

The Ghost of the Nearest Relative under the Mental Health Act 1983 – past, present and future

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Introduction

The 1990s have been characterised by an emphasis on public protection in response to high profile psychiatric homicides. This has led to greater use of compulsion and community controls and hence an increased need for civil liberties safeguards. This paper examines the background and safeguard potential of the nearest relative and its relationship with the Approved Social Worker. It further considers the implications of findings of the most wide-ranging in-depth research into the nearest relative against proposals to replace the designation with two new roles in anticipated legislative reform.

The term patient is used to describe people who are subject to the compulsory powers of the Mental Health Act, liable to be detained or in hospital on an informal basis. The term service user refers to individuals who receive psychiatric services but are neither hospitalised nor subject to compulsion.

Overview of the main issues

The nearest relative as defined in section 26 of the Mental Health Act 1983 has discretionary powers to influence the case for or against a close relative's compulsory admission. Although the role was introduced in 1959 without a set of governing principles or clearly defined purpose, it has become officially recognised as a patient safeguard¹. However, since its inception the role has sparked controversy because of longstanding concerns about relatives' powers to manipulate admissions and the lottery of family relationships. Dr Edith Summerskill the then shadow spokesperson for health, pithily located the main problem in the second reading of the Bill preceding the 1959 Act:

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1 DHSS (1976) Consultative Document A Review of the Mental Health Act 1959, HMSO, para 6.6; DoH (1999) Reform of the Mental Health Act 1983, Proposals for Consultation, Stationery Office, Chapter 10.

“There is another point I want to make about the nearest relative. It is easy to dismiss this, but 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 after our welfare, but can that be said about all people?”².

In spite of the importance of the nearest relative, the potential for bias and the length of its existence, its research and literature base is meagre. However, the fact that the role is set to disappear in legislative reform suggests it has not been seen as a resounding success.

The importance of safeguards

Under the Mental Health Act 1983 an order to detain a patient in hospital is in most cases founded on two medical recommendations and an application made either by an Approved Social Worker (ASW) or (rarely) the patient’s nearest relative. A person being assessed with a view to compulsory admission is considerably disadvantaged, not least by the disabling effects of mental illness. A relative or carer may be the only person who is present who is independent of the assessing team able to give an account of the crisis. However, as already identified, such accounts are prone to bias. Although the Code of Practice to the Mental Health Act 1983 allows for the presence of an advocate³ the urgency of the situation may prevent this from happening. Further Boyle contends that the assessment process arguably fulfils lower standards of jurisprudence than those exercised by the courts.⁴ With regard to the latter, people from ethnic minorities and those with special communication needs may be especially vulnerable as, contrary to official policy⁵, interpreters are not always available when an assessment takes place⁶ or even after admission⁷ when issues relevant to it arise. Yet the stakes are high. In addition to loss of liberty and the imposition of hospital regimes, patients can be subjected to chemical controls that have unpleasant and sometimes serious side effects.

Whilst there are times when compulsory admission is the only realistic option for the patient’s welfare and or for the protection of others, proper safeguards are highly important to ensure the State, families and others in authority do not abuse the psychiatric system. In exercising their powers professionals are exhorted to use their discretion to ensure compulsion is only used as a last resort⁸. Important safeguards to promote appropriate, and guard against inappropriate compulsion are part of the role of the nearest relative and the reciprocal duties of the ASW.

2 Hansard House of Commons 598 736.

3 DoH (1999) *Mental Health Act Code of Practice*, 3rd Edition, Stationery Office, para 2.13.

4 Boyle, M. (1996) *Diagnosis Science and Power*, video of conference “the Construction of Psychiatric Authority” Department of Psychiatry, University of Newcastle on Tyne. Boyle compares the operation of juridical and therapeutic or purposive law that combine in mental health legislation, the former operating in public according to strict legal codes and the latter in private by professionals according to diagnostic categories. Boyle challenges the scientific validity of psychiatric categories suggesting these have been reached with less rigour

compared with similar processes carried out in general medical science.

5 Code of Practice as above para 1.4.

6 Rapaport, J. (2001) *Am I making myself clear?* Professional Social Work, British Association of Social Workers, February issue; 11-12; SSI (1999) *Detained: SSI Inspection of Compulsory Mental Health Admissions*, Department of Health.

7 Warner, L. et al (1999) *Improving Care for Detained Patients from Black and Ethnic Minorities*, Sainsbury Centre.

8 Code of Practice as above, 2.7.

Both roles have been influenced by political and social change. The nearest relative will be replaced by the roles of Carer and Nominated Person and the ASW by the Approved Mental Health Applicant (AMHP) if the Mental Health Bill⁹ comes into force. Patient advocacy will also be enhanced. The Bill has generally been criticised by professional, user, carer and other groups for widening the grounds for compulsion and weakening patient safeguards¹⁰. In view of the proposed changes research into the nearest relative's background, current value and lessons for the future was both timely and necessary.

