Reform of the Mental Health Act 1983: Squandering an Opportunity?

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This article compares and contrasts two recently published documents. First, the Report of the Expert Committee (chaired by Professor Genevra Richardson) entitled 'Review of the Mental Health Act 1983'. I shall refer to it throughout as the Richardson Report ('RR').[1] Second, 'Reform of the Mental Health Act 1983 - Proposals for Consultation', which is referred to here as the Green Paper ('GP').[2]

Whilst both documents were published in November 1999 under the remit of the Department of Health ('DoH'), the Richardson Report preceded the Green Paper. It was delivered in July 1999 to the Parliamentary Under Secretary of State for Health, John Hutton. The Richardson Committee had been established in September 1998 by the DoH in order to provide them with expert advice. The Committee was serviced by the DoH. Accordingly, the contents of the final report would have come as no surprise to them, since they had themselves been fully exposed to the developing reasoning of Richardson. In publishing their own Green Paper some four months later, the DoH had had an opportunity to reflect upon the final Richardson Report. Nonetheless, some might argue that, given the time-scale involved in the production of other similar documents in the field, this rush to a Green Paper was unseemly and unwise. Moreover, since it departs markedly from the recommendations of Richardson, one might argue that the pressure to produce has been, and will prove, counter-productive.

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1 *Copies of the Richardson Report may be obtained free from Will Niblett, Department of Health, Wellington House, 135-155 Waterloo Road, London SE1 8UG. It is also available on the DoH website at: www.doh.gov.uk/mentalhealth.htm*

2 *Copies of the Green Paper are available from the same address, price £10.50, or on the same website.*

Disclosure and disclaimer

Whilst I was a member of the Richardson Committee, I had no explicit involvement in the production of the Green Paper.[3] Indeed, I had no sight of it until the morning of its publication. All that follows should accordingly be read in the peculiar light of someone who is inevitably biased in favour of Richardson (the Report was unanimously approved by its 12 members) and wary (a consequence perhaps of social exclusion) of the Green Paper. *Caveat emptor*.

In examining the two documents together my objective is not to promote the Richardson Report by casting the Green Paper into a less than glowing light. Richardson is not a perfect prescription for mental health law, nor even a complete one. Indeed, the Report recognised the complexity of both the issues and the context in which the government proposed to legislate; we argued vociferously for the need for further extensive consultation.[4] In publishing the Green Paper, the government *is* engaging in further consultation. However, I am concerned that this exercise will not properly address the issues Richardson had identified. This is partly because the Green Paper is itself a confusing morass of consultation points and recommendations without the required reasoning or justification, combined with elements plundered from the Richardson Report but taken out of their proper context, all set alongside other related policy initiatives; namely, with respect to dangerous severe personality disorder, incapacity and the national service framework.[5] It is also because the time-frame for further consultation is short (with final responses needing to be made by 31st March 2000) and because it is hard to imagine how those consulted for a third time (Richardson consulted twice), but about markedly different proposals, will have the energy to address the issues afresh. Indeed, for those issues where Richardson argued that further consultation was critical two will serve as examples; first, charging for services for those subject to or discharged from compulsion, and second, the implications for those with long term incapacity. These two issues are respectively subject, under the Green Paper, merely to the vague assurances that government 'will develop proposals'[6] or will 'consult closely with interested parties'.[7] Thus, whilst this article might be regarded as sour grapes from the scorned academic, it is intended to assist those reading and commenting on the Green Paper to understand its antecedents and prognosis.

Context and content

Before turning to the detail of the two documents, some further cautionary observations are necessary. First, the aims and objectives of the two differ. The Richardson Committee was set up with a fairly clear brief. It was not our task to formulate policy, rather to enable the legislative framework to reflect government policy. Whilst reform of the Act and not its abolition was the objective set, we *were* asked to undertake a 'root and branch review' and to adopt 'a fresh approach and find innovative solutions'.[8] However, one policy objective was stated with remarkable clarity, and presented as a central tenet critical to the whole programme of reform. That objective was the need for the Committee to address the issue of compulsory treatment in the community.

