardous' are clearly defined, 'immediately' which is the trigger for this section lies undefined. The immediacy should relate to the need for treatment and not to the consequences of non-treatment (Jones, 2014). ECT is only to be given in the context of life-threatening risk or serious risk of deterioration.

2.1.4. Treatment without consent

Under section 63 of the MHA, appropriate treatment for mental disorder (excluding the treatments stated under sections 57, 58 and 58A above) may be given by or under the direction of the approved clinician and this may be without consent for the first 3 months of detention. After, the first 3 months, the SOAD must be involved as described above but this applies only to medication.

The broad definition of 'medical treatment' perhaps suggests that several other 'psychosocial' treatments may be given under section 63 without recourse to the SOAD (Barber et al., 2017) although this is limited on the ground that psychotherapy will at least require patient's co-operation (Jones, 2014). Also, treatments for physical illnesses intrinsically linked to mental disorder are brought under treatment for mental disorder and this section applies. For instance, in *Re KB* (1997) and *Re VS (Adult: Mental disorder)* (1995), nasogastric feeding for anorexia nervosa or depression was regarded as part of treatment for mental disorder.

The authority to impose treatments for mental disorder on detained patients who have capacity but are non-consenting potentially violates articles 5(1 and 2) (equality and non-discrimination), 12(2) (equal legal capacity in all aspects of life), and 25(d) (right to healthcare based on free and informed consent) of the CRPD. *X v Finland* (2012) affirms that section 63 breaches article 8 of the ECHR with current opinion suggesting its abolition (Law Society, 2018; Minkowitz, 2011). However, the UN principles for the protection of persons with mental illness (1991) recognises the proportionality of giving non-consensual treatment to detained patients in the interest of individual or public safety while ensuring independent oversight of the treatment (principle 11(6)). Moreso, instruments such as the CRPD may be less conscious of clinical risks (Duffy & Kelly, 2017). Yet, the current regime under the MHA falls short of this ideal in not providing for a second opinion within the first 3 months and this delay could potentially constitute an unjustified breach of article 8 rights (Barber et al., 2017).

2.2. Mental Capacity Act 2005 (MCA)

The MCA represents a legal framework for making decisions on behalf of persons who are aged 16 years and above who lack the capacity to consent to their own treatment in the present or future i.e. advance directives. Incapacity is decision-specific, and it is due to an 'impairment of, or a disturbance in the functioning of, the mind or brain' (section 2) resulting in lack of understanding, retention, use or weighing of information or communication of decision (section 3). The need to demonstrate a causal link between the inability to make the decision and the abnormality of mental functioning was affirmed in *PC v City of York* (2013).

Section 5 permits decision-makers to consent to medical treatment on behalf of those lacking capacity (Department of Constitutional Affairs, 2007). Acts done under section 5 should be done in the patient's best interests and section 6 stipulates limitations. One important protection is that restraints may be used for the safety of the patient but not to prevent harm to others. Restraints for others' safety is considered an indication for the MHA (Barber et al., 2017). However, it has been suggested that the concept of 'best interests' may also be used to unduly broaden the scope of compulsory treatment for mental disorder (Fennell, 2008).

Section 28 of the MCA limits the authority to give treatment or provide consent to treatment on behalf of the incapacitated patient under the MCA if the patient is already under part 4 (treatment) of the MHA. This provision has been regarded as subverting individual autonomy as it appears to effectively nullify advance directives that negate compulsory treatment for mental disorder (Griffith, 2014). However, in *Nottinghamshire Healthcare NHS Trust v RC* (2014), the court of protection held that the advance directive of a detained patient indicating refusal of blood transfusion (on religious grounds) if he attempted suicide by cutting himself should be respected. It was established that when advance refusal pertained to basic rights such as freedom of religion or belief, overriding it required judicial oversight thus protecting patients' autonomy and article 9 rights¹ under the ECHR.

It is crucial in each case to determine the capacity of the detained patient to consent to physical treatment because some detained patients may demonstrate capacity to withhold consent to treatment for physical health problems. Prior to the MCA, in *Re C* (1994), the court had held that a detained patient with schizophrenia who retained capacity had a right to refuse limb amputation indicated by gangrene.