Historical and contemporary contexts

The nearest relative role

The origins of the nearest relative and also medical recommendations lie in an Act of 1774 to regulate private madhouses. This Act introduced the process of certification for the admission of private “lunatics” and required the names of the person sending the patient, usually a relative, and the advising physician or apothecary to be stated in the admission certificate. The role of relatives was hereafter shaped by the interplay between the legal, policy and social developments of the nineteenth and first half of the twentieth centuries that focused on the growth of the asylums and institutional care. The 1959 Mental Health Act introduced a hierarchy to identify the nearest relative based on British genealogical traditions, intentionally “the person closest in affection rather than nearest relative in kinship”¹¹, and assigned to the role powers consolidated from previous mental health laws, including the contentious power to make the application for compulsory admission. The nearest relative hierarchy and powers were modified under the Mental Health Act 1983 by which time the Victorian asylums were being closed under an ethos of community care.

Under section 26 of the Mental Health Act 1983 a “relative” is defined as any of the following:

- a) husband or wife
- b) son or daughter
- c) father or mother
- d) brother or sister
- e) grandparent
- f) grandchild
- g) uncle or aunt
- h) nephew or niece

The highest relative in the hierarchy is usually identified as the nearest relative. However, additional rules also apply. For example, the nearest relative must be 18 years of age or over and living in the United Kingdom (UK) if the patient also resides in the UK. The eldest at each rung takes priority.

9 DoH (2002) *Draft Mental Health Bill*, Cm 5538-1, Department of Health.

10 *Mental Health Alliance Response to the Consultation on Proposed Mental Health Act Reforms*, (2003) MIND/Rethink; Church of England (2003) *Emerging*

Issues in Mental Health Report by the Mission and Public Affairs Division.

11 N.K.H. (1959) *Drafts of the Mental Health Act*, Volumes 1-12, Office of Parliamentary Counsel.

Divorce or permanent separation ends the nearest relative tie. Partnerships of six months or more are counted as husband and wife relationships and, as a result of case law developments since the introduction of the Human Rights Act 1998,¹² this provision now also applies in the case of same sex partners. The 1983 Act added a non-relative with whom the patient had been living for five years or more to the list. Significantly, a relative living with or caring for the patient was also afforded priority with the effect that the nearest relative is now in many cases also the patient's carer.

The discretionary powers of the nearest relative interact and, in respect of the applicant functions, overlap with the ASW's duties. Under the civil sections of the Act the nearest relative is assigned the following legal powers:

- To require the local social services authority to direct an ASW to carry out an assessment of a patient to decide whether or not he or she needs compulsory hospital admission (section 13 (4));
- To make an application to detain the patient in hospital (section 11(1)) for assessment (section 2) or treatment (section 3);
- To make an application for the patient's reception by the local authority into guardianship (section 11(1); section 7);
- To notify the ASW that he or she objects to an application for admission for treatment or reception into guardianship (section 11(4));
- To seek to discharge the patient from 1) an assessment or treatment order or 2) from guardianship by a written application in the first instance to the hospital managers and in the second, to the local social services authority (section 23).

From the late 1980s and early 1990s there was a pronounced policy shift from the specific role of the nearest relative to that of the carer. As a result of carer initiatives carer nearest relatives are additionally entitled to an annual assessment of their own needs where they provide regular and substantial care¹³ and access to carer services¹⁴ (Carers and Disabled Children's Act, 2000). The carer's assessment is part of the ASW's remit. The round of carer's initiatives relate to the Government's interest in sustaining community care¹⁵.

The Approved Social Worker and core duties

The ASW's origins lie in the Poor Laws¹⁶, public protection duties introduced under the 1744 Vagrancy Act and separate roles of the Duly Authorised Officer (DAO) and professionally qualified Psychiatric Social Worker (PSW)¹⁷ who worked in child guidance clinics. The DAOs who became the Mental Welfare Officers (MWOs) under the 1959 Mental Health Act were unqualified

12 *R. (on the application of S.S.G.) v. Liverpool City Council, the Secretary of State for Health and L.S. (Interested Party)*, 2002.

13 *Carers (Recognition and Services) Act 1995*; DoH (1999) *National Service Frameworks for Mental Health*, Department of Health, Standard 6; DoH (1999) *Caring about Carers: National Strategy for Carers*, Department of Health.

14 *Carers and Disabled Children Act 2000*.

15 Parker, G. Clarke, C. (2002) *Making ends meet: do carers and disabled people have a common agenda?* *Policy and Politics*, Volume 30, number 3; 347-359.

16 Curran, C. Grimshaw, C. (1997) *The Role of the Approved Social Worker (ASW)*, *Openmind* 87, Sept/Oct; 21.

17 For an historical analysis see Ramon, S. (1985) *Psychiatry in Britain, Meaning and Policy*, Croom Helm, Chapter 6.

and generally regarded as practical officials who dealt with the legal and logistical formalities of an admission.¹⁸ They were not then in a position to provide a non-medical professional opinion to inform an assessment for admission, a factor that largely contributed to the nearest relative's retention of the applicant role. By the time of the 1983 Act, as a result of improvements in social work training and organisational changes, many of the social workers undertaking the MWO duties were professionally qualified, and in some cases were PSWs.

The 1983 Act introduced the ASW as a professional social worker specially qualified in mental health issues and law. Social Services Departments were additionally required to appoint a "sufficient number" (never defined) of ASWs to carry out duties conferred under the Act (section 114). Whilst the nearest relative retained all the rights and powers of the 1959 Act, changes to the social work role emphasised the discretionary nature of the nearest relative's powers. The introduction of section 13(4) (identified above) was pivotal in this regard. The power simultaneously confirmed that the nearest relative was under no obligation to make the application and that the ASW was the preferred applicant.

