

The Nearest Relative and Nominated Person: A Tale of Parliamentary Shenanigans

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The nearest relative (NR) has proved to be a resilient feature of mental health legislation. The powers and the rules for the identification of the NR remain largely unchanged since the role was introduced in the *Mental Health Act 1959*, with the *Mental Health Acts 1983* and *2007* only having made relatively minor modifications. The NR has even survived two attempts to abolish it, in the draft *Mental Health Bills* of 2002 and 2004.²

Few would doubt that the NR provides an important legal safeguard for the rights of mental health patients. However, the rules for establishing the identity of the NR relative are, by common consent, deeply flawed. The identification rules are rooted in the 1950s and reflect many of the assumptions about the structure and role of the family that were prevalent in the immediate post-war period. As such, they fail to reflect the lives and circumstances of mental health patients in the twenty-first century.

This paper outlines, briefly, the role of the NR and the changes introduced by the *Mental Health Act 2007*, and the main criticisms of the rules for identifying the NR. Its main purpose, however, is to set out the reforms to those rules that were nearly achieved by the *Mental Health Alliance* during the passage of the *Mental Health Bill 2006* and to document the ensuing Parliamentary debates. The paper concludes by considering the future of the NR.

Powers of the Nearest Relative

The powers of the NR were largely untouched by the *Mental Health Act 2007*, although they have been extended to cover Supervised Community Treatment. Those powers are summarised below.

(a) The right to require an assessment to be made

Section 13(4) of the *Mental Health Act 1983* (as amended) ('MHA 1983') enables a NR to require a local authority to ask an Approved Mental Health Professional ('AMHP') to consider a case, with a view to

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 2. For 'The Recent History of the Nearest Relative', see chapter 1 of '*The Nearest Relative Handbook*' by David Hewitt, Jessica Kingsley Publishers (2nd edition; 2009).

making an application for a person to be admitted to hospital. If admission does not take place, the NR is entitled to a written explanation from the AMHP concerned

(b) The right to apply for compulsory admission or guardianship

The NR can apply for a patient to be admitted to hospital under section 2, 3 or 4 of the MHA 1983, or for guardianship under section 7. In practice, however, this happens rarely, and the Code of Practice advises that in the majority of cases, an AMHP will be the more appropriate applicant.³

(c) The right to be consulted or informed

Section 11(4) of the *MHA 1983* states that, before making an application for detention under section 3 or for guardianship under section 7, an AMHP must consult the person appearing to be the NR, unless such consultation is not reasonably practicable or would involve unreasonable delay. Section 11(3) contains a similar qualified right for the person appearing to be the NR to be informed of (but not consulted about) a patient's detention under section 2.

(d) The right to object to section 3 admission or guardianship

Under section 11(4) of the *MHA 1983*, an application for admission to hospital under section 3 or for guardianship under section 7 cannot proceed in the face of an objection by the person consulted as NR. In such circumstances, an application can be made only if the NR is displaced by the county court and the new NR does not object.

(e) The right to order discharge of the patient

Under sections 23 and 25 of the *MHA 1983*, the NR can order the discharge of a patient who is detained in hospital under section 2 or 3, or is subject to Supervised Community Treatment, by giving the hospital managers at least 72 hours' notice in writing. The patient must be discharged unless, within 72 hours of the giving of notice, the Responsible Clinician certifies that in his or her opinion the patient, if discharged, would be likely to present a danger to themselves or others. Where such a 'barring certificate' is issued, the NR may apply to the mental health tribunal, unless the patient is detained under section 2 of the *MHA 1983*. So far as guardianship is concerned, the NR can direct discharge of guardianship forthwith. Since there is no provision for barring by the Responsible Clinician, a discharge order of guardianship by a NR will be effective immediately it is given.

The 2007 Amendments

The *Mental Health Act 2007* made a number of significant changes to the system for identifying and displacing a person's nearest relative.

