

Death of the Nearest Relative? Carers' and Families' Rights to Challenge Compulsion under Current and Proposed Mental Health Legislation

Victoria A. Yeates¹

The Mental Health Bill 2004² has recently undergone pre-Parliamentary scrutiny³ and the Government has now published its response.⁴ The Bill has a number of worrying implications for carers and families of psychiatric service users. It contains extensive discretionary powers to detain people with a wide range of mental disorders, including alcoholism and addiction, as well as to impose conditions on service users⁵ in the community, including a condition that the service user must desist from any specified conduct. The Bill places inordinate emphasis on public safety, which is likely to foster rather than reduce stigma.⁶ Given that the powers are so wide, and that

1 Senior Lecturer, Law School, University of Glamorgan

2 Department of Health, Draft Mental Health Bill 2004 and Explanatory Notes TSO 2004 Cm 6305-1 and II.

3 House of Lords, House of Commons, Report of the Joint Committee on the Draft Mental Health Bill Session 2004-2005 HL Paper 79(1), HC Paper 95(1).

4 Government response to the Joint Committee's report on the draft Mental Health Bill 2004 [HL Paper 79-1 HC 95-1]

5 Patient is the legal term for service user.

6 The anti-stigma agenda is reflected in the National

Service Framework for Mental Health: Modern Standards & Service Models Department of Health; September 1999, accessible at www.doh.gov.uk/pub/docs/doh/mhmain.pdf, and the Welsh Assembly Government, Strategy Document for Adult Mental Health Services in Wales: Equity, Empowerment, Effectiveness, Efficiency (2001). See also the report of the Social Exclusion Unit on Mental Health and Social Exclusion (9 June 2004) Office of the Deputy Prime Minister), where the Prime Ministerial foreword notes the need for 'determined action to end the stigma of mental health – a challenge not just for Government, but for all of us.'

many service users liable to compulsion may be vulnerable or lack mental capacity, it is of great concern that carers and relatives will lose significant rights to resist detention or compulsory treatment of a family member or partner suffering from a mental disorder. The Scrutiny Committee has recommended that some of these rights should be retained, including the right to direct discharge a service user who is not dangerous to self or others. The Government's response to these recommendations is disappointing though no great surprise given its avowed commitment to the risk management / public safety agenda.

The dilemma for reformers is how to ensure that mentally disordered people who may need to be subject to compulsory powers have the support of a loved one or family member to press for the provision of care in the least restrictive setting. In many cases the person most suited to carry this function out will be the service user's nearest relative, as defined in section 26 of the 1983 Act, spouse, parent, sibling, gay or straight live-in partner, or long term cohabitant or carer. The Joint Parliamentary Scrutiny Committee on the Mental Health Bill 2004 heard evidence from carers and nearest relatives arguing passionately for the retention of the power of discharge. For example the seventy five year old mother of a man with severe mental illness said this: 'If the family do NOT wish it and cannot support the service user they will not use the law. *Please do not cover us all under the same proposal.* (emphasis added).. do not throw the baby out with the bath water.'⁷ In other words, just because some nearest relatives are unsuitable or abusive, the rights of nearest relatives generally should not be reduced. The presumption of beneficence, that blood relatives and spouses will act in the best interests of their mentally disordered family members, no longer remains unchallenged.

This article explores the scope of carers and family members' current entitlements to be involved in decisions about the use of compulsion under mental health legislation and the impact of the European Convention on Human Rights on these rights. It then examines the proposals in the Draft Mental Health Bill in relation to family rights, the recommendations of the Joint Parliamentary Scrutiny Committee concerning carers and nominated persons and the Government's response to these recommendations. It will be argued that the 2004 Draft Bill would represent a significant erosion of the rights of families, which is potentially profoundly anti-therapeutic where a public safety agenda based on risk management predominates. It would involve a major shift in the boundary between the public and the private sphere, which is of constitutional significance, and it is argued that the Government should follow the recommendations of the Joint Parliamentary Scrutiny Committee.

The Public/Private Distinction

Bartlett and Sandland describe the existing process 'as very much the vestige of its nineteenth century predecessors' reflecting 'middle class Victorian ideologies of public and private life.'⁸ Latterly the public/private distinction has been extensively criticised because state permission for unregulated self-expression within the family in fact could authorise violence and oppression,⁹ including oppressive use of the power to apply for compulsory hospitalisation. However, the nearest relative under existing legislation has powers not only to apply for compulsion, but also to

7 DMH (MEMO) 103 Evidence to the Joint Parliamentary Committee on the Mental Health Bill 2004

Practice, Oxford University Press (2nd ed) (2003) 193

9 Peter Alldridge, *Relocating Criminal Law* (Ashgate 2000), 106.

8 Bartlett and Sandland, *Mental Health Law, Policy and*

resist it, to resist removal of their family member from private care by the family into the care of the state. At a time when a person's mental health is in crisis, they will benefit from someone who has a close connection and who can support the case for care in the least restrictive setting, in short, the case against compulsory hospitalisation. The nearest relative concept provides this.