Core functions underpin the ASW statutory role. These comprise 1) observance of civil liberties to ensure procedures are properly followed 2) an independent professional opinion and 3) advocacy to observe the principle of the least restrictive alternative¹⁹. Specifically, the Act requires the ASW to interview the patient in a "suitable manner" and make a thorough exploration of all the circumstances to satisfy him or herself that an application ought to be made (sections 13(1) and 13(2)). The local authority must respond to a nearest relative's request for an assessment under section 13(4) and in such circumstances, where no application is made by the ASW directed to undertake the assessment, written reasons must be given. Where the nearest relative objects to an application for treatment or reception into guardianship the ASW cannot make the application, unless narrow legal criteria to displace the nearest relative on grounds of unfitness to act or unreasonable use of the role are met (section 29). If conversely the nearest relative makes the application the ASW has no power of veto. However, the Act requires the local social services to arrange for a social worker to visit the patient and provide the hospital managers with a social circumstances report after the admission.

ASW duties at the point of assessment (section 13(4), and duties to provide information and consult the nearest relative regarding an admission (sections 11(3) and 11(4)) arguably enhance the civil liberties and public protection functions of the nearest relative's powers. Examination of Parliamentary debates highlights that section 13(4) was introduced to secure an early social assessment of the patient's circumstances with a view to seeking the least restrictive alternative to hospital admission²⁰. The nearest relative's power to object to an application for admission for treatment strengthens the role's position to argue for the least restrictive alternative, as does the power of discharge. However, in spite of the critical importance of the interaction of the ASW and nearest relative the Act does not require Social Services to publicise information about the two roles. Furthermore, a national audit of the critical point of assessment under the Act has never been instituted.

18 See for example HC 562 1696-7.

19 Manktelow, R. (1999) *Approved Social Work in Northern Ireland: time for change, Practice, Volume 11, Number 1*; 23-34.

20 *Hansard House of Lords 426 556*; Baroness Faithfull promoted the early involvement of the social worker, sufficiently informed and with expert knowledge of community resources to advise relatives on the alternatives to hospital.

The ASW like the nearest relative has undergone considerable identity-change. Since the 1990s most ASWs have moved from working in local authority teams to multi-agency Community Mental Health Teams. Recent research suggests that the ASW's professional independence from the psychiatrist and healthcare team is not apparent to carers and patients and service users²¹. Shortages in ASW numbers are reported²² and whilst community services have diversified and increased, real alternatives to hospital are still lacking²³. These factors have influenced the ASW's ability to divert people from hospital in the spirit of the 1983 Act.

Problems in practice

The nearest relative has been most seriously discredited because of the lottery attached to the identification process and weaknesses in the displacement criteria to address real-life problems of abusive and poor relationships. In spite of concerns about allegations of abuse, particularly sexual abuse made by the patient against the relative²⁴ essential recommendations made by the Mental Health Act Commission in 1991 to address the deficiencies of the displacement criteria of the Act²⁵ were ignored, thus allowing this serious situation to continue. Local authorities have also faced costly and time consuming litigation where relatives have objected to detention or guardianship although the patient has been deemed to be in serious need of treatment²⁶. In a few instances relatives have challenged the validity of a detention order because of ASW failures to identify and consult the right relative²⁷. These problems have tarnished the nearest relative's image. The case for changes to the nearest relative under legislative reform was finally won with the advent of the Human Rights Act 1998 and two cases that successfully highlighted the role's potential to breach Article 8 of the European Convention on Human Rights (ECHR)²⁸. However, the proposals to reform the current Mental Health Act have been delayed. In an ever lengthening interim, the Government's failure so far to honour its undertaking to allow a patient to change his or her nearest relative in reasonable circumstances²⁹ has come under judicial consideration.³⁰

With regard to the positive safeguard potential of the role the picture is equally bleak. A small body of literature suggests that relatives generally do not know their rights and that the powers are little used³¹, although applications to discharge may be less rare than assumed³². The outcomes of

21 Hogman, G. Pearson, G (1995) *The Silent Partners, The needs and experiences of people who provide informal care to people with severe mental illness*, National Schizophrenia Fellowship; Barnes, M. et al (2000) "There Ought to be a Better Way", *Compulsion Under the 1983 Mental Health Act*, Birmingham University.

22 Cited in MHAC (1999) *Mental Health Act Commission 8th Biennial Report 1997-1999*, HMSO, para 4.36.

23 Barnes et al (2000) as above.

24 Hegarty, D. (1989) *Escape from a nearest relative*, *Social Work Today*, Volume 20, Number 3: 20-21; Rapaport, J. (1999) *Rise and Demise of the Nearest Relative*, *Professional Social Work*, June; 14-15.

25 MHAC (1991) *Mental Health Act Commission 4th Biennial Report*, HMSO; para 11 3d.

26 for example *R v Wilson and another ex parte Williamson* [1996] COD 42.

27 For example *S-C* [1996] 2 WLR 146.

28 *JT v UK*, 26494/95; *FC v UK* 37344/97

29 *JT* as above.

30 *R. (on the application of M.) v. Secretary of State for Health* (2003) ADMINISTRATIVE COURT.

31 *Silent Partners* as above, Hart, L. (1998) *Nearest and Dearest*, *Openmind* 94, December; 14; Gregor, C. (1999) *An Overlooked Stakeholder? The Views of the Nearest Relative on the Mental Health Act Assessment*, Anglia Polytechnic University.