Section 26(1) of the *MHA 1983* lists the people who might qualify to be a patient's NR. That list, which in fact provides for a hierarchy of relatives, was not changed by the 2007 Act, save that civil partners were added to it and given equal status with spouses, and with cohabitants of more than 6 months' standing.⁴

Furthermore, section 29 of the *MHA 1983* now allows patients themselves to apply to a county court for the displacement of their NR. Prior to this, only a relative, someone living with the patient or an Approved Social Worker (the predecessor to the AMHP) could make such an application. The 2007 Act

3. *Department of Health, Code of Practice: Mental Health Act 1983 (2008) paragraph 4.28.*

4. *Mental Health Act 2007, section 26(2) -(5).*

also added a fourth ground for displacement:⁵ the NR is not, in the court's opinion, a 'suitable' person to act as such. Section 29 was amended to provide that where the person nominated by the applicant is, in the court's opinion, not suitable or there is no nomination, the court may appoint any other person it considers suitable.⁶

Finally, the 2007 Act introduced a new right for the patient to apply to discharge, or vary, an order appointing an acting-NR. A displaced NR, too, can apply for such an order, but he or she must first obtain leave of the court. The courts were given a new power to appoint an acting-NR for an indefinite period in certain circumstances; previously, appointments were only for a fixed period.⁷

Ongoing Criticisms

While welcoming the changes to the NR provisions, the Mental Health Alliance described them as little more than a sticking-plaster and criticised the failure to address some of the fundamental deficiencies in the rules for identifying a NR. These deficiencies are summarised below.

(a) The identification lottery

The process for identifying a NR can be described as a lottery. It may select the best person for this role and, equally, it can select the worst. The NR might easily be someone the patient hardly knows – for example, a nephew or niece to whom he or she speaks only once-a-year.

During the Parliamentary debates on the Mental Health Bill 2006, Baroness Murphy said,

*“The business of the nearest relative is a complete nightmare. If you section someone in London who is looked after by their brother next door but has an older brother in Edinburgh, the brother in Edinburgh is classified as the nearest relative. It is as simple and stupid as that.”*⁹

It may be, of course, that in Baroness Murphy's example, the London brother would be promoted to become the patient's NR by virtue of section 26(4) (a) of the MHA 1983. That would, however, depend upon how much care he was providing to the patient.¹⁰

Furthermore, the role of the NR can be a burdensome imposition for some carers, many of whom have no-one to whom they can delegate their powers. AMHPs are not obliged to find alternatives in these situations,¹¹ and cash-strapped local authorities may be reluctant to fund court applications unless the situation is sufficiently serious.

5. Section 29(3) (a)-(e) set out the grounds for displacement of a NR, and appointment of an acting nearest relative. Ground 29(3) (a) is not in effect concerned with displacement, since it covers the situation where the patient has no NR, or it is not reasonably practicable to identify one.

6. Mental Health Act 2007, sections 21 & 23, and Schedule 2, paragraph 7.

7. These provisions are set out in the amended sections 29(5) and 30 of the MHA 1983.

8. The Mental Health Alliance was a coalition of 75 organisations from across the mental health spectrum, working together to secure improved mental health legislation.

9. Hansard (HL), 17 Jan 2007, volume 688, column 668.

10. The care provided will have to be 'more than minimal': *Re D (Mental Patient: Habeas Corpus)* [2000] 2 FLR 848.

11. Although, at paragraph 8.10 *et seq*, the revised Code of Practice to the MHA 1983 urges 'consideration' of a county court application by an AMHP.

(b) “Staid and out of date”¹²

The rules that govern the identification of the NR have become outdated. During the Public Committee stage of the Mental Health Bill 2006, Angela Browning MP provided the following analysis of the NR list:

“[T]he list set out in section 26 of the 1983 Act is now somewhat anachronistic. It reads like an inheritance tax situation in which the bloodline goes down through the family and people find that they have been left a lot of money by a nearest relative whom they have never met. The idea when talking about someone’s mental health that a person, simply because of a blood relation, is suddenly responsible for or is even interested in them, is not how society works now. Many years on from the 1983 Act, families tend to be more disparate, and other relationships come into play.”¹³

The *Bournewood* case was often cited during the Parliamentary debates as an example of why choice is important:¹⁴

“[I]n that famous *Bournewood* case, HL’s carers, although they were paid carers, had responsibility for his day-to-day care, whereas his blood relative had nearly no contact with him at all. They were well placed, had the psychiatrists at the time been willing to engage them in conversation, to explain his behaviours, how he reacted in certain situations and so on.”¹⁵

It is important to note, however, that HL’s carers, or at least the elder of them, could have become his NR by virtue of section 26(3), (4) and (7) of the *MHA 1983*.

