

The Lord Bishop of Manchester: My Lords, as the noble Lord, Lord Rix, powerfully indicated from his very considerable experience and wisdom in this area, many aspects of the Bill are a disappointment. As he said, it marks the latest stage in a lengthy argument about the purpose of mental health legislation. The decision not to proceed with the 2004 draft Bill was wise, not least in view of the breadth of opposition to it. However, the Bill now before your Lordships has not taken sufficient account of the criticism brought against several of its proposals, not least, as the noble Lord, Lord Rix, indicated, by the comprehensive report of the Joint Committee chaired by the noble Lord, Lord Carlile of Berriew.

The Bill seeks to strike a balance between the rights and autonomy of patients and the safety of both patients and the public. Certainly, Christian teaching in its concern to protect vulnerable people requires due weight to be given to both aspects. Autonomy is a vital safeguard for mentally ill people in giving priority to their opinions, feelings and interests concerning care and treatment over and against the interests of others, including the relatively powerful professionals and institutions treating them. However, autonomy may need to be limited or indeed overridden, either because, as the noble Baroness, Lady Carnegy, said, someone poses a danger to themselves or, less commonly, to other people, or because their ability to make decisions has been significantly impaired by their illness. Regrettably, the latter criterion is absent from the Bill.

Six issues are of particular concern to these Benches. First, as the noble Lord, Lord Rix, said, is the absence from the Bill of a set of general principles for the care and treatment of people with mental health problems. That is very disappointing. Such principles expressed in statute rather than in codes of practice would be helpful to practitioners and reassuring to service users not only when facing questions about compulsory powers but as a broad guide to good practice.

Secondly, if the definition of “mental disorder” is to be simplified, as proposed in Clause 1, it is important that the specific exclusions from coverage of the Act should be maintained and, preferably, extended. Compulsory detention and treatment should be based strictly on mental disorder and should certainly not be used for the purpose of social control. I welcome the continued restriction on the circumstances in which people with learning disabilities can be subjected to compulsion, and the exclusion of substance abuse. I note what the Minister has said and what has been written in background material on sexual deviance. In Committee, it may be useful to debate all these matters and possibly certain cultural and political beliefs when considering grounds for exclusion. Problems in applying the categories should be tackled by training and not by the adoption of an excessively broad definition.

Thirdly, the potential danger posed by a relatively small number of people with severe personality disorders that are judged to be untreatable must not be allowed to blur the distinction between compulsory treatment and preventive detention. The criterion of “appropriate medical treatment” employed in Clauses 4 to 6 without the requirement of therapeutic benefit to the patient is unacceptably vague. It threatens to turn mental health professionals into guardians of public safety rather than what they are meant to

be, which is agents of care and healing. If, as the Government argue, there is no desire to detain people without a clinical purpose, why not say so explicitly? Those who are untreatable but are believed to pose a serious risk to other people should be dealt with under criminal justice rather than mental health legislation.

Fourthly, there is perhaps the most controversial part of the Bill, the proposals in Clauses 25 to 29 for supervised community treatment. They arise from real shortcomings at present in dealing with patients who have been discharged from hospital and then suffer relapse in the community. However, those failings, which as we know sometimes have tragic results, are not solely the result of the absence of compulsory treatment. Too often, they reflect the inadequacy of aftercare and support services and failure to work effectively with patients and carers within the existing law. That said, I accept that there is a case for community treatment orders to be applied to what the Joint Committee described as a,

“clearly defined and clinically identifiable group of patients”.

That would entail raising the threshold of eligibility to include previous relapse, requiring consultation with carers, narrowing the conditions of the order to residence and availability for treatment, and setting a time limit. The requirement that a patient should abstain from particular conduct is, as the Mental Health Alliance has commented, tantamount to creating a “psychiatric ASBO”. We must think carefully about designing community treatment orders so that they will be effective for their intended purpose.

Fifthly, it is welcome that in Clause 38 the Government have moved to remedy the so-called Bournemouth gap, which was referred to both by the Minister and the noble Lord, Lord Rix, by amending the Mental Capacity Act. While logical in its way, this has the effect of creating a complicated set of procedures with safeguards that are inferior to those of the Mental Health Act. Patients who lack the capacity to consent to detention and treatment will be disadvantaged in terms of their rights to a second medical opinion, to a hearing and to aftercare. They will be disadvantaged in the maximum length of a detention order and lack of access to a mental health review tribunal. In addition, their relatives will not be able to request an assessment of detention or an ordering of their discharge. This smacks of minimal compliance with human rights legislation and I hope that in subsequent debate in Committee your Lordships will be able to suggest suitable improvements.

Finally, I regret that the limited scope of the Bill has diverted attention from the primary need to improve mental health services. If we were to take seriously the right of patients to timely assessment of mental health needs, to independent advocacy and to non-discriminatory treatment, we would be less preoccupied with crisis intervention and a great deal of avoidable suffering and distress would have been prevented. The Scottish mental health Act of 2003 offers a good starting point in that respect. We will need to return to these urgent questions which, together with families and carers, directly affect one quarter of the population of this country.