32 Rapaport, J. (2000) *Survey of the Institute of Mental Health Act Practitioners – The use of the Nearest Relative Powers, Detention and Discharge*, *The Care Programme Association*, Issue 15, October; 11-13; Shaw, P. et al (2003) *In relative danger? The outcome of patients discharged by their nearest relative from Sections 2 and 3 of the Mental Health Act*, *Psychiatric Bulletin*, Volume 27; 50-54.

research into assessments under the Act³³ support the case that ASW's more generally practise risk avoidance, whilst risk taking models that exploit crisis situations to help people use their strengths to grow and change are largely ignored³⁴. Yet the successful outcomes of models supporting hospital diversion³⁵, family group conferencing³⁶ and a substantial body of psychoeducation literature³⁷ suggest that more could be done to develop hospital diversion and supportive frameworks that involve the nearest relative and family unit. This conclusion is in part further supported by a recent six-year study that found discharges by the nearest relative against psychiatric advice were not associated with a poor clinical outcome³⁸.

The nearest relative and ASW have operated in a climate of pre-occupations with risk assessment³⁹ following a spate of highly publicised homicides committed by people with psychiatric histories. These incidents have contributed to increased use of compulsion⁴⁰ and an emphasis on the "social policing" role of social workers and health workers rather than extra community resources, and a culture of blaming professionals when tragedies occur⁴¹. Although the numbers of psychiatric homicides are proportionately small and are actually declining⁴², they continue to have a powerful impact on the media, Government policy and professional practice. The introduction of supervised discharge (section 25A-J) and expansion in medium secure provision are key public protection strategies. The high-risk environments in which users of psychiatric services are often forced to live⁴³ and inadequate community re-provision following the closure of the Victorian

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- 33 Barnes et al, (1990) *Sectioned, Social Services and the 1983 Mental Health Act 1983*, Routledge; Keeble et al, (1995) *What users and significant others think about Barnet's Mental Health Crisis Intervention Service*, LB Barnet; Quirk et al, (2000) *What really goes on in Mental Health Act assessments? Findings from an observational study*, Conference 6th March 2000, Royal College of Psychiatrists Research Unit; SSI, (2001) *Detained: SSI Inspection of Compulsory Mental Health Admissions*, Department of Health.
- 34 Ramon, S. (2002) *From Risk Avoidance to Risk Taking Mental Health Social Work*, BASW Conference 20th November, 2002, Birmingham.
- 35 Identified in Keeble et al, as above. For example the study by Keeble et al found that in two thirds of assessments people were successfully treated at home. This contrasts with two thirds of assessments ending in compulsion as found by Barnes et al in a study involving 42 local authorities and the recent study conducted by the SSI as above.
- 36 Essex County Council (2002) *Supporting People Together*, North Essex Mental Health Partnership Trust. – Family group conferences involve service users, families and professionals in care planning and strengthen client support networks with positive outcomes – study of 16 families shows a high satisfaction rate.
- 37 see for example Falloon, I. et al, (1984) *Family Care of Schizophrenia*, Guilford Press; Buchkremer, G. et al (1987) *Psychoeducational psychotherapy for patients and their key relatives of care givers: results of a 2-year follow-up*, *Acta Psychiatrica Scandinavia*, Volume 96;

- 483-498. *Psychoeducation programmes teach families problem solving, communication and management skills. These programmes are shown to be successful in reducing relapse, especially in the short term and where additional therapies are used. They are however criticised notably because they require high levels of professional input and are highly selective in respect of the families identified for help. Psychoeducation is identified here as having a contribution to make in providing hospital alternatives.*
- 38 Shaw et al, 2003 as above.
- 39 Bech, U. (1999) *World Risk Culture*, Polity.
- 40 Wall, S. et al (1999) *Trends in the use of the Mental Health Act: England: 1984-96*, *British Medical Journal*, Volume 318; 1520-1521.
- 41 Hansard House of Commons 262 193 argued vehemently by Ann Coffey MP for Stockport a former social worker in the Second Reading of the Mental Health (Patients in the Community) Bill. Regarding the vulnerability of workers – "They are the people at whom a finger can be pointed when something goes wrong, enabling the Minister to wash his hands of any responsibility to provide resources for them to do their jobs. As the Minister is aware, even social policemen need resources".
- 42 Taylor, P. Gunn, M. (1999) *Homicides by people with mental illness: myth and reality*, *British Journal of Psychiatry*, Volume 174; 9-14.
- 43 Davis, A. (1995) *Risk Work and Mental Health*, In Kemshall, H. Pritchard, J. (Eds) *Good Practice in Risk Assessment and Risk Management*, Kingsley Publishers; 109-120.

asylums⁴⁴ are not highlighted as prime concerns. The ASW's "wider" responsibilities to support individuals and families in crisis and duties to seek alternatives to hospital⁴⁵ have thus been clipped by political pressure as well as resource and personnel shortages.