The NR identification rules fail to recognise non-traditional family structures, for example where relatives ordinarily reside abroad. Such relatives are normally excluded from the role unless the patient also ordinarily resides abroad.¹⁶ Similarly, the identification rules will normally exclude a long-term friend of the patient irrespective of how well they know the patient or whether they are best placed to act in the patient’s best interests (unless the two have ordinarily resided with each other for at least five years¹⁷).

The NR rules also fail patients who have no identified relatives. This is particularly a problem in inner-city populations, where a large proportion of patients have lost contact with their families. Finally the rules for identifying the NR of a child are also outdated. For example, the father of a child cannot (at least by reason solely of the paternity) be the NR unless he is married to the child’s mother or otherwise has parental responsibility for the child.¹⁸

(c) Identification complexities

Identifying the NR can be straightforward in some instances, but in others it can be one of the most complex tasks in the *MHA 1983* and as a result mistakes are common. In some cases, these mistakes may invalidate the detention and mean that the patient is unlawfully detained.¹⁹

It can be particularly difficult to identify the NR in circumstances where a patient has or appears to be having relationship problems, or is in the process of separating from their husband, wife or civil partner

12. *Hansard* (HC), 8 May 2007, *Mental Health Bill Committee*, 8th sitting, column 272 by David Kidney MP.

13. *Ibid*, column 277. See also footnote 32.

14. *HL v United Kingdom*, Application number 45508/99, Decision of 4 October 2004. See also: *R v Bournewood Community and Mental Health NHS Trust, ex parte L* [1999] 1 AC 458.

15. *Hansard*, *op cit*, columns 277 to 278.

16. *MHA 1983*, Section 26 (5)(a).

17. *MHA 1983*, section 26(7).

18. *MHA 1983*, Section 26(2)(b).

19. As noted in the text, the obligation on the AMHP to inform or consult, is towards the person who appears to be the NR. (*MHA 1983*, sections 11(3) and 11(4)).

but it is uncertain how permanent this separation will be. In such circumstances, it is often unclear legally whether the person is still the NR. Some of these difficulties will be exacerbated by the nature of the patient's mental health problems, such as where they are delusional or paranoid about the nature of their relationship with the NR.

In order to establish the identity of a NR, AMHPs may be required to ask what will often appear to be inappropriate or intrusive questions of the patient or their family, such as "who is your oldest grandparent?" or "were your parents married when you were born?". These types of question might provoke hostile reactions at the best of times, but even more so during the trauma of a mental health breakdown and alongside a full Mental Health Act assessment.

(d) An inactive safeguard

There has not been much research into the NR, but the small body of literature that does exist suggests that generally, NRs do not know their rights and, perhaps not surprisingly, seldom use their powers.¹⁹

The research also indicates that the role of the NR as a safeguard of the rights of the patient varies according to the quality of the relationship between the patient and the NR.²⁰ If the relationship is good, the NR has the patient's best interests at heart and is more likely to be assertive (in which case, the role of the NR is an effective safeguard). If the relationship is poor, or even based on abuse, the NR is virtually useless as a safeguard

(e) Difficulties with the displacement process

A patient who wants to be free of an inappropriate NR will often have to rely on the displacement process. This can be complex and protracted. Access to a county court, and the procedures that such access entails, are daunting to many people, let alone to someone with mental health problems who is, by definition, likely to be unwell and possibly in hospital.

To expect the patient to take a case to a court stating that their relative is 'unsuitable' is unreasonable in any circumstance. In a situation where the patient is at their most vulnerable, and is dependent emotionally or financially on the relative to some extent, it will be simply unfeasible.

This was recognised by Lynne Jones MP during the Mental Health Bill 2006 debates:

"[A]t various meetings we have had put to us examples of people who have no contact whatever with their relatives, but who would find the prospect of a court process to displace them somewhat daunting. I am disappointed that the government cannot find a way to make provision that enables the nearest relative to be changed without going to a court."²¹

Furthermore, the displacement process often ends with the Director of the Local Social Services Authority being appointed as the NR, which removes the independent characteristic of the role.

