Dilemmas of insanity

The mental health bill fiasco is a classic dilemma of public protection versus human rights

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Half a mile from where I live, a mentally ill man recently killed a retired couple in their home. Daniel Gonzalez's family had made more than 100 unanswered pleas to get help for him. He was apparently treatable, but, reluctant to engage with services that didn't try hard enough to engage with him, spiralled into drug abuse and beyond. There are countless stories of people in distress, often supported by despairing carers, failing to get help, but the outcome in Gonzalez's case was highly unusual: he harmed people he didn't know. If they harm at all, such people far more often harm themselves than others. Gonzalez and his victims were failed not by mental health law, which makes it clear that pleas for help must be met, but by individuals and services failing to implement it.

That does not prevent such cases being viewed, particularly in the media, as evidence that something legislative needs to be done. And this highlights an uncomfortable distinction, already enshrined in the 1983 Mental Health Act, between mental and physical illness. Bird flu might conceivably change this, but at the moment no law can force people with contagious physical illness to be treated for their own sake or that of others. Not so with the minefield of mental health legislation, which exists to do precisely that.

This minefield has just seen an eight-year, £8m struggle over the new draft mental health bill come to a messy end. The attempt to rewrite mental health law began with an earlier individual case; a tragic event which re-enforced in the public mind the link between mental illness and violence. Michael Stone, convicted in 1996 for killing Lin and Megan Russell, had a dangerous, severe personality disorder, but could not be held under mental health legislation because he was considered untreatable. The proposed new bill abandoned this criterion, so that people like Stone could be deprived of their liberty before they offended—to protect the public.
If it had been merely a public protection bill, it might conceivably have been coherent. In this case, the very few mentally ill people who are genuinely dangerous might more easily be detained—although the many more who aren't would also face losing their liberty. Such a bill would have risked scooping up people with learning disabilities alongside those with mental illness. It would have been draconian, depriving people of their liberty in order to pre-empt the possible future risks that they posed. It would have meant giving psychiatrists without treatment to offer the power to act as jailors. It would have had terrible consequences, but it might have made at least logical sense.

Instead, the new bill failed because it sought to combine this public protection urge with a conflicting one that sought to preserve human liberties. One aim of the bill was to change the definition of what conditions should be considered "treatable," allowing psychopaths and those with personality disorders to be "sectioned" and held against their will. But the proposals had another ambition—to ensure that England's mental health legislation complied with the Human Rights Act. This meant inserting safeguards so that anyone detained could

challenge their incarceration with access to an advocate and a tribunal. Aside from the philosophical muddle of it, the bureaucracy would have been an expensive nightmare. It was, perhaps, doomed to fail.

Behind this clash between public protection and human rights, there lies a deeper failure—to consider the idea of the "positive" right to good care. Needing to strike a balance between providing care for “them” while protecting “us” from harm (a clearly false but enduring distinction), the bill’s architects had two main options, and they essentially took the simplest, proposing laws curtailing “their” freedoms to keep “us” safe. How sad that they shirked the more imaginative alternative of enshrining good care in law (something that imaginative doctors and policymakers are working together to achieve in the realm of physical illness). Good care would mean making mental health services less horrible, more accessible and responsive to individual need; it would also mean ensuring that the one in four people turned away when seeking help instead receive it.

So what now? The new idea is to amend the 1983 act, but it’s an odd fudge, not least regarding the knotty “treatability test.” The proposed amendment wouldn’t exactly remove it, but replace it with the principle that compulsory treatment is all right if “appropriate” treatment is available. This, along with an increasingly broad definition of mental illness, means hordes of people could be compulsorily treated, even if this simply boils down to locking them up, with no requirement that they will be helped. It is mental health law based on fear.

The reality is that people with mental illness do kill, and we need to find ways to help them before they do. But the equally simple truth is that most of the 700 or so murders committed annually are not linked with the mentally ill. Of the 40 or so murders that do involve the mentally ill, half the perpetrators are already receiving mental health care. If we want safety, we need to find ways to help this tiny group—not by embedding law in coercion, but by improving care.

It is, of course, easier to decry attempts to balance public protection, individual freedom and good healthcare than to get it right. The fiasco of the mental health bill represents a classic double-bind of New Labour legislation, heightened by the discomfort which media, public and politicians experience when contemplating the reality of caring for, and dealing with, the mentally ill. It is this reality, as well as the scaremongering, that now needs to be confronted.