3 *Whilst the usual disclaimer applies, namely that the particular expression of the views in this article are mine, its content was circulated to the chair and other members of the Richardson Committee, who have not demurred.*

4 *RR at pp 15-17*

5 *See 'Managing dangerous people with severe personality disorder - proposals for policy development' Home Office/Department of Health (1999); 'Making Decisions' Lord Chancellor's Department (1999) Cm 4465; 'Mental Health National Service Framework' Department of Health (1999). For the government's background strategy to improve services to those with mental disorder see 'Modernising Mental Health Services' Department of Health (1998)*

6 *GP at p 43*

7 *GP at p 74*

8 *Speech by Paul Boateng, then Parliamentary Under Secretary of State for the Health Department, delivered at the first plenary meeting of the Richardson Committee. Reproduced in RR at pp 140-145*

As Paul Boateng put it

'.. if there is a responsibility on statutory authorities to ensure the delivery of quality services to patients through the application of agreed individual care plans, so there is also, increasingly, a responsibility on individual patients to comply with their programmes of care. Non compliance can no longer be an option when appropriate care in appropriate settings is in place. I have made it clear to the field that this is not negotiable'.[9]

Thus, 'non compliance is not an option' was to apply both to patients and to clinicians.

The foreword to the Green Paper sets out its objectives, namely 'to modernise the legal framework within which mental health care is delivered'. The emphasis is on the need for services that are 'genuinely safe, sound and supportive'. Again there is an emphasis on the demands posed by the shift to community care: hence, 'people with mental health problems often need more active and intensive support'. But, where Richardson was urged to be radical (albeit there was a clear bottom line in the need to produce proposals for some compulsion *in* the community), the Green Paper's conception of modernising mental health services entails a controlling and cautionary emphasis. In short, it is reactionary. This is perhaps most explicit in its discussion of the need for compulsory care and treatment in the community

'..too often, patients treated in hospital - both formally and informally - fail to follow their treatment plans on discharge and need to be re-admitted to hospital because their condition deteriorates following loss of contact with care services. It is totally unacceptable that a group of patients who are known to pose a risk either to themselves or to others when they fail to comply with treatment, should so easily drop out of care in this way - sometimes with tragic results'.[10]

Second, the genesis of the two documents bears comparison. The Richardson Report sets out its methodology,[11] authorship,[12] sources[13] and time-scale, with the Committee holding various meetings and making site visits, and issuing both a 'Key Themes' document[14] and a draft report for further consultation, over a period of some 10 months. In total, over 600 submissions from individuals and organisations were received. The Green Paper, albeit typical of such documents, fails to set out is own methodology in any meaningful fashion. Whilst the Green Paper has a forward written by Alan Milburn, the Secretary of State for Health and Alan Michael, the First Secretary, National Assembly of Wales, it would be surprising if either of these had had a hand in the production of the Green Paper. Indeed, Alan Milburn had only just been appointed following Frank Dobson's 'mayoral' resignation. Since civil servants do not put their names to such published policy documents it is impossible to know for certain who, or how many, were involved in its drafting. The provenance of the Green Paper is thus largely unclear.

However, what the Green Paper does disclose about its own background is curious. First, it asserts that

'The work undertaken by the Committee has been a very valuable first phase of the review of the Act. Although not all of their recommendations are accepted.....the overall framework for new legislation described in the Committee's report has been adopted as the framework for the proposals in this consultation paper'.[15]

The thrust of this article casts some doubt on that proposition. The Green Paper further asserts that its proposals have 'been informed by discussion with researchers who are currently engaged in an extensive programme of projects that we commissioned to look into the way that the 1983 Mental Health Act operates'.[16]

9 RR at p 142
10 GP at p 37
11 RR at pp 129-132
12 RR at pp v-vi
13 RR at pp 133-139, 150-170
14 RR at pp 146-149
15 GP at p 7
16 GP at p 7

Again, as one of those researchers it suffices at this stage for me to observe that even the Green Paper accepts that the bulk of this research was only completed *after* the publication of the Green Paper.[17] Both of these assertions are accordingly economical by comparison with Richardson's 32 pages detailing its methodology, meetings, expert reports commissioned and responses received. In short, Richardson has laid bare its roots; the Green Paper is clothed, if not cloaked, in the terminology of 'Yes, Minister'.