(f) Human rights concerns

The High Court, in *R (E) v Bristol City Council*²², recognised the importance of the patient's wishes and feelings in circumstances where the patient had capacity and objected to the NR being consulted and

19. Joan Rapaport, 'The Ghost of the Nearest Relative under the Mental Health Act 1983 – Past, Present and Future' (2003) 9 *Journal of Mental Health Law*, page 51.

20. *Ibid.*

21. *Hansard (HC)*, 18 June 2007, volume 461, column 1110.

22. 2005] EWHC 74 (Admin).

there were significant relationship problems between the patient and the NR. It was held that where such a course would be detrimental to the patient, in that it would breach his or her right to respect for private and family life under Article 8 of the European Convention on Human Rights (ECHR), the Approved Social Worker (now, the AMHP) should not consult the NR.

As the Joint Committee on Human Rights concluded during the passage of the Mental Health Bill 2006: “Under this Bill, [*R (E) v Bristol City Council*] will remain good law, and the patient can choose [sic] who will not be consulted as their nearest relative, but the only way of displacing a nearest relative, and replacing them with someone acceptable to the patient, will be if they are ‘unsuitable’”.²³

Summary

The difficulties associated with the NR were summed up eloquently by Diane Hackney, a campaigner and a user of mental health services:

“My mother is my nearest relative but she is 76 years old and lives 150 miles away from me. My sister has an eating disorder and is currently in hospital receiving treatment for it – she is likely to be there for at least 6 months. For these reasons, I have changed my next-of-kin to someone who lives close to me, someone who knows me well and with whom I have a good relationship. This person is not related to me in any way.

“My mortgage provider and other financial institutions have accepted this change as indeed has my GP. Therefore as far as anything to do with my financial assets, my property and my physical health is concerned this non-blood relative will be contacted, but when it comes to my mental health and my nominating the same person to be contacted and consulted about my care and treatment should I become unwell and/or sectioned is impossible. This is just not logical.”²⁴

The Parliamentary Campaign

During the passage of the Mental Health Bill 2006, six issues dominated proceedings: exclusions from mental disorder; treatability; the renewal of detention; age-appropriate treatment for children; impaired decision-making; and Supervised Community Treatment. One of the consequences of this focus was that other important issues, such as the NR, were over-shadowed. Behind the scenes, however, the Mental Health Alliance nearly achieved significant amendments to the statutory process by which the NR is identified.²⁵ These amendments aimed to introduce a new system whereby patients could nominate their nearest relative.

The House of Lords

Although the then Government was in a minority in the House of Lords, opposition peers did not call for a division on the NR amendments. Only seven votes in total took place on the Mental Health Bill 2006 in the Lords. Voting in the Lords can only take place when sufficient opposition and backbench peers are guaranteed to be available, and the divisions themselves can take a substantial time. Consequently, only

23. *House of Lords & House of Commons Joint Committee on Human Rights, Legislative Scrutiny: Mental Health Bill: Fourth Report of Session 2006-07, HL paper 40, HC 288, paragraph 37.*

24. *Mental Health Alliance, Nearest Relative: House of Lords Committee Stage Briefing (2007) page 6.*

25. *The author was ‘behind the scenes’. The authority for much of what follows within this article, derives from his ‘ringside seat’.*

a small number of votes were possible. At most, only three divisions took place in a single sitting, and no votes ever took place after 7.30pm. So, apart from the six amendments passed in the House of Lords, the Mental Health Alliance had to rely upon its powers of persuasion and the goodwill of the Government to achieve any changes to the Mental Health Bill 2006.

The House of Lords Committee Stage

During the Committee stage in the House of Lords, the Mental Health Alliance put forward an amendment to make it possible for a person to nominate anyone of their choice to act as NR, with a default position of the *MHA 1983* section 26 list if no nomination is made.