Despite the clear safeguards afforded by the MCA, there have been arguments that the current formulation of capacity is too 'cognitivist' (Charland, 1998) with no recognition of the effect of emotional factors such as feelings, preferences and values, in decision-making (Glass,

¹ Freedom of thought, conscience and religion.

1997; Harding, Bursztajn, Gutheil, & Brodsky, 1991). Empirical evidence equally supports the view that theoretical logic (e.g. in schizophrenia) is not enough in demonstrating practical rationality (Owen, Cutting, & David, 2007).

2.3. Deprivation of Liberty Safeguards (DOLS)

Within the MCA framework, the DOLS are available to those aged 18 and above who have mental disorder, require treatment in hospital (i.e. meeting the criteria for sections 2 or 3 or the MHA), or lack capacity but do not object to treatment. The 'acid test' of deprivation of liberty is as set out in *Cheshire West* (2014) and involves complete supervision and control of patient's movement by others. When such situations arise, the precedent in *AM v SLAM & Secretary of State for Health* (2013) indicates that the choice between the MHA and DOLS should be made based on which act is less restrictive. This is consistent with principle 9 of the UN Principles for the protection of persons with mental illness (1991) which specifies least restrictive treatment environments. DOLS authorisation is provided by a supervisory body which commissions the patient's treatments thus preventing arbitrary use.

DOLS came into existence to remedy the so-called 'Bournewood' gap which refers to the lack of statutory protections available for those detained under the MHA but not afforded those who were technically 'detained' but informally (*R v Bournewood Community and Mental Health NHS Trust, ex p L* 1998). According to the European Court of Human Rights, the rights engaged relate to Article 5(1 and 4) (*HL v UK* 2005).

2.4. Prisoners with mental disorder who are not transferred to 'hospital'

The involuntary treatment of prisoners with mental disorders who are not transferred to hospital is impossible under the MHA but may be undertaken under common law and provisions of the MCA (Royal College of Psychiatrists, 2015). This is because prison 'hospital wings' under the care of Her Majesty's Prison Service do not fall within the MHA definition of a hospital (section 145) (Reed & Lyne, 2000).

Common law approaches which may be adopted in prisons are founded on the principles of necessity and proportionality (Linford, 2005). In *Herczegfalvy v Austria* and *Keenan v UK*, the European court held that a therapeutic necessity undertaken in the absence of consent was lawful and not inhuman or degrading (art 3 of the ECHR). A similar finding was reached in *Munjaz v UK* in which it was held that a 'treatment' such as seclusion pursuing a legitimate aim satisfied the test of necessity. In *Huang*,² Proportionality was determined as relating to whether a measure pursues an important clinical objective, has a clear connection with the objective, is no more than necessary to achieve the objective and represents a fair balance between individual and community interest (Curtice et al., 2011).

Prisoners who lack capacity to provide consent to treatment may be treated under section 5 of the MCA with the limitations imposed by section 6 considered. Voluntary treatment may be provided under section 7 of the *Prison Act 1952* and in accordance with rule 17 of the Prison Rules 1964.

2.5. Other treatment considerations

Seclusion and restraint are sometimes adopted for patients with dangerous behaviour. While the MHA does not have specific provisions for these, the MHA Code of practice (Paras 26.75 and 26.103) (Department of Health, 2015) has clear guidelines on restraint and seclusion, and directs each hospital to produce local seclusion policies. In *Munjaz*, the European court tested and affirmed that the code of

practice afforded protection of secluded patients' right to liberty/security and freedom from inhuman and degrading treatment.

