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A MATTER OF NECESSITY? ENFORCED TREATMENT UNDER THE MENTAL HEALTH ACT

R. (JB) v. Responsible Medical Officer Dr A Haddock, Mental Health Act Commission Second Opinion Appointed Doctor Dr Rigby, Mental Health Act Commission Second Opinion Appointed Doctor Wood

[2006] E.W.C.A. Civ. 961.

Introduction

This case concerned the substantive prerequisites for involuntary treatment under the Mental Health Act 1983 (MHA). The parties agreed that following the European Court of Human Rights ruling in *Herczegfalvy* v. *Austria*, treatment for mental disorder could be enforced only if it were 'medically necessary'.[1] At the core of the decision in *Haddock* was how this phrase is to be construed. In particular, did *Herczegfalvy* require a two-part approach to the issue, first identifying with some certainty the disorder afflicting the patient and then determining whether the proposed treatment was necessary for that disorder, or could 'medical necessity' instead be determined as a single, multi-faceted question? Also at issue was the court's appropriate process and standard of review in such matters. Because of developments in the factual evidence and in the relevant case law during the litigation, a variety of other factors were considered, most particularly the relevance of a review tribunal's classification of mental disorder to the court's view of an individual's diagnosis.

At the commencement of the case, B, then aged 27, had been detained at Ashworth Special Hospital for nine years, having been diagnosed as suffering from psychopathic disorder. He had a history of violence, and was still considered to be at high risk of violent offending should he be moved outside a high-security institutional environment. It was proposed to treat him with a course of anti-psychotic medication. While he had consented to some such treatment in the past, he was currently refusing all treatment, and it was thus proposed to treat him pursuant to section 58 of the MHA.

Beyond this, most of the relevant facts were contested. In particular, B's experts took the view that he was not suffering from a mental disorder at all, while the respondents took the view that B was affected by both psychopathic disorder and mental illness. It was contested whether B lacked capacity to consent to the medical treatment proposed. The prescription of anti-psychotics for B was also challenged, both on the basis that B was not suffering from a mental disorder at all, or alternatively that if he

[1] (1993) 15 E.H.R.R. 437.

was, it was a personality disorder for which anti-psychotic medication was an inappropriate treatment.

The application for judicial review was made prior to the House of Lords decision in *R. (B) v Ashworth Hospital Authority*.[2] Consistent with the Court of Appeal decision in that case,[3] B claimed that he could not be treated for mental illness, but only for the psychopathic disorder for which he was formally confined. While he alleged he did not have a mental disorder at all, he further alleged that treatment with anti-psychotic medication did not constitute appropriate treatment for psychopathic disorder. Concurrent with the High Court application challenging the medical necessity of the treatment, the respondent RMO applied for B to be reclassified under section72(5) of the MHA, so that his detention would be justified both because of his psychopathic disorder and his mental illness. Collins J. delayed his decision until the House of Lords judgment and the tribunal decision had been issued.

While this process was no doubt the best that could be done under the circumstances, the result is unfortunate, as both the law and the factual landscapes became moving targets over the course of argument. Overruling the Court of Appeal, the House of Lords decision in *Ashworth* held that sections 63 and 58 of the MHA allowed the involuntary treatment of patients for whatever disorder afflicted them, not merely for those contained within the category of disorder for which they were formally confined. As a result, that aspect of B's case was abandoned. The respondents had initially argued on the expectation that their application for re-categorisation would be successful. It was not: the review tribunal remained convinced that B was suffering from psychopathic disorder such as warranted his continued confinement, but declined to expand the grounds for his confinement to include mental illness. Thus both sides in the case were required to change gears mid-argument. Their previous arguments still lingered on in the litigation, however, and temper the eventual reasons for judgment.

Treatment without the competent consent of the patient under section 58 may only be administered upon the certification by a doctor other than the responsible medical officer (RMO) proposing the treatment that 'having regard to the likelihood of its alleviating or preventing a deterioration of [the patient's] condition, the treatment should be given'.[4] This opinion must be provided by a doctor duly approved to provide such opinions – a so-called 'second-opinion approved doctor' (SOAD). The delay between commencement of the proceedings and the eventual first instance judgment was about a year, and the second and third respondents were SOADs who had authorised the treatment by antipsychotics in this period.