The nomination would have to be made using a legal form, both the nominator and the nominated person would need to have the requisite mental capacity and the nomination would have to be certified by a mental health professional. The amendment was introduced by Baroness Neuberger and supported by Lord Patel of Bradford. The Government rejected the amendment and, in doing so, the Minister set out the main reasons:

“[T]he powers of the nearest relative mean that they are not just patient representatives, although most nearest relatives very effectively represent their patient relatives ... We also think that, in order to exercise his power the nearest relative must be free to act in a way that represents his understanding of the best interests of the patient. Sometimes that might mean that the nearest relative will use, or not use, his powers in ways that do not concur with the wishes of the patient. Of course, many people chosen by the patient would feel duty bound to act in the way that the patient wished, but the powers of the nearest relative have not been designed that way ... Someone might be chosen who will simply carry out the wishes of the patient. Given the role, the nearest relative needs to be able to act, as I said, in a way that represents their understanding of the patient’s best interests and not simply to carry out the patient’s wishes.”²⁶

The Minister was also asked to explain why the Government was opposed to a nominated person system when it had supported this in the draft Mental Health Bills 2002 and 2004 and even though this system had been implemented successfully in the the *Mental Health (Care and Treatment) (Scotland) Act 2003*. In response, the Minister argued that in the draft Mental Health Bills and the Scotland Act the introduction of an enhanced independent tribunal which authorised compulsion had meant there was no longer a need for the independent counterbalancing role provided by the NR.²⁷ In effect, nomination could only be contemplated if the powers of the NR were removed. This became an important argument for the Government that was repeated throughout the Parliamentary debates.

Finally, Baroness Murphy supporting the amendment, referred to an “anxiety over those patients who nominate the next eccentric person on the ward as their nearest relative”.²⁸ This concern was acknowledged by the Minister but not developed.

Opposition peers attempted to allay the Government’s concerns. Many disagreed that someone nominated by a patient would be inherently less likely to act in his or her best interests. It was pointed out that there are already checks and balances to deal with the NR’s misuse of power, such as

26. *Hansard (HL)*, 17 Jan 2007, volume 688, columns 670 & 671 by Lord Hunt of King’s Heath.

27. *Ibid*, columns 671 & 672.

28. *ibid*, column 669.

displacement and the power to 'bar' discharge; these would also apply to the nominated person. Comparisons were made with the *Mental Capacity Act 2005*, which authorises delegated decision-making on health care matters using a Lasting Power of Attorney. Many of the Government's arguments relied on the notion of the NR as an *active safeguard* of the patient's best interests; consequently some peers pointed out that the NR is too often an *inactive* and *hypothetical* safeguard.

The House of Lords Report Stage

At Report Stage in the House of Lords, the Mental Health Alliance adjusted its nominated person amendment to acknowledge some of the Government's concerns. Once again, the amendment was moved by Baroness Neuberger and supported by Lord Patel. Under the revised amendment, the patient could nominate their NR (using the same procedures stipulated in the original amendment), but they would only be able to nominate someone from the existing section 26 list (to which would be added any "carer" of the patient, as defined in the *Carers and Disabled Children Act 2000*).

In effect, this would, have given patients a restricted power to choose their NR. The nominated NR could not be simply *anyone* the patient knew or, for example, "the next eccentric patient on the ward".²⁹ By restricting choice to the section 26 list of relatives, the amendment also provided that the NR could only be someone who, *under the Mental Health Act 1983*, was deemed to be suitable to carry out this role and act in the patient's best interests.

For the Government, Baroness Royall of Blaisdon recognised that while the revised amendment

"... addresses the issue of patients nominating totally inappropriate strangers as their nearest relative, it still suffers from the difficulties associated with patients having nomination rights over the person who can block their admission to hospital or discharge them from compulsion ...The role of the nearest relative is not one based on acting in the name of the patient but one that provides for nearest relatives to act in a way that they consider is right. The process of nomination can introduce an unhelpful and damaging dynamic into the relationship between the patient and the person who is to exercise the rights of the nearest relative."³⁰

The Alliance's amendment was therefore rejected.

Smoke-filled rooms

The Mental Health Alliance believed that was the end of the matter. It had failed to convince the Government that reform was necessary and the issue could not be raised again at Third Reading because by convention, the House of Lords cannot discuss an issue at the third stage that has been fully debated in Committee and on Report. The Alliance also had little chance of success in the House of Commons, where the Government had a clear majority.