The length of the substance of the two documents is also telling. The Richardson Report covers 126 pages; the Green Paper 70 pages. Pedants engaged in a visual inspection of the Green Paper would argue that much of it reproduces (in the blue background boxes) Richardson's text. Moreover, the Green Paper acknowledges that it does not set out in detail everything that a new Act would include, which, it asserts, will be done in its formal proposals to be published later this year (presumably in a White Paper).[18] However, the Green Paper is markedly short on explanation. Proponents of its approach might argue that these are to be found in the concurrently published Richardson Report; devotees of Richardson would respond by arguing that Richardson's philosophical underpinnings support its framework, not that actually set out in the Green Paper.[19]

Finally, and lest it be thought that the Green Paper is wholly without merit, two features are noteworthy at this stage. First, the Green Paper recommends that all patients subject to compulsory care and treatment beyond 28 days should have their case *automatically* considered by an independent mental disorder tribunal. Secondly, the 'burden of proof' will shift from those subject to compulsion (under the current Act) to the care team (under the new Act); henceforth it would be for the care team to demonstrate that the criteria for making a compulsory order were met.[20] Taken together, these recommendations should significantly enhance the position of those already under a disability and disadvantage by reason of their mental state.

The differences detailed

The contrast between the Richardson Report and the Green Paper is stark. The latter has been described as taking parts of the skeleton of Richardson, but abandoning its ethical heart[21]; to this one might add, and its principled musculature. The tone of the two documents is also markedly different, with Richardson's emphasis on non-discrimination, patient autonomy and capacity and the Green Paper focusing on risk as being a, if not the, key factor on which compulsion should turn. Moreover, whilst Richardson provides a reasoned justification for its approach, the Green Paper assumes risk to be an aproblematic notion and one that requires no justification beyond recitation of the Government's desire for services that are 'genuinely safe, sound and supportive'. Finally, whilst the Green Paper urges that the provisions of a new Act should be 'fairly and consistently implemented',[22] 'clear',[23] and that people with mental illnesses 'should be treated in the same way as people with any other illnesses'[24] it then goes on to advocate criteria for compulsion that are so broadly drawn that it is almost impossible to conceive of an individual who is suffering, or has suffered, from mental disorder who would *not* fall within the proposed criteria.[25] The criteria have the *potential* to make compulsion the rule for the treatment of

17 *GP at p 7*

18 *GP at p 6*

19 *Equally, whilst the GP cites the National Service Framework as being another element of the strategy to improve mental health services, the NSF is itself at odds with the GP. Detailing the departures of the GP from the NSF could form the basis of another article; however, p.4 of the NSF (DoH:1999), which stresses non-discrimination, service user involvement, rights for carers etc will suffice here.*

20 *GP at p 75*

21 *N. Eastman (1999: personal communication)*

22 *GP at p 10*

23 *GP at p 11*

24 *GP at p 9*

25 *GP at pp 32-33*

mental disorder. Since they clearly can be discriminatory against those with mental disorder, it is perhaps understandable that the Green Paper has also abandoned Richardson's recommendation that the principle of non-discrimination should be a central tenet of any new Act.

In promoting an alternative model to Richardson's capacity based model, the Green Paper tacitly if not overtly rejects a major plank in the Richardson scheme. The rejection of capacity with the concomitant stark difference in the entry criteria proposed by Richardson and the Green Paper is perhaps the most significant divergence between the two documents, at least in terms of their practical impact. I shall return to the differing nature of the criteria in more detail below.[26]

In asserting that people with mental illness should be treated in the same way as people with any other illness, the Green Paper reflects both the approach of Richardson and (unknowingly) anticipates the recent major report by the US Surgeon General on mental health.[27] Indeed, the latter report, in its 'Vision for the Future', acknowledges that the *majority* of those who need mental health treatment do not seek it, and further asserts that its key recommendation, of *encouraging* people to seek help, will only be achieved if society dismantles the 'sizable and significant' barriers, including stigma, which impede the treatment of those with mental illness.[28] Richardson similarly emphasised the need for non-discrimination to be a central principle in the provision of treatment and care. Indeed, it recommended that 'wherever possible the principles governing mental health care should be the same as those which govern physical health'.[29] Moreover, Richardson was cautious about the counter-productive impact of law, and sought to achieve a balance which would not result in an overall increase in the use of compulsion. In contrast, the Green Paper is content to see non-discrimination (together with other of the Richardson principles, namely patient autonomy, consensual care, reciprocity, respect for diversity, equality, respect for carers, effective communication and provision of information, and evidence based practice) consigned to a Code of Practice. Relegating these principles, together with the rejection of capacity and the adoption of extremely broad entry criteria, based on a status test, will do little to put the treatment of mental and physical disorders on an equal footing. Indeed, even the very existence such broadly drawn criteria are likely to impact on the genuineness with which people with mental disorder *consent* to informal care. Thus, one might ask whether the government's commitment to the principle of parity of care is aspirational rather than one to be embodied in legislation with a practical impact. Or expressed in language not behoven to civil servants, they are being downright deceitful.