First Instance Decision

Without exception, Collins J. preferred the professional evidence presented on behalf of the respondents. Relying on that evidence, he held that B did not have capacity to consent to the treatment in question. His Lordship took the view that B suffered from personality disorder, complicated by at least occasional psychosis.[5] Diagnoses were

[2] [2005] U.K.H.L. 20.
[3] [2003] E.W.C.A. Civ. 547.
[4] MHA s.58(3)(b).
[5] [2005] E.W.H.C. 921 Admin.

in any event not clear cut, and different diagnoses might be reached for a given patient by different clinicians, or by the same psychiatrist at different times in the patient's illness. He quoted favourably the review of a psychiatrist called on behalf of respondents to the effect that 'the distinction between mental illness and personality disorder is probably more imagined than real'.[6] He concluded that *Herczegfalvy* should not be read as separately requiring both a certain diagnosis and proof that the proposed treatment was appropriate for the diagnosed disorder, suggesting that too great a focus on the specifics of diagnosis risked imposing strictures that bore little resemblance to the realities of clinical practice. Treatment with antipsychotics had proven beneficial in the past, and it was clinically warranted in this case. Further, he expressly doubted the view of B's expert, that antipsychotics were not an appropriate treatment for personality disorder. The treatment was therefore justified in B's case.

While this would have been sufficient to decide the case, His Lordship made a number of additional observations that warrant note. The Court of Appeal in *R. (Wilkinson)* v. *Broadmoor Special Hospital Authority*[7] had held that when issues under the Human Rights Act were at issue, the court on a judicial review hearing was obliged to make a full assessment of the circumstances and to reach its own conclusions on matters of fact. To this end, it was not restricted to the written evidence serving as the basis of the judicial review application, but was also entitled to hear witnesses. His Lordship expressly doubted whether he would have reached such a conclusion as to the appropriate procedure, except for the binding precedent of *Wilkinson*. The role of the SOAD was also discussed. His Lordship stressed the importance of this safeguard, noting the duty to reach an assessment of the appropriateness and efficacy of the treatment independent from the RMO,[8] and to provide reasons for the decision.[9] The SOAD was further to have in mind the substantive standards implied by the Human Rights Act and ECHR.[10]

Court of Appeal Decision

The decision of the Court of Appeal was delivered by Auld L.J. His Lordship viewed the central question on appeal to be similar to that described above, that is, whether the court need be satisfied both of the specific diagnosis of mental disorder experienced by an individual and that the treatment proposed was medically necessary for that disorder in order to uphold a decision that the individual will be forcibly treated. The Court analysed this question from four overlapping approaches: whether this dual approach was required by *Herczegfalvy*; whether the domestic law imposed such a dualist approach, or whether the question of necessity could be approached as a single question, how far the court must take cognisance of the views of a MHRT regarding the form of the individual's mental disorder; and further to *Wilkinson*, the nature and intensity of review by the court.

On the first two points, the Court held that neither *Herczegfalvy* nor domestic law required a two-stage assessment of necessity. Like Collins J., the Court took the view

[6] Ibid. at [26].
[7] [2002] 1 W.L.R. 419.
[8] *Supra* n.5, at[8].
[9] Ibid. at [16].
[10] Ibid. at [11].

that diagnosis in an inexact science in psychiatry, and may be changed at different times in the patient's illness. As Baroness Hale had stated in *Ashworth*, the objective of the clinician should be to treat the whole patient. ECHR safeguards 'should not be deployed so as to cut across the grain of medical good practice.'[11] 'Realism and practicality' were the order of the day.[12] Considerable argument had been devoted to what standard of proof should be applied to the demonstration of medical necessity: beyond reasonable doubt, clear and convincing, or mere balance of probabilities. The Court eschewed the fixing of an evidential standard of proof, holding instead that a finding of medical necessity was 'a value judgment as to the future – a forecast – to be made by a court in reliance on medical evidence according to a standard of persuasion.'[13] Insofar as a standard were appropriate, it was to be decided on the balance of probabilities.

Collins J. had taken the view that the previous courses of antipsychotics to which B had been subjected had improved his condition, and that was sufficient for purposes of both the ECHR and domestic law. The Court held that he did so after a careful analysis of the evidence, and his view should therefore not be disturbed.