However, an unexpected life-line was thrown by Baroness Neuberger, who contacted the Alliance with news that she had met with Baroness Royall to discuss the NR amendments. Baroness Neuberger described the discussions as extremely helpful and suggested that the Government might be interested in the idea of a nominated NR, but only if the Alliance could find a way of preventing a patient nominating

²⁹. *Ibid.*

³⁰. *Hansard (HL)*, 26 February 2007, volume 689, column 1403.

someone completely unsuitable. It was suggested that the Government might concede if the Alliance could devise an independent check on the suitability of the nominated NR.

The amendment was therefore revised a third time. It now provided that once a patient had nominated a NR (from the section 26 list and using the same procedures stipulated in the original nominated person amendment), the person nominated would have to be approved by a 'prescribed authority'. No such authority was defined in the amendment, but it was suggested that it might be the hospital managers or, in the case of guardianship, the local social services authority. The person nominated could be rejected if the prescribed authority was satisfied that he or she was not 'suitable' to act as such. There would be a right to appeal against this decision to the mental health tribunal.

It is understood that this amendment was considered with interest by the Government, and that while no promises were made, there was a positive response to what the Alliance was trying to achieve. In the meantime, Baroness Neuberger informed the Alliance that the Government had, somewhat unusually, agreed to this amendment being tabled at Third Reading. It appeared that the Government might be on the brink of agreeing to a nominated NR.

The Third Reading

Once again, Baroness Neuberger tabled the revised amendment. In doing so, she referred to the "helpful and informative" discussions that had taken place with Baroness Royall and paid tribute to the Government's desire "to find a way through on this issue".³¹

For her part, Baroness Royall confirmed the discussions with Baroness Neuberger and, while giving no guarantees, promised that the Government would take the amendment away and explore the issue further.³² Accordingly, the amendment was withdrawn.

House of Commons Public Bill Committee

By the time the Mental Health Bill was introduced in the House of Commons, the Alliance had still heard nothing from the Government. The Alliance was always aware that given the Government's large majority in the Commons, concessions were unlikely. However, by this time the row between the Commons and the Lords over the Bill had intensified and any possibility of concessions seemed more unlikely than ever.

At Committee stage in the House of Commons, both the Conservatives and the Liberal Democrats advised that it would be better not to table the amendment that the Government had taken away, on the basis that it might force the Government into a corner and make it more likely that the amendment would be rejected.

Instead, the Opposition decided to re-hash the nominated NR amendment from the House of Lords Report Stage. Alongside this amendment, David Kidney MP, a back-bench Labour MP, tabled his own NR amendment. This proposed that a patient be permitted to nominate his or her NR in an advance decision. Essentially, it took the relevant sections of the *Mental Capacity Act 2005* and applied them to the NR, so as "to bring mental health legislation in line with the more modern mental capacity

31. *Hansard (HL)*, 6 March 2007, volume 690, column 134.

32. *Ibid*, column 135.

33. *Hansard (HC)*, 8 May 2007, *Mental Health Bill Committee*, 8th sitting, column 272.

legislation". This proved to be a useful way of highlighting some of the discrepancies between the two pieces of legislation on the subject of delegated decision-making.³³ The Alliance had met with and advised Mr Kidney, but although his amendment received support from Rethink,³⁴ it was not an official Alliance amendment.

Disappointingly, both the Alliance's and Mr Kidney's amendments were marshalled to be discussed alongside the Opposition's advocacy amendments, and the accompanying debates were not, therefore, focused on the NR amendments.

In Committee, the relevant Minister rejected both NR amendments and presented a rather different line of argument to that put forward in the Lords. The Minister suggested that the Government's own amendments had increased patients' input into the choice of NR, since there would be a new duty placed on the court, in cases of displacement or where no NR existed, to appoint the person nominated by the applicant if that person was suitable and willing to act.³⁵

Furthermore, the Minister argued that if patients were given free reign, they might simply appoint as NR the person whom they considered most willing to block admission or try for discharge. Alternatively, they might constantly change their NR, because the individual concerned had not done what the patient wished them to do.³⁶