3. Independent review of the MHA

An independent review of the MHA is ongoing (Wessely, Gilbert, Hedley, & Neuberger, 2018) in view of significant deficiencies within it (Kelly, 2011). Given the inadequacies identified above, the following recommendations specific to medical treatment for detained patients are made:

3.1. Consent to treatment and treatment without consent

Based on the judicial reasoning in *X v Finland* reflecting the incompatibility of treatment without consent with article 8 of the ECHR, such treatments under section 63 should be limited to 1 month and brought under the independent opinion of the SOAD as currently applies after the first 3 months. Urgent treatment provided under section 62 should be amended to differentiate between those with incapacity and those retaining capacity. For those lacking capacity (without advance directives), treatment should be reviewed within 7 days by a SOAD under the safeguards outlined in sections 57 and 58 (Law Society, 2018). For those possessing capacity and refusing consent, it is recommended that urgent treatment intended for them should be reviewed by the SOAD prior to commencement of treatment. The SOAD should only authorise treatment without consent when the conditions set out in section 62 (a-d) are met (Law Society, 2018).

3.2. Minimum invasive treatments

In consonance with the WHO guideline on mental health legislation (World Health Organisation, 2005) which indicates the need to minimise invasive treatments, sections 58, 62 and 63 should be amended to state that the minimum amount of medication necessary for achieving the objectives of treatment should be instituted. 'Minimum' may be defined based on dose, number and formulation. Given the long-acting nature of depot medications, these sections must emphasise their use as last resort after other alternatives of less enduring effect have been considered. This should form part of the considerations of the SOAD providing authorisation.

3.3. Advance directives

Guided by the judicial decision in *Nottinghamshire Healthcare NHS Trust v RC*, it is recommended that sections 58, 62 and 63 should have the inclusion that treatments without consent should consider any valid advance directive of the patient or a decision made by a donee or the court of protection among those lacking capacity. The *Mental Health (Care and Treatment) (Scotland) Act 2003* section 276 gives guidance in this regard in stating conditions to be complied with when such advance directives are not followed by clinicians. While this perhaps represents a subtle infusion of MCA approaches to treatment under the MHA, it is not a recommendation to adopt fusion legislation. Though fusion law might remove the discriminatory approach to the treatment of those suffering from mental disorder in terms of respect for their autonomy and permit consistent application of ethical principles across medical law (Dawson & Szmukler, 2006; Szmukler, Daw, & Callard, 2014; Szmukler & Hollowoy, 1998), it has the risk that a wholesale adoption of MCA approaches could lead to detention without treatment (Jones, 2014; Wessely et al., 2018). Mutual recognition between both principles is reasonable (Dawson, 2015).

3.4. Seclusion and restraint

Consistent with the WHO guideline on mental health legislation (World Health Organisation, 2005), it is recommended that an

² This established the four-pronged Huang test which can be adopted for clinical use.

additional section be inserted to include the statutory regulation of seclusion and restraint. Specific details should remain in the MHA Code of Practice. Violation of standards should constitute an offence under the act.

3.5. Appeals against Involuntary treatment

Currently, the First-Tier Tribunal (FTT) does not have any jurisdiction over challenges about treatment as this is done through judicial review (Barber et al., 2017). It is recommended that detained patients should have the right to challenge compulsory treatment at the FTT. This will apply to patients who have capacity at the time the treatment is offered against their wishes as well as patients who lack capacity but have executed valid advance decisions.

3.6. Discharge from treatment

While offenders detained under s. 37/41 are discharged by the FTT, those under 47/49 usually undergo both FTT and parole board hearings. The court, in Vowles, while noting that this requirement for two judicial bodies did not necessarily violate art 5(4) of the ECHR, suggested that a single body considering all factors relevant to release would increase public confidence in the process. This is recommended.

4. Conclusion

The existing legal framework for the treatment of mental disorder for hospital detainees is a complex interaction of provisions codified in the MHA, MCA and DOLS while prison detainees are treated under the MCA as well as common law. These legal protections attempt to uphold individual autonomy in the context of enforceable human rights while ensuring public safety. In many respects, they do not satisfactorily protect human rights or sustain ethical principles. Thus, critical legislative reforms are recommended to address these deficiencies.