i) Principles and perspective

Richardson adopted the view, reflecting many of the submissions it had received, that future legislation should be underpinned by a series of principles which should be both articulated and central to the devising and implementation of a statutory framework. In addition to the paramount principles of non-discrimination and patient autonomy, ten further principles were spelt out and subsequently threaded through the Report. The Green Paper would adopt only two of these in a new Mental Health Act (informal care and service user participation) whilst creating a new 'principle' of safety of the patient and of the public, and bastardising Richardson's principle of 'least restrictive alternative', which stressed the need to provide care *both* in the least invasive manner and in the least restrictive manner, into one which stressed only locating treatment in the least restrictive setting. Thus, whilst in the Green

26 *See also the article by Professor M Gunn on capacity in this edition of the Journal at page 39*

27 *US Public Health Service (1999/2000) Mental Health: A Report of the Surgeon General. Available at www.surgeongeneral.gov/library/mentalhealth/home.html*

28 *Surgeon General's Report at pp 453-454*

29 *RR at p 21*

Paper the adoption of principles are presented as a key reform,[30] in fact, the Green Paper dismantles if not decimates Richardson's principles.

Consistent with this shift away from patient oriented principles, the Green Paper generally focuses on the views and interests of others rather than on the service user, so that Richardson's preference for a patient based 'best interests' test becomes in the Green Paper 'best interests should be determined by members of the multi-disciplinary care team, and based on their professional opinion';[31] similarly, whilst Richardson wanted treatment to take account of the safety of 'other patients, carers and staff' the Green Paper puts the emphasis on the patient's 'safety *and the safety of the public*'. Richardson also stressed the need for evidence based practice to take account not only of research evidence, but also of the views of service users; the Green Paper dismisses evidence based practice as already being part of clinical governance. Finally, Richardson stressed the need for advance agreements about care to be considered routinely,[32] the Green Paper does not endorse this view. Thus, Richardson's approach has a primary focus on the patient and attempts to facilitate and encourage patients into treatment; the Green Paper has a much greater emphasis on the interests of the public, consistent with its overarching theme of managing risk, and thus emphasises the need for widely drawn powers of compulsion.

ii) Entitlements

The Richardson Committee was greatly concerned about how to protect the principle of reciprocity, namely that where society imposes a duty on people with mental disorders to comply with treatment there should be a parallel duty on health and social care authorities to provide an appropriate standard of care and treatment, without distorting the pattern of care away from informal care to compulsory care.[33] In addition to wrestling with this problem, Richardson also made a series of recommendations about rights which should properly flow from the use of compulsion[34] and additional rights concerning access to services, including the right of a user to an assessment of their mental health needs and the right of prisoners to a similar mental health assessment. Finally, Richardson made further recommendations concerning the safeguarding of an in-patient's remaining rights. All of this receives either short shrift in the Green Paper, or, worse still, no mention at all.

iii) Entry criteria

The Green Paper presents both the Richardson criteria (with a crucial omission) and its own, as alternatives for consultation. Since the Green Paper comments following the Richardson criteria

'The principal concern about this approach is that it introduces a notion of capacity, which, in practice, may not be relevant to the final decision on whether a patient should be made subject to a compulsory order. It is the *degree of risk* that patients with mental disorder pose, to themselves or others, that is crucial to this decision'[35]

it may reasonably be assumed that capacity has not found favour with the DoH, despite there being widespread practitioner and service user support for it.