"There is an issue about whether there is an incentive for prospective nearest relatives who do not believe in compulsion, for example, to put themselves forward and offer to discharge patients whatever the circumstances ... [The NR] is not a replacement for an advocate, for example, or a patient representative. The person needs a certain degree of independence because of the issues involved in being able to block admission or ask for discharge."³⁷

The debate ended, however, with the Minister agreeing to look at inserting guidance into the *Mental Health Act 1983* Code of Practice, to assist in situations where a NR neither has nor intends to have a relationship with the patient.³⁸

The Report Stage/Third Reading

By the time of the Report Stage in the House of Commons, the Mental Health Alliance had received confirmation via third parties that the Government had rejected the amendment put forward in the House of Lords, for a nominated NR who must be approved by a prescribed authority. No reasons were given as to why this decision had been made. The Alliance realised that time was running out, and so it made a final attempt to introduce some element of choice into the selection of the NR. To this end, two further amendments were drafted and tabled.

Under the first, a person would be able to nominate their carer as NR, and it would only be possible for a nomination to be made by a person who was not detained under the MHA 1983. By highlighting the position of carers, the Alliance hoped to appeal directly to the Minister and to other MPs who had an interest in carers' issues. Furthermore, if the Government could be persuaded to agree to some element

34. *Rethink* is a national mental health membership charity.

35. *Ibid*, column 265.

36. *Ibid*, column 266.

37. *Ibid*, column 274.

38. *Ibid*, column 284.

of choice, however small, it was believed this would establish an important benchmark for any future reform of mental health legislation. The second amendment would allow a patient to seek displacement of a NR on the basis that it was not, in the reasonable opinion of the patient, appropriate to permit that person to act as such. The aim was to widen the criteria for displacement.

At Report Stage, the nominated carer amendment was tabled by the Labour back-bench MP, Lynne Jones.³⁹ This was a welcome development, given her influence as chair of the All-Party Group on Mental Health, and a surprise one given that she had been a high-profile supporter of the Bill. Her speech articulated clearly the main arguments in favour of patient choice and also lent support to the amendments on widening the displacement criteria:

“[T]he appointment of the nearest relative is extremely important. However ... there is all too often no nearest relative who is willing to perform that role. If someone suitable is available, it is thus important that it is as easy as possible for a patient to appoint that person as the nearest relative ... I have attempted to address several concerns expressed by the Government. I realise that it would not be appropriate to allow frivolous changes or appointments of the nearest relative, so my amendment would confine the appointment or changed appointment as the nearest relative to the carer ... a carer is someone who is not living with the patient, but who has their best interests at heart, spends a great deal of time with them and knows their case, and is someone whom the patient can trust.

“At various meetings, we have had put to us examples of people who have no contact whatever with their relatives, but who would find the prospect of a court process to displace them somewhat daunting. I am disappointed that the Government cannot find a way to make provision that enables the nearest relative to be changed without going to court, although I am pleased by the Minister’s assurance that she intends to make the system as user friendly as possible. Of course, it is not necessary for the patient to take the action themselves; they can be supported in doing so, or the process can be carried out on their behalf.

“[The amendments on the displacement criteria] are designed to make it possible to seek displacement on broader grounds than the Bill allows. The Joint Committee on Human Rights has criticised the provisions of the Bill and the associated code of practice, saying that they are too narrow to enable the nearest relative to be displaced unless there is some undercurrent of abuse. That important point must be addressed, and I am grateful that the Minister is willing to consider the code of practice and to discuss further whether those concerns can be properly dealt with.

“As the relative of someone who has been very ill and undergone the process of sectioning, I am well aware of the concern of nearest relatives that they should not easily be set aside. I know that, at times of crisis, patients can turn against family members—the people who are most concerned about them. I therefore understand the Government’s concerns, but I hope that they will do all they can to address the worry that lies behind [the proposed amendments].”⁴⁰

The Government, however, rejected both of the Alliance’s amendments. The Minister pointed to concerns expressed by carers’ groups that broadening the criteria for displacement would mean that

39. *Hansard (HC)*, 18 June 2007, volume 461, column 1094.