Replacement roles under legislative reform

The tough risk-conscious climate both intensifies the need for civil liberties safeguards and threatens their functioning and future. Indeed, under the proposals to reform the 1983 Act the replacement roles of nominated person (appointed by the patient although subject to the AMHP's approval) and carer will have rights⁴⁶ not powers that even when combined in no way equate with those possessed by the nearest relative. The carer and nominated person (who may be one and the same) are distinguished in that the former has the right to request an assessment of the patient whereas the latter can make an appeal to the new tribunal, convened within 28 days of a preliminary assessment, on the patient's behalf. Both roles have rights to be consulted about care plans and discharge and staff will have duties to provide information about services and how these can be accessed. However, professionals appear to be given enhanced discretion to exclude the carer from consultations especially where:

"consultation will be inappropriate or counter-productive, for example where there is conflict of interest between the patient and carer".⁴⁷..

This seems to assume that professionals have a crystal ball and that conflict, far from being commonplace and relevant, is inappropriate. Clause 8 considerably reduces the new carer's position in comparison with the statutory authority of the nearest relative and also possible opportunities for helping the patient and his or her carers to address important issues through crises. It also threatens the continued existence of traditional social work responsibilities towards families located in the nearest relative and suggests that complex relationships can be surgically removed. Brazier's wisdom however suggests otherwise:

"It is very dubious whether it is ever possible to divorce the interests of the individual entirely from the interests of the carer"⁴⁸.

The hardening attitude towards mental health carers visible in the unfolding proposals to reform the Mental Health Act 1983 conflict sharply with generic carer policies, previously identified, that declare intentions to raise the carer profile. Furthermore, the proposals have been made in the absence of research into the nearest relative, who is often the patient's main carer and against a background of largely negative information.

The Government rejected the recommendations of its Expert Committee to incorporate the principle of reciprocity into the proposed legislative reform⁴⁹. Although the Committee's intention was to compensate compulsory patients with appropriate services, the principle has wider relevance and is embedded in the nearest relative functions under the current Act. However, the reciprocal potential of the nearest relative and its interface with other professionals, in particular the ASW, has not previously been explored.

44 Ramon, S. (2000) *A Stakeholder's Approach to Innovation in Mental Health Services A reader for the 21st Century*, Pavilion, Chapter 1.

45 LAC 86 (15) *Mental Health Act 1983 – Approved Social Workers*, para 14.

46 *Draft Mental Health Bill as above paras 127,128,153,160 and 161.*

47 DoH (2002) *Draft Mental Health Bill Explanatory Notes*, Department of Health, Clause 8.

48 Brazier, M. (1992) *Medicine, Patients and the Law*, New Edition, Penguin Books; 109.

49 DoH (1999) *Reform of the Mental Health Act as above*; Chapter 3, para 1.

Empirical study

The nearest relative was introduced under the Mental Health Act 1959 and modified under the consolidating Act of 1983. Robust stakeholder representation was not involved at either stage. There has been little research into the operation of the 1983 Act⁵⁰ and the attitudes and knowledge of those responsible for its implementation⁵¹. The nearest relative is a particularly neglected topic⁵² and has not even been subject to routine monitoring. In view of negative stereotypes of relatives implicating families in the aetiology of mental illness⁵³, and the problems of abuse and exploitation of patients by relatives, perceptions regarding the role's value are particularly vulnerable to the impacts of negative attitudes and bias.

Although since the 1990s Government policy has emphasised the importance of stakeholder consultation, those most affected by the role were not fully represented on the Government appointed Expert Committee that recommended its abolition.⁵⁴ Thus the deficits of the two previous reforms have been repeated for a third time. Yet experiences shape personal meanings and understanding of real-life-situations⁵⁵. The case for research to investigate the views of main stakeholders involved in the nearest relative role, viz. carers, users of psychiatric services and ASWs, was both timely and necessary.

Main methods and findings

The main aims of contemporary research undertaken by the author as a PhD⁵⁶ were to investigate the values, attitudes and actions of carers, users of psychiatric services and ASWs in relation to the nearest relative and their views about legal change. The historical element provided an important starting point for the contemporary study, a means of co-ordinating fragmented information and a comparative perspective to assist the analysis of the empirical data. The contemporary study was of an exploratory nature and used qualitative methods. Grounded Theory⁵⁷ and the Case Study⁵⁸ method provided frameworks for the research design, data collection and analysis, and for comparing outcomes. Focus group⁵⁹ interviews comprising homogenous groups of carer, user and ASW stakeholders were augmented by topic guides, vignettes, information guides and group exercises to generate data. The research used

50 Wall et al, 1999 as above.

51 Eastman, N. et al (2000) *A study of attitudes, legal knowledge, decision processes and decisions outcomes of professionals with responsibilities under the Mental Health Act 1983*, Conference 6th March 2000, Royal College of Psychiatrists.

52 Gregor (1999) as above.

53 Laing, R. Esterson, A. (1970) *Sanity, Madness and the Family*, Penguin Books. Laing and Esterson belonged to the anti-psychiatry movement. The movement described schizophrenia as a meaningful response within dysfunctional families.

54 Stakeholder representation: Users were originally invited – they either withdrew or were withdrawn from the Committee because of disagreement over the Government's insistence on the introduction of community treatment orders. The carer was atypical as

he was also a GP. The social work representative although a very senior manager had no ASW experience.

55 Giorgi, A. (1985) *Sketch of phenomenological research*, Dusquesne University Press; Brandon, D. (2000) *Autobiography and Innovation*, In: Ramon, S (Ed) *A Stakeholder's Approach to Innovation* as above.

56 Rapaport, J. (2002) *A Relative Affair The Nearest Relative under the Mental Health Act 1983*, PhD thesis, Anglia Polytechnic University.