Regarding the third issue, the Court held that decisions of the MHRT were about the propriety of detention, not diagnosis. As such, the failure of the MHRT to say that B suffered from a mental illness of a nature and degree that it would be relevant to his continued confinement did not necessarily mean that B did not have a mental illness. Further, the MHRT did not find that B did not have a mental illness; it merely found that it was not convinced that he did have one, on the balance of probabilities. Given the difficulties of diagnosis in psychiatric contexts, such a lack of certainty was unsurprising.

Finally, the Court re-affirmed the principle in *Wilkinson* that where involuntary treatment under section 58 is challenged, the court must engage in a full merits review, including the hearing of witnesses where requested by the applicant.

The survival of *Wilkinson*

The Court of Appeal decision does bring some good news. Collins J.'s decision at first instance is but the most recent in a slow erosion of the decision in *Wilkinson*. The view of the Court of Appeal in *R.(N)* v. *M* had approached the case restrictively, holding that *Wilkinson* should not be viewed as 'a charter for routine applications to the court for oral evidence in human rights cases generally'.[14] This hesitancy was repeated in challenges to involuntary psychiatric treatment in cases such as *R. (PS)* v. *RMO*.[15] The Court of Appeal in *Haddock* is markedly more expansive. The patient challenging involuntary treatment under section 58(3)(b) is 'entitled to require the attendance of witnesses to give evidence and to be cross-examined.'[16] This

[11] At [33].
[12] At [39].
[13] At [42].
[14] [2002] E.W.C.A. Civ. 1789 at [39].
[15] [2003] E.W.H.C. 2335 (Admin) at [22-3].
[16] [64].

formulation is mandatory: an applicant has a right to oral evidence, a right that the Court must grant subject only perhaps to a qualification based on relevance.

At least for issues surrounding compulsory treatment under the MHA, this must be correct. As the Court of Appeal notes, such decisions are outside the scope of MHRTs: the application for judicial review is the first time the applicant's rights will be considered in a judicial context. As such this is not simply a judicial review hearing where the issue is the reasonableness of administrative conduct; it is instead the only forum where the individual can have factual issues relevant to their rights under the Human Rights Act determined. In *Haddock* neither party asked for the professional witnesses to be called to give oral testimony, and therefore the failure to call them was thus not open to criticism. B's counsel did ask that B be called as a witness, a request that Collins J. declined, holding that 'it did not seem to me that his evidence would conceivably assist me in reaching my decision'.[17] The Court of Appeal concurs with this approach. While the requirement that evidence must be such as would assist the court may make sense as a general principle, the failure to call B warrants some discussion. It creates a sense that B himself is somehow peripheral to the decision at issue. Collins J.stated that he was content to take B's written statement 'at face value'. [18] The medical evidence is analysed in considerable detail. By comparison, B's statement is quoted only once, briefly, to the effect that his value system has long been opposed to medication, and that 'for this reason … a number of medical reports, both recent and in the past, have been inaccurate, and have failed also to fairly or accurately reflect my views'.[19] In this statement, B calls into question the accuracy of the medical records upon which the Court relies in its decision. If his statement was in fact being taken 'at face value', it is difficult to see that such a challenge could be ignored, and if such a challenge were taken seriously, it is difficult to see that B's evidence would not assist the Court.

Further, B's capacity was contested at first instance. Consistent with some of the previous case law, Collins J. had taken the view that B's capacity was relevant to whether treatment should be enforced upon him. [20] The relevant evidence was disputed. While there was certainly evidence consistent with a lack of capacity in the reports of some of the professionals testifying on behalf of the respondents, a psychiatrist and a professor of psychology testifying on behalf of B took the view that B was not suffering from a mental disorder at all. Insofar as B's resistance to treatment was based on a similar belief, it is not obvious that it indicates a lack of capacity, even if the belief was erroneous. Further, at least one of the experts testifying on behalf of the respondents viewed the finding that B lacked capacity as 'highly debateable'.[21] If B's capacity is a matter of relevance, it is surprising that B's evidence was taken to be irrelevant, given the complexity of the determination of capacity.

SOADs

[17] *Supra* n.5, at [14].
[18] Ibid.
[19] Ibid. at [28].
[20] *Supra* n.5, at [8] quoting para 16.21 of the Code of Practice; at [10], quoting Simon Brown L.J. in *Wilkinson* at [30].
[21] Ibid., at [29].