40. *Ibid.*, columns 1109 & 1110.

carers who were NRs would be too easily displaced.⁴¹ The nominated carer amendment was also rejected, on the basis that, in order to comply with the ECHR, nominations would have to be ratified “by an independent process with a suitable mechanism for appealing decisions”.⁴² This would mean that the Government would have to set up a new body to do this. The Minister also pointed out that, for ECHR reasons, it would be impossible to have one system for people who were not detained and a different system for people who were detained and therefore had no access to that right. The Alliance, of course, agreed with the Minister’s final point, but its conclusion was very different, in that it believed that all people with the capacity to do so should have the ability to choose their NR.

Ultimately, therefore, the Mental Health Alliance failed to achieve any amendment to the way that a NR is identified. Although the NR is still a strong legal safeguard, identification remains a lottery and there is minimal ability for a patient to choose their NR.

The Future of the Nearest Relative

The introduction of the *Mental Capacity Act 2005* may prove to have a significant impact on the future of the NR. This Act places the views and choices of people who lack capacity – and, indeed, those who *have* capacity – at the centre of decision-making.

There are two aspects of the *Mental Capacity Act* which allow people to choose representatives whose role is comparable with that of the NR. First, using a Lasting Power of Attorney, a person may appoint someone to make important decisions about their health and welfare when they lose capacity.⁴³ Those decisions might include consenting to or refusing life-sustaining treatment. Second, under the Deprivation of Liberty Safeguards, a person with capacity must be invited to select their own representative and in most cases this person will be appointed to this role.⁴⁴ The representative has powers to initiate a review of the deprivation of liberty and to make an application to the Court of Protection. However, even though a person with capacity can nominate an attorney or representative, they cannot choose their NR. *The Mental Capacity Act* therefore enshrines choice in a much more positive manner than the *Mental Health Act* does, even though it can apply to equally vulnerable people in equally vulnerable situations. Increasingly, the NR is looking “staid and out-of-date” in comparison.⁴⁵

There is also a complex relationship between the various representatives under the *Mental Capacity Act* (including advocates, representatives and attorneys) and the NR under mental health legislation. In some cases – where, for example, an attorney or representative takes one view about a patient’s best interests and the NR takes a different view – it might be difficult to decide which view should prevail. Professionals must be clear under which legislation decisions are being taken and who should be consulted as a result. When making everyday decisions about a patient’s care, professionals may naturally lean towards involving representatives who have been appointed under the *Mental Capacity Act*, on the basis that they have been chosen by the patient. If the NR increasingly becomes a formal role, reduced entirely to its statutory functions and not otherwise involved in the patient’s care, it is difficult to see how the NR can adequately represent a patient’s best interests (which was a key argument used by the Government in rejecting the NR amendments).

There is also the possibility that reform of the NR will be introduced by the back door, via the courts.

41. *Ibid*, column 1098.

42. *Ibid*.

43. Sections 9 and 10 *Mental Capacity Act 2005*.

44. Paragraph 7.12 of the *Deprivation of Liberty safeguards supplement to the MCA 2005 Code of Practice*.

45. See footnote 12.

The interpretation of 'suitability', when deciding whether to replace a NR may allow the patient's wishes and feelings to be taken into account. Furthermore, in order to comply with the requirements of the ECHR, it is possible that if new cases come to light where a NR was consulted in the face of opposition from the patient and this has had a detrimental effect, the courts may seek to broaden the circumstances in which the patient can influence who should not be consulted as their NR. Ideally, reform should take place in the open and be based upon a fully reasoned and well- debated set of principles negotiated by service-users, carers and practitioners; it should not be effected *ad hoc* by judges.

The NR role remains intact, despite several attempts either to amend or to abolish it. Its longevity is particularly surprising given all of the difficulties associated with the identification rules. These difficulties were brought to light as long ago as the parliamentary debates on the *Mental Health Act 1959*, when Dr Edith Summerskill, who was then shadow spokesperson for health, gave the following analysis:

"It is quite conceivable that the nearest relative is not necessarily the person most concerned to promote the welfare of the patient ... At the moment we are discussing imponderables, but I confess that I find it difficult to suggest an alternative. No doubt we are thinking of our relatives and that "but by the grace of God there goes ..." some of us. We should be quite content that our relatives should be there to look at our welfare, but can that be said about all people?"