References

- Andrews, G., Issakidis, C., Sanderson, K., Corry, J., & Lapsley, H. (2004). Utilising survey data to inform public policy: Comparison of the cost-effectiveness of treatment comparison of the cost-effectiveness of treatment of ten mental disorders. *The British Journal of Psychiatry*, 184(6), 526–533.
- Bach, M., & Kerzner, L. (2010). *A new paradigm for protecting autonomy and the right to legal capacity*. Law Commission of Ontario.
- Barber, P., Brown, R., & Martin, D. (2017). *Mental health law in England & Wales: A guide for mental health professionals* (3rd ed.). London: Learning Matters, An imprint of SAGE Publications Ltd.
- Charland, L. (1998). Is Mr. Spock mentally competent? Competence to consent and emotion. *Philosophy, Psychiatry, and Psychology*, 5(1), 67–81.
- Chisholm, D., Sweeny, K., Sheehan, P., Rasmussen, B., Smit, F., Cuijpers, P., & Saxena, S. (2016). Scaling-up treatment of depression and anxiety: A global return on investment analysis. *The Lancet Psychiatry*, 3(5), 415–424. [https://doi.org/10.1016/S2215-0366\(16\)30024-4](https://doi.org/10.1016/S2215-0366(16)30024-4).
- Curtice, M., Bashir, F., Khurmi, S., Crocombe, J., Hawkins, T., & Exworthy, T. (2011). The proportionality principle and what it means in practice. *The Psychiatrist*, 35, 110–116. <https://doi.org/10.1192/pb.bp.110.032458>.
- Dawson, J. (2015). A realistic approach to assessing mental health laws' compliance with the UNCRPD. *International Journal of Law and Psychiatry*, 40, 70–79. <https://doi.org/10.1016/j.ijlp.2015.04.003>.
- Dawson, J., & Szmukler, G. (2006). Fusion of mental health and incapacity legislation. *British Journal of Psychiatry*, 188, 504–509.
- Department of Constitutional Affairs (2007). *Mental capacity act 2005: Code of practice*. London: TSO.
- Department of Health (2015). *Mental Health Act 1983: Code of practice*. London: TSO.
- Dickens, G., & Sugarman, P. (2008). Interpretation and knowledge of human rights in mental health practice. *British Journal of Nursing*, 17(10), 664–667.
- Duffy, R. M., & Kelly, B. D. (2017). Rights, laws and tensions: A comparative analysis of the convention on the rights of persons with disabilities and the WHO resource book on mental health, human rights and legislation. *International Journal of Law and Psychiatry*, 54, 26–35. <https://doi.org/10.1016/j.ijlp.2017.07.003>.
- Fazel, S., Zetterqvist, J., Larsson, H., Långström, N., & Lichtenstein, P. (2014). Antipsychotics, mood stabilisers, and risk of violent crime. *The Lancet*, 384(9949), 1206–1214. [https://doi.org/10.1016/S0140-6736\(14\)60379-2](https://doi.org/10.1016/S0140-6736(14)60379-2).
- Fennell, P. (2008). Best interests and treatment for mental disorder. *Health Care Analysis*, 16, 255–267. <https://doi.org/10.1007/s10728-008-0088-6>.
- Glass, K. (1997). Refining definitions and devising instruments: Two decades of assessing