The High Court and Court of Appeal adopt rather different approaches to the role of the SOAD. For Collins J. the SOAD is to be a meaningful safeguard for persons potentially subjected to treatment without consent. He reminds us of the processes with which they must comply prior to providing their opinion, including consultation with two members of the treatment team who are not doctors.[22] He further quotes the relevant portions of the Code of Practice, noting the need for the SOAD to form an independent view of the appropriateness of treatment, based on the consensus view of appropriate treatment for the condition, the therapeutic efficacy of the treatment, the reasons for any capable refusal of the patient, any other options for treatment, and the patient's experience of similar treatments and episodes of a similar disorder. [23] He notes the duty of an SOAD to provide reasons for his or her decision. [24] While the Court of Appeal does acknowledge the need of the SOAD to form an independent view,[25] the Court appears to view the role of the SOAD as much less rigorous:

> Plainly, the notion of 'likelihood' in section 58(3)(b) should, if possible, be construed compatibly with ECHR jurisprudence. But the SOAD's task is a medical one, to be undertaken on the Bolam principle, which is likely in almost all cases to involve consideration of the best interests of the patient, and may also take into account non-clinical factors;… However, it does not, and could not, properly include a conclusion by him as to whether his decision is a Convention compliant application of the section 58(3)(b) threshold of 'likelihood' of therapeutic benefit.[26]

The expectation that the SOAD will adopt a *Bolam* approach, approving the treatment if it is consistent with a reasonable body of medical opinion, is cause for concern. While certainly SOADs should be receptive to different professional approaches, *Bolam* is a test of professional negligence. It would significantly reduce the value of the SOAD as a safeguard, if his or her role were merely to ensure that a patient was not treated negligently. The SOAD role would add nothing to the common law standard, applicable in any event: it would provide no new substantive safeguard to the patient. It is difficult to see that this is the intent of the legislation. As noted above, the movement elsewhere in law is to tighten up the decision-making criteria, so that a standard higher than *Bolam* is expected; it is not obvious why such a move should be resisted in the current context.

Herczegfalvy

The Court of Appeal took as its starting point the decision of the European Court of Human Rights in *Herczgelfavy* v. *Austria*. In that case, the Court ruled that:

> The established principles of medicine are admittedly in principle decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot

[22]Ibid. at [8].
[23] Ibid. [8-11].
[24]Ibid. at [16].
[25]At [9].
[26] At [34].

> be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist.[27]

The Court of Appeal adopted a rather broad reading of Heczegfalvy, noting that:

> The section 58(3) power to treat a patient capable of consent against his will or a patient incapable of consent is potentially a violation of his Article 3 right not to be subjected to degrading treatment and/or his Article 8 right to respect for his private life. However, it is common ground that, while the risk of infringement of those rights may be greater when the patient is capable of giving or refusing consent, it is not necessarily an infringement to treat him against his will where such treatment can be convincingly shown to be medically or therapeutically necessary.

Such a reading of *Herczegfalvy* is not appropriate. Mr Herczegfalvy lacked capacity to make the specific treatment decisions at issue, had been held to lack capacity by a court, and had had a substitute decision-maker appointed on his behalf who had been consulted and agreed throughout to the treatments at issue. When the ECtHR refers to 'such cases', it is referring to people who are 'entirely incapable of deciding for themselves'. [28]

The factual, and arguably historical,[29] context of *Herczegfalvy* should therefore not be lost. Medical necessity is only part of the picture, and the case has nothing to say about refusals of treatment by competent patients. Articles 3 and 8 of the ECHR have a rich and expanding case law which will no doubt raise new issues before the ECtHR relating to psychiatric treatment.[30] *Herczegfalvy* shows the ECtHR dipping its toe for the first time into the waters of psychiatric treatment. It should be understood as the Court's first word on the subject, but certainly not its last. In this context, there is a certain artificiality about asking whether the *Herczegfalvy* test should be read as one question or two. The judgment does not provide a detailed approach: the ECtHR deals with his entire Article 3 complaint in five paragraphs. There was no dispute as to Mr Herczegfalvy's diagnosis; merely on the appropriateness of treatment. It is not necessarily helpful to become too fixated on how the Court would have answered a question it was not asked.