57 Grounded Theory: A systematic method of analysing complex social phenomena and building theory.

58 Case Study: An empirical inquiry that investigates a topic in its real-life context.

59 Focus group: A special type of group defined by purpose, size, composition and procedures. It facilitates carefully planned discussion.

“methodological triangulation”⁶⁰ and additional qualitative approaches to enhance scientific rigour. Five carer, four user and four ASW groups participated, a total of thirty-six carers, twenty-one users and twenty-four ASWs. The research incorporated county and urban locations and Afro-Caribbean carer and user groups. Carers and users were interviewed twice to ascertain their understanding of the role and to verify their views about its relevance. The empirical element of the research was conducted between 1997 and 1999. All except one of the interviews were completed before the Expert Committee’s recommendations were announced.

The findings covered three main areas regarding stakeholder views about the benefits and burdens of the role namely, the identity of the nearest relative, carer and user knowledge base and implementation of the powers.

Safeguard and identification

Participants quickly identified the safeguard concept of the nearest relative to protect the patient’s best interests. However, whether the safeguard principle was likely to be fulfilled depended entirely on the relationship between the nearest relative and patient. If the relationship was good, the nearest relative had the patient’s best interests at heart and was able to be assertive the role was an effective safeguard. Conversely, if the relationship was poor, the nearest relative had abused the patient or vice versa, or the relative did not know the patient well enough the safeguard was worse than useless and certainly a violation of patient privacy (Article 8). Several accounts of manipulations by relatives to force hospital admission came to the fore mostly, although not exclusively, from user and ASW groups. One user alleged that her husband had used his powers to enhance his case for custody of their children. ASWs also recounted several stories of husbands seeking to “ditch” their wives (husbands were seemingly never such victims). Further, with serious implications regarding patient choice of nearest relative or equivalent representative, in some cases the nearest relative’s true motives in prompting an admission only emerged over a considerable period of time.

ASW 1 “... the nearest relative is not always ... the most appropriate person to be consulted.

ASW 2 ... I would agree ... the whole category is an historical anachronism ... we’ve got to think quite carefully about what we’re going to replace it with. It’s just riddled with all sorts of contradictions and problems for relatives who use the powers ... and for users as well. ... You can’t make assumptions until you know people quite well. ... You may also have nearest relatives who’ve been themselves subjected to violence as a consequence of which they might not be willing to use the powers as they might precipitate violence”.

The role was also a potential imposition on the privacy of burdened carers (particularly widows) who had no one to whom to delegate their responsibilities. Nearest relatives in these circumstances cannot totally divorce themselves from their role. ASWs are not required and the research participants were not supported by the workplace infrastructure to help nearest relatives to find willing and suitable alternatives. Although nearest relatives can choose to do nothing ASW duties to contact and consult them could impose an unwanted burden. In addition, the role might unexpectedly make disagreeable demands. One inner city carer described how she had been “forced to sign” her son into hospital. There had been no ASW present and she had not known of the ASW role. She described the incident as her “worst nightmare”.

60 Yin, R. (1994) *Case Study Research Design and Methods*, Sage; 92.

Whilst the identification process could select the worst person it could also exclude the very best. Equally involved relatives, also found by Carter⁶¹ and gay partners highlighted by Lindow⁶² and recent case law⁶³ were discriminated against. The role did not in all cases suit Afro-Caribbean matriarchies: involved relatives living abroad were also excluded. ASWs felt professionally compromised when occasionally required to contact and consult relatives about the patient's detention regardless of the patients wishes and their own best judgement. In some cases this caused terrific patient anger. Patients and other family members probably wise to the system overcame the difficulty by withholding family information.

ASW powers to displace the nearest relative were found to be hopelessly inadequate. Even where the grounds existed the process could be very long-winded and arduous. The interim displacement order enabling the court to resolve the issue of nearest relative displacement under the ex parte provisions of the County Court⁶⁴ had only just been identified and was not widely known. Even so budgetary constraints were important factors to be considered before making the application and could sometimes override professional decision-making. One influential nearest relative had connived with senior management against the autonomy of the ASW who was seeking to displace the nearest relative in order to detain the patient under section 3. To the ASW's great relief the nearest relative went abroad just before the court hearing and another relative signed the application. Another nearest relative, aided by legal advice, had discovered a way of protracting her displacement endlessly by repeatedly re-assigning her powers to different relatives. The responsible medical officer had found the process wearing and discharged the patient who immediately left hospital and vanished without trace. In addition, displacement was perceived as a poor solution as the customary replacement of the nearest relative with the Director of Social Services removed the independent characteristics of the role and imposed a sense of officialdom.

The role additionally failed patients who had no identified or committed relative. Discretionary powers to find substitutes for such patients failed largely because suitable and willing volunteers were generally unavailable. The problem was particularly acute in the inner city area where a large proportion of patients had seemingly lost contact with their families. Yet all stakeholders agreed that inappropriate and disaffected relatives should be displaced (as advised by the Mental Health Act Commission in 1991) and that, as revealed by the hospital inquiry reports⁶⁵, patients without relatives were particularly vulnerable. To resolve the main current problems users, ASWs and the majority of carers favoured full patient autonomy in the choice of relative or representative, backed up by safeguards.