Respect for privacy and family life are fundamental tenets of liberal rights theory, protected by Article 8 of the European Convention on Human Rights, which requires interference with these rights to be in accordance with law and proportionate. Conflict between different parties' Article 8 rights may occur. For example, a family may consider it part of their right to respect for family life to participate in decisions about the care of the mentally ill family member. On the other hand the service user may consider their right to respect for privacy to dictate that the family should have no such involvement, as would be likely in cases where family members are exploitative, disinterested or ineffectual.

Balancing these competing rights may be difficult. Obviously the choice of a capable service user as to who should be their nominated person should take priority over the rights of other family members. There are undoubtedly cases where service users legitimately consider that they do not want any involvement by the person identified as 'nearest relative' under s 26. The core problem is that many service users need someone to uphold their rights, but strict application of the statutory formula often produces a person who is unacceptable to them. A further problem is that the service user's perception of who is appropriate to represent their interests may be skewed by their mental disorder.¹⁰

The Nearest Relative

The concept of nearest relative was introduced in 1959 as the person entitled to apply for detention, to be consulted about compulsion, in certain cases to block compulsion, to discharge the service user from hospital, and to appeal to the MHRT if discharge is blocked on grounds of dangerousness to self or others. The 1983 Act retained the nearest relative concept but sought to 'modernise' it by providing for a person who has lived with the service user for six months or more as man and wife to be treated as a spouse. Any common law partner with whom the service user has been residing as husband or wife counts as the husband or wife, provided the service user is separated from anyone to whom they are married. Since the Human Rights Act 1998 this includes gay partners.¹¹ Anyone with whom the service user has been residing for at least five years is also added to the list of potential relatives. The Act rightly provides that a relative who is caring for the service user or with whom the service user ordinarily resides will take priority over others higher up the list of family ties.

There is increasing recognition of the fact that carers can be 'experts by experience' and should have a significant say in the care plan, especially since it is they who will be almost entirely responsible for its delivery. The carer will often, but not always, be the person best placed to know the service user as a person, and therefore able to decide when the time has come for admission to hospital, and when care can safely be provided in the community. The way in which the current

¹⁰ See Evidence 254 given by Cliff Prior of Rethink House of Lords, House of Commons, Report of the Joint Committee on the Draft Mental Health Bill Session 2004–2005 HL Paper 79(II), HC Paper 95(II), Ev 254, Question 275.

¹¹ *R (SSG) v Liverpool County Council Secretary of State for Health and LH (interested party) 2002* where the court declared that a gay partner who had resided with the service user for more than six months should be entitled to be regarded as the nearest relative.

Act works is that where there is a carer who resides with the service user that person (provided they qualify as a 'relative') will probably be the nearest relative, with a floor of rights on the basis of which they can, if necessary ask for compulsory admission to hospital or guardianship, but more importantly, can object to compulsory admission, have a power to discharge compulsory detention of the service user unless s/he is dangerous to self or to others, and to apply to the MHRT if discharge is blocked.

There are two aspects of the reform proposals in the 2004 Bill. The first is welcome, and is aimed at recognizing the right of a capable service user to determine who their nominated person should be, and displace someone who is unsuitable. The second, which is deeply unwelcome to many carers, is the partial dismantling of the floor of rights which the nearest relative currently enjoys.

The Floor of Family Rights: Nearest Relative's Powers under the Mental Health Act 1983

Four planks make up the floor of rights: 1. to initiate compulsion; 2. to advocate for care in the least restrictive setting; 3. to direct discharge of a service user who is not dangerous to self or to others; and 4. the right to apply to a Mental Health Review Tribunal (MHRT) for discharge. The Human Rights Act 1998 has had a significant influence on the position.

1. Powers to initiate compulsion

(a) The power to apply for compulsory admission or guardianship

These powers entitle the nearest relative to hand the service user into the compulsory care of the state, from the private to the public sphere of care.¹² In practice this rarely happens, the Approved Social Worker (ASW) being the preferred applicant as better placed to carry out this task. It is questionable whether this power is appropriate in that it may cause resentment and possible feelings of betrayal between the caring relative and the service user. Few tears are being shed over the proposed loss of the nearest relative's right to apply formally for compulsion, such applications only to be used by public officials such as AMHPs¹³. The aim of this proposal is to limit the emotional toll on the relationship between the family carer and the service user.