However, it is worth briefly reviewing Richardson's criteria, since the Green Paper has managed in its presentation to misrepresent them by omission (see below). Richardson adopts *some* criteria that would

30 *GP at p 75*
31 *GP at p 34*
32 *RR at p 106*
33 *RR at pp 27-28*
34 *RR at pp 28-31*
35 *GP at p 32*

be common to all compulsory orders (namely, the presence of mental disorder of such seriousness that the patient requires care and treatment under the supervision of specialist mental health services; and that the care and treatment proposed for and consequent upon, the mental disorder is the least restrictive and invasive consistent with safe and effective care; and that the proposed care and treatment is in the patient's best interests[36]). Thereafter, a capacity test applies. For those who lack capacity the compulsory order must be 'necessary for the health or safety of the patient or for the protection of others from serious harm or for the protection of the patient from serious exploitation that s/he be subject to such care and treatment, and that such care and treatment cannot be implemented unless s/he is compelled under this section'.[37] For those who retain the capacity to consent Richardson proposes two alternative approaches, which are described respectively as the consistent and the pragmatic approach to autonomy. For the consistent approach there would need to be 'a substantial risk of serious harm to the safety of other persons if s/he remains untreated'. For the pragmatic approach the criteria would be wider with 'a substantial risk of serious harm to the health or safety of the patient or to the safety of other persons' etc . Richardson recognises that the choice between these two approaches is essentially a moral one, and one for politicians to take.[38] The Green Paper ducks this issue, by eliding the two approaches[39] and then effectively dismisses the moral dilemma they pose by proposing, as an alternative, a model without a capacity test. Finally, Richardson proposes a treatability criterion (that is, going beyond that in the current Act) for all patients who retain capacity; namely, that there should be 'positive clinical measures included within the proposed care and treatment which are likely to prevent deterioration or secure an improvement in the patient's mental condition'.[40]

The dilemma which Richardson highlights with its dual (and mutually exclusive approaches) is that of 'risk to whom?' Where the risk is only to the capacitous patient then, on one analysis, it ought to be tolerated (as it would be for the physically ill). On the alternative analysis, risk to the patient's own health or safety ought to provide a basis for compulsory intervention even in the lives of capacitous patients.

In contrast, the Green Paper confuses the degree of risk with the question of risk to whom. Its preferred criteria are extremely wide.[41] It adopts Richardson's preliminary criteria, whilst omitting those relating to 'least invasive manner' and 'patient's best interests', but then goes on to require the following criteria to be met; namely, that the care and treatment be 'necessary for the health or safety of the patient and/or for the protection of others from serious harm and/or for the protection of the patient from serious exploitation'. Moreover, the patient's health or safety is explicitly to *include* issues relating to welfare and to self-harm. Since the Green Paper also seemingly envisages a compulsory community order being made without a patient first being admitted to hospital,[42] there will not be the 'restraint of beds' which Richardson envisaged on the initial use of the order. Thus, under the Green Paper proposals the use of compulsion (and its concomitant costs including those associated with automatic legal review) is likely to increase exponentially.

iv) Structure

The Green Paper is schematic and lacking in detail. There is no explanation of the process of formal assessment in community. There is no detail of the criteria that would apply before a patient could enter assessment beyond 'The application must be based on medical evidence, usually from two clinicians, and should take account of the patient's wishes and social circumstances including social care needs'.[43] The

36 RR at p 70
37 RR at p 70
38 RR at p 20
39 GP at p 31
40 RR at pp 70-71
41 See GP at pp 32-33
42 See the case of Mrs O at p 39
43 GP at p 22

Green Paper does consult on its proposal to abolish the role of the approved social worker in the initial application process. But, this is a proposal which Richardson had floated in its Draft Report and then abandoned in its final report. Whilst the Green Paper adopts much of Richardson's proposed scheme for a new multi-disciplinary tribunal,[44] there is clear disagreement about Richardson's proposal for independent review at day 7 of compulsion. The Green Paper advocates independent review at day 28. Which of the options one prefers is to some extent dependent on the premium one places on the need for consistent, fair and lawful application of the law, and on the desirability of achieving clinical effectiveness. However, combining review only at 28 days with the ability to treat patients on a compulsory basis prior to this, may run the risk of the government finding itself challenged before the ECHR. Making legislation ECHR compliant was something to which the Richardson Committee remained alive. Perhaps though, of most practical importance is the Green Paper's seeming failure to recognise that its proposal for a broad compulsory order in the community will entail a consequent hike in the numbers of tribunal hearings (with the concomitant problems and costs) for patients on the orders in the community.