Knowledge base and implementation

With reference to the principle of fair process underpinning Articles 5 (security of the person) and 6 (fair trial) of the ECHR the research found that users did not know how the role could enhance or restrict their prospects of freedom. As carers were also generally unaware of their powers to

61 Carter, D. (1999) *The Nearest Relative under the Mental Health Act*, MA thesis, Anglia Polytechnic University.

62 Lindow, V. (1998) *Threats & promises*, *Openmind* 94, November/December; 11.

63 R. (on the application of S.S.G.) *Liverpool City Council* 2002 as above.

64 *R v Central London County Court ex parte Ax London* [1999] 3 All ER 991

65 Martin, J. (1985) *Hospitals in Trouble*, Blackwell cited in Rogers, A. Pilgrim, D. *Mental Health Policy in Britain*, MacMillan Press Ltd; 73.

access treatment and prevent unnecessary admission, the potential benefits of the role were immediately thwarted. Because of this poor knowledge base the powers were rarely implemented, although carers and users identified personal scenarios that underlined the role's relevance.

The research revealed the inadequacies of information systems and resources. In some cases ASWs had problems identifying the nearest relative because hospital databases did not record the nearest relative. They also had problems contacting relatives on holiday, out at work or whose mobile phones were not working. The inner city ASWs who felt overwhelmed by the volume of requests for statutory assessments, were unable to pursue relatives who were not immediately available at the assessment stage. Where such situations arose, in spite of official policy⁶⁶, the nearest relative might never be located and hence would not receive information about the role. Furthermore, ASWs were rarely involved during the pre-crisis stage and were reluctant to provide information in the heat of a crisis, when the patient and his/her relatives were in a state of emotional turmoil. Information from hospitals sent to identified nearest relatives about the legal aspects of detention (section 132((4)) and the imminent discharge of the patient (section 133(1)) (where the patient allowed) was either not received or not read. However, the repeat interviews also revealed that participants had problems recalling and understanding the role, although it was explained in a variety of formats.

Carers really wanted recognition, respect, information, support and responsive services and viewed their powers as a "last resort" measure. However, the power to procure an assessment under section 13(4) was keenly valued. If they had known of this power and of the ASW and ASW duties, tragedies that had occurred (actual and very serious attempts of suicide) might have been avoided. The research indicated that mental health professionals were also ignorant of section 13(4):

Carer: "... Every time we've approached a mental health worker we are seriously told there's nothing we can do about him. Basically he's practically got to kill himself before we can do anything about it. Now if that applies (refers to S13(4)) when we were given that advice we would have done that without hesitation. ,, If I had known of this position in law ... my son would never have committed suicide, or tried to. ... He had horrific injuries. ... I'm horrified no one has ever told me that I could ask a social worker before now. ... If I'd known that ... it wouldn't change the fact that my son was seriously ill but it would have been a much happier story".

ASW information also indicated that section 13(4) policy required under the Code of Practice⁶⁷ had not been instituted. Carers were in addition mystified that although they were "in a sense recognised people", in practice they were often excluded from decision-making and had to be "pushy" to obtain information, even where the patient would be returning to their care. Some carers were also reluctant to give information to psychiatrists fearing that their carer confidences would be indiscriminately passed on to the patient. However, others felt that communications had improved where section 25A-J, authorising carer consultation, had been imposed. Also on a positive note, ASW duties to consult and involve the nearest relative resulted in three, possibly four, successful diversions from hospital. Individual examples of ASWs helping nearest relatives to attain their "encoded" right to be involved in decision-making embedded within the role⁶⁸, procure a carer's assessment and debrief after the trauma of a compulsory admission emerged.

66 Code of Practice as above paras 2.15 and 2.16.

67 Code of Practice as above para 2.38 a & b.

68 Twigg, J. (1994) *Carers, Families and Relatives: Socio-*

legal Conceptions of Care-giving Relationships, Journal of Social Welfare and Family Law, Volume 3, 279-98 (quote from page 295).

An ASW also provided a scenario of the carer's assessment having given the "whole picture" of a patient's circumstances. This had apparently prevented a precipitous discharge and also helped the patient to understand the effects of his behaviour on his carers. Users generally liked the idea of the carer's assessment as they foresaw better prospects for themselves and were aware that their carers needed support and information to help them withstand the emotional burdens of care.

With regard to hospital diversions promoted by nearest relative interventions, the few stories that emerged suggest that the relatives concerned had very assertively used their powers. Reciprocal nearest relative powers and ASW duties were fundamental to these rare examples of the role's positive potential. By supporting the nearest relative to exercise his or her powers the ASW was empowered to apply rigorously the principle of least restrictive alternative and seek community solutions. These usually entailed providing extra support to the carer. The process of supporting the carer also enhanced the importance of the social work role.

Interpreters and ethnic insights

Afro-Caribbean carers were concerned that their facial expressions and behaviour could be misinterpreted and that such situations could lead to an inappropriate admission. This information underlines the importance of involving someone familiar with the patient in the assessment and hence the relevance of the nearest relative in general, as well as in specific cultural contexts. However, a particular difficulty emerged in relation to non-English-speaking people and those with communication impairments, as ASWs in some areas could not find interpreters to attend the assessment. At the point of desperation the empowered nearest relative was occasionally used as the translator, although the social workers concerned were aware of the nearest relative's increased potential to manipulate the outcome. A senior ASW said that she had been trying to raise the issue of access to interpreters with senior management for three years, but without success. This situation additionally highlights the general picture of woeful neglect of the assessment process and patient safeguards.