- mental competence. *International Journal of Law and Psychiatry*, 20(1), 5–33.
- Glover-Thomas, N. (2011). The age of risk: Risk perception and determination following the Mental Health Act 2007. *Medical Law Review*, 19(4), 581–605. <https://doi.org/10.1093/medlaw/fwr023>.
- Griffith, R. (2014). Mental capacity and mental health acts part 1: Advance decisions. *British Journal of Nursing*, 23(14), 812–813.
- Harding, H., Bursztajn, H., Gutheil, T., & Brodsky, A. (1991). Beyond cognition: The role of disordered affective states in impairing competence to consent to treatment. *Bulletin of the American Academy of Psychiatry and the Law*, 19(4), 383–388.
- Jones, R. (2014). *Mental health act manual* (17th ed.). London: Thomson Reuters (Professional) UK Limited.
- Kelly, B. D. (2011). Mental health legislation and human rights in England, Wales and the Republic of Ireland. *International Journal of Law and Psychiatry*, 34(6), 439–454. <https://doi.org/10.1016/j.ijlp.2011.10.009>.
- Law Commission (1995). *Mental incapacity* (No. 231).
- Law Society (2018). *Mental health act 1983 independent review: Call for evidence*. Law Society response.
- Leung, W.-C. (2002). Human rights act 1998 and mental health legislation: Implications for the management of mentally ill patients. *Postgraduate Medical Journal*, 78, 178–181. <https://doi.org/10.1136/pmj.78.917.178>.
- Linford, S. (2005). Mental health law: Compulsory treatment in a general medical setting. *British Journal of Hospital Medicine*, 66(10), 569–571. <https://doi.org/10.12968/hmed.2005.66.10.19895>.
- Mason, J., & Laurie, G. (2013). *Law and medical ethics* (9th ed.). Oxford: Oxford University Press.
- Minkowitz, T. (2011). Prohibition of compulsory mental health treatment and detention under the CRPD. *Paper submitted to the law committee reviewing the Norwegian mental health act* (January).
- Owen, G., Cutting, J., & David, A. (2007). Are people with schizophrenia more logical than healthy volunteers? *British Journal of Psychiatry*, 191, 453–454.
- Reed, J., & Lyne, M. (2000). Inpatient care of mentally ill people in prison: Results of a year's programme of semistructured inspections. *BMJ*, 320, 1031–1034.
- Royal College of Psychiatrists (2015). *Standards for prison mental health services*.
- Shah, A. (2012). The relationship between the use of mental health act and general population suicide rates in England and Wales. *Journal of Injury & Violence Research*, 4(1), 26–29. <https://doi.org/10.5249/ijvr.v4i1.66>.
- Skeem, J., Steadman, H. J., & Manchak, S. M. (2015). Applicability of the risk-need-responsivity model to persons with mental illness involved in the criminal justice system. *Psychiatric Services*, 66(9), 916–922. <https://doi.org/10.1176/appi.ps.201400448>.
- Szmukler, G., Daw, R., & Callard, F. (2014). Mental health law and the UN convention on the rights of persons with disabilities. *International Journal of Law and Psychiatry*, 37(3), 245–252. <https://doi.org/10.1016/j.ijlp.2013.11.024>.
- Szmukler, G., & Holloway, F. (1998). Mental health legislation is now a harmful anachronism. *Psychiatric Bulletin*, 22, 662–665.
- Wessely, S., Gilbert, S., Hedley, M., & Neuberger, J. (2018). *The independent review of the mental health act: Interim report*.
- World Health Organisation (2005). *WHO resource book on mental health, human rights and legislation*. Geneva: World Health Organisation.

Statutes

Mental Health Act.
Mental Health Act.
Human Rights Act.
Prison Act.

Cases

- A v The Scottish Ministers (2002). 1 WLR 1460.
- AM v SLAM & Secretary of State for Health (2013). UKUT 0365 (AAC).
- Cheshire West and Chester Council v P (2014). UKSC 19.
- Herczegfalvy v Austria (1992). 15 EHRR 437.
- HL v United Kingdom (2005). 81 BMLR 131.
- Huang v Secretary of State for the Home Department (2007). UKHL 11.
- Keenan v United Kingdom (27229/95) (2001). 33 EHRR 38.
- MD v Nottinghamshire Healthcare NHS Trust (2010). UKUT 59 (AAC).
- Munjaz v United Kingdom (2913/06) (2012). M.H.L.R 351 ECHR.
- Nottinghamshire Healthcare NHS Trust v RC (2014). EWHC 1317 (COP).
- PC and NC v City of York Council (2013). EWCA Civ 478.
- R v Bournemouth Community and Mental Health NHS Trust, ex p I (1998). 3 All ER 289.
- R v Vowles and Others (2015). 2 Cr App Rep (S) 6.
- Re C (adult: refusal of medical treatment) (1994). 1 All ER 819.
- Re KB (1997) (1997). 2 FLR 180.
- Re VS (Adult: Mental disorder) (1995). 3 Med. L. Rev. 292.
- Reid v Secretary of State for Scotland (1999). AC 512.
- Winterwerp v Netherlands (1979). 2 EHRR 387.
- X v Finland (34806/04) (2012). M.H.L.R. 318 ECHR.

International instruments

European Convention on Human Rights.
UN Convention on the Rights of Persons with Disabilities.
UN Principles for the Protection of Persons with Mental Illness.