Curiously, the Green Paper also floats the new idea of the tribunal either regulating the discharge of compulsory orders by permitting the tribunal to reserve the exclusive power to discharge to itself in civil cases or permitting the tribunal to decide at the point where the compulsory order is imposed to reserve to itself the right to review the discharge plan before the patient is released.[45] Those eligible for this 'extra safeguard' of tribunal only endorsed discharge might be those 'known to have a history of non-compliance with treatment, or to pose a serious risk to other people'.[46] Whilst the Green Paper promotes this approach on the grounds that it would ensure that the tribunal were satisfied that patients would receive appropriate care at the end of the period of compulsion (thus underlining the tribunal's responsibility for the process as a whole) what it would also permit (but is not spelt out) is further compulsion where the tribunal takes a different view to the care team about the continuing existence of risk. Thus, where the care team felt that no further compulsory treatment was necessary or justifiable, the tribunal might nonetheless leave an unwilling patient in their unwilling care until such time as the tribunal also shared that view. Given the well documented problems with countering probabilistic notions of risk, such a period might be considerable, thereby increasing the numbers of those subject to compulsory orders at any given time. In short, it would perpetuate the 'doctor as unwilling gaoler' situation, already resented by clinicians with respect to offender-patients who enter the mental health system on restriction orders.

v) Treatment

The Richardson Committee deliberated at length as to whether the link between loss of liberty and the use of compulsory treatment was inextricable. Ultimately, we concluded that it was not. This led logically to two propositions. First, that someone did not need to lose their liberty in order for compulsory treatment to be given, thus paving the way for some form of compulsion in the community. Second, having lost one's liberty, the imposition of invasive treatment on an unwilling but capacitous patient constituted a further infringement, which required separate justification. Amongst other options, we canvassed opinion in our Draft Report on the issue of 'detention with and without forced

44 *For further details see the article by Mark Mullins in this edition of the Journal at page 28*

45 *GP at p 41*

46 *GP at p 41*

treatment'. Whilst detention without treatment for those who pose a risk to the health and safety of others is a legal option for those suffering from infectious physical diseases,[47] such thinking is seemingly not to be applied to those with mental disorders. Having explicitly posed the possibility (with all of its drawbacks) in the Richardson Report as a moral judgment for politicians to take,[48] the Green Paper makes no mention of it.

Consistent with this notion that compulsory treatment constituted a further invasion of a patient's integrity, Richardson generally proposed a more restrictive and cautious approach to the use of compulsory treatment than has the Green Paper. In particular, Richardson argued that it could not recommend the compulsory (forcible) administration of medication in any location other than a hospital unit.[49] Whilst Ministerial statements are unequivocally clear; thus, 'We are not talking about forcibly administering treatment over the individual's kitchen table'[50] the Green Paper is worrying vague on the detail of how this would be constrained, referring merely to compulsory treatment 'in a community setting'.[51] Is a reliance on good practice and the need to reflect the views of the Minister to suffice?

Finally, the Green Paper is less than enthusiastic about Richardson's recommendations on ect and rejects its suggestion that depot medication should be subject to special safeguards. There is no mention of Richardson's recommendation that s.63 be abandoned.

vi) Criminal Justice

In dealing with matters relating to offender-patients, the Richardson Report attempted to assess the extent to which its principles, as developed for civil patients, could logically and properly be applied to those individuals whose mental health problems are disclosed in the context of offending. Whilst it came as no surprise that our recommendation that the Home Secretary should give up his exclusive power to authorise transfer and leave in restricted cases was rejected, the Green Paper barely acknowledges at all Richardson's other proposals in the criminal justice context. Given that Richardson had canvassed the views of all of the major criminal justice players, some might regard it as unacceptable that its recommendations barely receive a mention.

As controversially, but without seemingly recognising that such an approach is controversial, the Green Paper's recommendations assume that doctors can address offending behaviour through medical intervention and that compulsion will continue based primarily on the level of risk.[52] Since untreatability is not to be an impediment to continued compulsion, this recommendation again potentially casts health care professionals into the role of gaolers. However, it is consistent with the Green Paper's approach above in respect of civil orders.

Finally, it is worth observing that should the Green Paper be adopted in its present form, whatever resolution there is of the current debate over dangerous severe personality disorder (DSPD) will be redundant. For under the Green Paper's proposals, where there is no treatability criterion, there will be no impediment to admitting those with personality disorder and detaining them indefinitely on the grounds of risk.