Conclusions and observations on the proposals for reform

The research confirmed that the nearest relative was better known for its vices than its virtues and in its current form was generally a poor safeguard. On the vices tack, whilst breaches of Article 8 in respect of patients were confirmed, the role could also intrude on the privacy of carers, especially widows living on their own who missed the support of their deceased partners. However, the research also showed that the role's positive potential was grossly overshadowed by a negative image that might have been considerably remedied had the vital recommendations of the Mental Health Act Commission to revise the displacement criteria in the Act not been ignored.

Although carers generally wanted recognition, support and responsive services rather than actual powers, the role was shown to have positive potential in achieving several successful hospital diversions and engaging caring carers. These scenarios support the findings of Gregor⁶⁹ and Shaw et al⁷⁰ that the nearest relative is an overlooked but very important lay safeguard. The apparent effort required to attain these goals suggests that if more relatives had been supported to use their

69 Gregor (1999) as above.

70 Shaw et al (2003) as above.

powers, more alternatives to hospital care might have come to light. Even so, nearest relative information was not publicised and rarely provided before the crisis situation. Most carer and user participants, even those with repeated statutory experiences, professed ignorance of the ASW role, let alone section 13(4). Section 13(4) policies were missing. Interpreters were not always available when required. The workplace infrastructure did not fully support the ASWs to expedite nearest relative and related patient duties, adding to a general impression of nearest relative and ASW marginalisation. These findings have further implications for the nearest relative's civil liberties and human rights potential, and also highlight the iniquity of absent monitoring systems.

Research lessons and the future Act

Whilst many of the nearest relative's shortcomings could and should have been remedied, the research also highlighted that the role was outdated. The findings support the introduction of the nominated person and carer roles under the proposed legislation, although further clarification is required to disentangle their overlapping functions. The introduction of the nominated person should at least resolve many of the problems associated with inappropriate nearest relatives. In line with the Expert Committee's thinking the majority of the stakeholders agreed that the patient should be allowed to choose their representative, albeit in the context of safeguards. It was also clear that the roles of patient representation and carer combined in the nearest relative were sometimes incompatible and potentially burdensome. However, ASW problems in ascertaining the nearest relative's true motives strongly suggests that the patient should initially have full autonomy to choose the nominated person, rather than be subjected to the AMHP's approval, with provision to alter the arrangement at a later date if hard evidence shows this to be necessary. In addition, whilst the new arrangements technically cover patients without relatives, the problems of finding substitute nearest relatives suggests that local pools of potential nominees should be identified to ensure that the proposed safeguard is universally available.

The research revealed that the principle of reciprocity, recommended by the Expert Committee but rejected by the Government, has silently underpinned the positive objectives vested in a role that has suffered from political neglect and is not widely understood. At a general level this finding highlights the dangers of ignoring the importance of governing principles and objectives in shaping legislation and offers a new perspective on the principle of reciprocity. More specifically, the carer and nominated person and also AMHP roles run the risk of sharing the nearest relative's fate unless these key elements, supported by monitoring systems, are put in place. With regard to the safeguard objective the carer and nominated person will have rights rather than powers. Whilst the research found that carers generally wanted recognition, information, support and responsive services, the removal of powers considerably weakens the safeguard potential of the new roles. However, given the suggestion that reciprocity has silently underpinned the intended objectives of the nearest relative, the new roles may have more influence if they are properly supported by the reciprocal functions of professionals who are themselves properly supported to fulfil their obligations. This would mean that contrary to the current position the new roles and the reciprocal duties of professionals should be publicised, with support and advice available at every step through the admission process. Steps should be taken to ensure that policies are expedited and that policy consultations involve all the relevant stakeholders, contrary to the hapless position of section 13(4). Professionals should also have access to a range of community resources to fulfil their obligations to seek the least restrictive alternative to hospital, including psychosocial

interventions that support families in crisis and enhance the carer's contribution. To address negative stereotypes of carers, multi-agency training on carers' needs, abilities and responsibilities will also be essential for the new roles to be effective. In addition, carer involvement should be given greater ethical prominence, rather than subject to diminution as currently indicated under Clause 8 of the Bill's guidance.

The ASW like the nearest relative will undergo changes if the new Act is implemented, although these largely concern the extension of the role to other non-medical professionals rather than radical changes to the role itself. The research found that ASWs were struggling to fulfil even basic statutory functions because of high workloads, missing policies, and poor and at times undermining management systems. Yet the applicant role is important not only in expediting the requirements under the Act but also in enabling lay roles, whether nearest relative, carer or nominated person, to fulfil their potential to help the patient attain his or her rights. The AMHP should expect the support of management in respect of access to effective databases, interpreters and other professional support systems to safeguard not only the integrity of the assessment process, but also to promote the importance of the applicant role. Given that the AMHP will not be independent of the assessing team it will be even more vital that these elements are addressed to ensure the new applicant is respected as a distinctive professional role, not only by users, carers and other professionals, but also the role-holders themselves.

Finally, whilst the delay in the proposed legislative reform provides opportunities to address the above concerns, it has the serious disadvantage of perpetuating problems associated with abuser relatives. This matter requires very serious attention as the law as it stands has adversely affected many people's lives. However, although judgements made by the European Court of Human Rights require changes to the nearest relative, there is still no sign that the Government is proactively considering interim remedies.

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