None of this necessarily means that compulsory treatment cannot be compliant with the ECHR. It does, however, serve as a warning sign: we cannot assume that the provisions of the MHA, which provide no safeguards for the first three months of treatment and only minimal procedural safeguards thereafter, will be found to be compliant by the Strasbourg court. That is the pending crisis. A debate as to whether the *Herczegfalvy* test involves one question or two is unlikely to progress us very far in its resolution. A proper debate about the appropriate safeguards to involuntary

[27] At [12].
[28] (1993) 15 E.H.R.R. 437, at [82].
[29] The case pre-dates the standards relating to psychiatric facilities of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, CPT/Inf/E (2002 1, pp. 52-62, originally published as part of the Committee's 8th General Report, CPT/Inf (98) 12.
[30] See P. Bartlett, O. Lewis and O. Thorold, *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff 2006) ch 3 and 4.

treatment belongs at first instance in the legislative realm. The Government has shown no stomach for engaging in such a debate. Even when intending an extensive re-writing of the current MHA, substantive criteria for involuntary treatment were few. Now that the government has retreated from that more ambitious programme of reform, it looks as though it intends no reform at all for the provision of substantive criteria for compulsory treatment. This is unfortunate, as it means policy reform is likely to be driven on a case-by-case basis, followed by hurried and reactive legislative responses.

Medical Necessity and Human Rights

In a relatively short case note, it is barely possible to commence a discussion of how we might conceptualise justified cases of compulsory treatment in the context of human rights. A few thoughts flowing from the reasons for judgment of Collins J. and Auld L.J. are nonetheless appropriate.

In the English tradition, reflected in the drafting of the ECHR, human rights are in essence about individual freedom and the limits of state power. Certainly, other human rights discourses have modified that to some degree by conceptualising human rights as a floor to substantive standards of living, but the core of the ECHR Articles, drafted in the response to authoritarian governments in pre-war Europe, is about controlling the state and protecting individual freedom. Non-consensual treatment is thus a constitutional question. We should therefore be hesitant about adopting models from tort, such as *Bolam*: they are not designed to resolve constitutional issues. Treatment without consent of people with capacity raises important issues, as the autonomy of the individual is overruled by the authority of the state. There is a line of argument that maintains that involuntary treatment should be able to follow from involuntary confinement. As Baroness Hale states in *Ashworth*, 'once the state has taken away a person's liberty and detained him in a hospital with a view to medical treatment, the state should be able (some would say obliged) to provide him with the treatment which he needs.' [31] From a human rights perspective, this is not as clear as this quotation suggests. Forced physical confinement is quite a different intervention into liberty from the introduction of drugs into an individual's body. While many certainly find the beneficial effects of the drug treatments outweigh the adverse effects, this does not change the fact that they act within the body, and are as such extraordinarily intrusive. The recent policy trends have stressed the confinement of people that are dangerous, for public safety. If we understand that to be the state's justification for confinement, the public safety aim is accomplished with the confinement. It is not obvious what the further state objective would be, that would justify an additional infringement on the individual's liberty to make treatment decisions when he or she has capacity to do so.

The Court of Appeal decision acknowledges that the right to be free from enforced treatment is based on a recognition of the importance of individual autonomy:

> invasion [i.e., involuntary treatment] of a mentally disordered person's being and privacy without his consent should, in any civilised system of law, only be

[31] [2005] U.K.H.L. 20 at [31].

> permissible on clear proof of medical necessity, which is a composite of a number of considerations.[32]

Involuntary treatment – psychiatric or otherwise – is an invasion of an individual's autonomy, and requires a clear legal structure if it is to be justified. If we are to take human rights seriously in this context, that structure must contain both procedural and substantive elements, and be clear enough to provide meaningful guidance to practitioners and patients alike. It is here that the approach of the English courts becomes problematic. The Court of Appeal continues:

> These include the likelihood of the treatment benefiting the patient therapeutically and/or otherwise for his protection and/or for the protection of others, the availability of viable alternatives and -- to the extent that they may not be covered by therapeutic benefit -- the best interests of the patient. [33]

The first difficulty with this list is that it does not reflect a coherent view of the constitutional question, but instead reflects a range of policy goods and other health law standards. This is most clear regarding therapeutic benefit and best interests: simply because a treatment may benefit an individual, it does not follow that the state is justified in enforcing the treatment on the individual. The state does not consider itself justified in so doing for physical disorders; it is not obvious why mental disorders should lead to a different result. Second, no guidance is provided as to how the items identified are to be weighted against each other, nor how effective a treatment must be in achieving these aims. As such, the approach fails both on the constitutional question, and the problem of practicality: the criteria do not make it clear why is the state justified in intervening in the individual's life; nor do they provide a framework of sufficient clarity that a reasonably competent practitioner will receive adequate guidance as to how to proceed in individual cases.