47 *See ss 37-38 of the Public Health (Control of Disease) Act 1984. Equally of note, s.35 of the same Act permits court ordered medical examination and testing of those with notifiable diseases, but not their treatment.*

48 *RR at p 95*

49 *RR at 75*

50 *Paul Boateng to the Richardson Committee: see RR at p 142*

51 *GP at p 39*

52 *GP at p 46*

vii) Other omissions

It would be possible for me to detail at much greater length the varied and various ways in which the Green Paper differs from the Richardson Report, fails to address critical matters in detail, or makes proposals which will clearly have wholly unworkable implications, particularly by extending the boundaries and use of compulsion. But space does not permit me to be so ungenerous. Instead, I should just like to touch on the flavour of some other omissions and departures.

First, in respect of safeguards, the Green Paper is lukewarm on issues of advocacy and advance agreements (with its rejection of a capacity based approach, this is perhaps inevitable). Second, it makes no commitment to introduce the essential statutory framework to resolve the *Bournewood* problem, namely, that arising where patients with long term incapacity with mental disorder, and who are currently treated informally, may or may not be unwilling to receive treatment. Whilst Richardson made no pretence that it had 'solved' the *Bournewood* problem, it did address the issue and make some recommendations for an appropriate framework. Third, the Green Paper, whilst recognising the Government's need to implement a programme of research so that it might better understand how the current Act is being applied, does not adopt Richardson's recommendation for monitoring use of and compliance with any new legislation, including the Code of Practice; rather, it merely 'welcomes comments on the list of functions proposed by the Committee' for the Mental Health Act Commission.[53] Thus, the government again risks finding itself in the position it did when it came to undertake its current review of the Act; namely, not knowing, and having no means of finding out within the necessary time-scale, whether and how the current Act was working. Fourth, in an attempt to meet some of the problems relating to race discrimination in the use of the current Act, Richardson recommended both the monitoring of its principles and the introduction of a requirement that there be 'objective' evidence on which to order compulsory assessment. Neither of these proposals is mentioned in the Green Paper. Finally, in rejecting a capacity based test for compulsion and a treatability test, but adopting a broad definition of mental disorder which does not exclude learning disability or personality disorder, the Green Paper, whilst seemingly desirous to promote patients' 'ability to consent to treatment and involve them in decisions on their own care'[54] is unclear as to how this might be achieved. This problem is made more acute since the Green Paper omits all of Richardson's supporting mechanisms for a capacity based test. Thus, the Green Paper is content to leave to 'good practice' and a (non-statutory) Code of Practice all of the problems that will arise where patients with learning disability or personality disorder retain their capacity to make treatment decisions. While clinicians may know best, they do not always know best and nor do patients necessarily share their views. In practice, however, the Green Paper will leave such patients with few options successfully to challenge those views.

53 *GP at p 64*
54 *GP at p 33*

Conclusion

The Richardson Report was very clear in its recommendation that its proposals represented a coherent whole, capable of delivering the government's objectives in a way that would be acceptable to those whose co-operation would be vital to its success. Whilst we believed that our final report did reflect the values and ethics of those exposed to mental health services on the ground, we also argued the report 'must be taken as a whole, few elements of it could survive on their own'.[55] For this reason we urged that it not be cherry picked. Regrettably, the Green Paper has not just cherry picked, but it has sought to justify its own controversial proposals (for example, for a broad compulsory order in the community) by reference to Richardson's proposals (which were for a highly constrained community order). As the Green Paper states seemingly without irony 'We accept the Committee's proposals for extending the powers of compulsory care and treatment beyond hospital'.[56] This is little short of tendentious.

However, it is also dangerous. Whilst at the beginning of this article it was argued that one aspect of merit in the Green Paper was its advocacy of an automatic tribunal with a reversed burden of proof, it should now be clear that even this safeguard is an empty shell. For, given the extremely broad criteria that the Green Paper advocates, no care team will be inconvenienced (let alone challenged) by the need to satisfy the tribunal that the criteria are met. Richardson's approach, with initially broad criteria which become progressively more detailed as clinicians seek to impose treatment on those who retain capacity, would have had a legally constraining impact, giving the tribunal something on which to bite. Challenging the Green Paper's criteria would be like getting to grips with a blancmange.

It remains a mystery as to whether the Green Paper misrepresents the Richardson Report, fails to understand it or is rejecting of it in the politest of civil service fashions. But, despite the laudatory language, reject it it most certainly has.

55 *RR at p 14*
56 *GP at p 39*