Both Auld L.J. and Collins J. stress the intrinsic difficulties in the practice of psychiatry. Auld L.J. warns that 'the safeguards of the ECHR should not be deployed so as to cut across the grain of medical good practice'. [34] The risk of this, it would seem, flows from inherent difficulties of psychiatric practice:

> First, the discipline of psychiatry is one which, notoriously, poses particular difficulties of diagnosis and distinction between mental illness in a clinical sense and personality disorders or other failings. An overly prescriptive or compartmentalised treatment of the processes provided by the Act, with a view to attempting precise and mutually exclusive diagnoses, would bear little relationship to the practicalities of psychiatrists' therapeutic and associated forensic work. [35]

This is an odd argument from a human rights standpoint, as it suggests that the fact that an area is fraught with uncertainty is a justification for restricting human rights protection within that area. If we are serious that treatment without consent constitutes an 'invasion', to use Auld L.J.'s word, it would instead seem that enforced

[32] At [6].
[33] Ibid.
[34] At [33].
[35] At [36].

interventions in such uncertain circumstances ought to be approached with particular caution. If we accept that enforced treatment is a constitutional question, it is far from clear that the state is more justified in restricting an individual's rights in cases where the knowledge base of the intervention is so fluid.

It is also necessary to question the deference shown to the medical profession. Similar arguments apply whenever human rights protections cut across professional practice. No doubt police officers and prison guards, for example, feel themselves undercut by the safeguards provided by the ECHR and other human rights legislation. We would nonetheless not argue that 'the safeguards of the ECHR should not be construed so as to cut across the grain of good policing'. To do so would make human rights subject to professional practices that do not necessarily place human rights high on the professional agenda. If we believe in human rights as at the core of our constitutional democracy, they cannot be made subservient to professional practice.

In *Haddock*, Collins J. was notably hesitant to insist that professional practice be justified by hard evidence. B's expert witness had called into question the appropriateness of treatment with antipsychotic medication for personality disorder. He acknowledged that such treatment was used by some clinicians, but stated that the evidence base for its efficacy was weak. Evidence-based practice is not a new concept in medicine; it seems not unreasonable to insist that practitioners wishing to treat persons without consent should at the very least be able to demonstrate a solid and objective foundation for their belief that the treatment would be beneficial to the patient. Even a superficial trawl of the literature would suggest that a more careful analysis would have been appropriate. The Cochrane Collaboration, the leading repository of meta-studies of medical treatments, contains an analysis of pharmacological treatment for borderline personality disorder.[36] It concludes that 'Evidence of the effects of commonly prescribed drugs is poor but not without some areas of hope.'[37] Its optimism is however directed primarily at anti-depressants, not anti-psychotics. Either way, it notes that 'pharmacological treatment of people with BPD is not based on good evidence from trials'.[38] The judgment does not tell us whether B was diagnosed with borderline personality disorder or some other form of personality disorder – indeed, the Court declines to make a finding regarding diagnosis. Nonetheless, the similarity between the Cochrane review and the views of B's expert are striking, and suggest that more careful investigation and analysis by the Court might well have been appropriate.

Conclusion

The outcome of the *Haddock* case would appear to be that any rights under Articles 3 or 8 of the ECHR to be free from involuntary treatment are to be subject to the professional practice of the psychiatric profession: that is not to be subject to significant scrutiny. The survival of *Wilkinson* is a significant victory for a rights-

[36] C.A. Binks, M. Fenton, L. McCarthy, T. Lee, C.E. Adams, C. Duggan, "Pharmacological Interventions for People with Borderline Personality Disorder" 2006(1) *Cochrane Database of Systematic Reviews* Art. No.: CD005653. DOI: 10.1002/14651858.CD005653.
[37] Ibid., p. 2.
[38] Ibid., p. 1; see also p. 19.

based approach, but it can only have substantive effect if, the courts couple it with clear and substantive safeguards that must be met prior to the imposition of involuntary treatment. The substantive discussion in *Haddock* shows how little advance has been made in articulating a framework robust enough to pass human rights scrutiny, and clear enough to assist practitioners.