(b) The power to ask for an assessment

The current right of the nearest relative to request assessment of the need for compulsory admission will be replaced under the Draft Mental Health Bill 2004 with a provision whereby 'any person' can apply for assessment, and will be entitled to written reasons if compulsion is not instituted.¹⁴ This particular proposal has provoked alarm among a variety of stakeholders, their fear being this could lead to the creation of a 'busybody's charter', given the breadth of the new criteria for compulsory powers.¹⁵ It is therefore submitted that the right to ask for an assessment and to be given reasons for not using compulsion should be limited to the nominated person or next friend.

12 *Mental Health Act 1983, s 11(1) which confers on the nearest relative the power to apply for admission for assessment for up to 28 days (s 2), for treatment (s 3), or into guardianship (s 7).*

13 *Approved Mental Health Professionals*

14 *Mental Health Bill 2004, cl 14 (1)*

15 *See evidence of Hafal, The Mental Health Alliance and of Health and Social Services Committee for the National Assembly for Wales to the Joint Scrutiny Committee on the Mental Health Bill 2004*

2. The power to advocate for care in the least restrictive setting¹⁶

Relatives and carers have an important role in acting as advocates for care in the least restrictive setting commensurate with the service user's mental health care needs. These rights are currently available to nearest relatives under the 1983 Act, in the form of the right to be consulted over compulsory admission, the right to object to compulsory admission for treatment, and the right to direct discharge provided the service user is not dangerous to self or to others. These rights are all subject to important qualification

(i) Detention for assessment under Section 2

Where an application for detention for assessment is made by the ASW, 'before or within a reasonable time after the application is made, the ASW must 'take such steps as are practicable to inform the person (if any) appearing to be the nearest relative of the service user.'¹⁷ In *R (E) v Bristol City Council*¹⁸ Bennett J followed the approach adopted by Richard Jones' *Mental Health Act Manual*¹⁹ and held that the terms practicable and reasonable in section 11(3) and (4) had to be interpreted so as to give effect to the service user's right to respect for privacy under article 8 of the European Convention on Human Rights. On the facts E's Article 8 rights would have been infringed unless the words 'practicable' and 'reasonable' in s 11 were interpreted so as to take account of her wishes and her health and well-being. This is a welcome development in recognition of patient autonomy. Subject to this, in deciding whether it is appropriate to make an application the ASW must have regard to any wishes expressed by the service user's relatives.²⁰

A nearest relative's objection may block admission for treatment under s 3, but not for assessment under s 2. Section 29(4) of the 1983 Act allows for the 28 day period of detention for assessment under s 2 to be extended if an application has been made for the displacement of the nearest relative, until that application has been disposed of by the county court.²¹ A nearest relative's objection to s 3 admission may be circumvented by applying for admission for assessment under s 2, and then by applying to the county court to displace the nearest relative on grounds of unreasonable objection to admission for treatment. In *R (MH) v Secretary of State for Health and others* the issue before the court was the compatibility of the displacement system with the European Convention on Human Rights. What Buxton LJ called 'the section 29(4) problem' is that during that period of extended detention, a service user will not be able to apply to the tribunal for discharge. A patient capable of challenging their detention may have done so during the first 14 days of the section 2 but there is no provision within the MHA for the case of an incapable section 2 patient to be automatically referred to the tribunal. The nearest relative may direct discharge under section 23 but if that direction is barred by the responsible medical officer (RMO), the NR

16 The least restrictive alternative is reflected in s 3(2) of the Mental Health Act 1983 and in a diluted form in the Mental Health Bill Clause 9(5) that medical treatment cannot lawfully be provided without him being subject to the provisions of this Act. Since the 2004 Bill allows for compulsory treatment in the community, this imposes a lower threshold for compulsion, a 'necessity for treatment' test rather than a 'necessity for treatment under detention' test. Clause 1(4) which requires the Code of Practice to state as a principle that 'the interference to service users in providing medical treatment to them and the restrictions imposed on them during that treatment are kept to the

minimum necessary to protect their health or safety or other persons.' The principle is further diluted in that it can be disapplied to groups or categories of service user.

17 *Ibid.*, s 11(3)

18 *Administrative Court [2005] All ER (D) 57 (Jan) 13 January 2005* (for a review of this case, see further on in this issue of the JMHL)

19 Most recently, at pp 81–83 in the 9th edition (Sweet & Maxwell, 2004)

20 *Ibid.*, s 13(1)

21 *Mental Health Act 1983*, s 29(4).

becomes impotent. S/he has no right of access to the Tribunal, which s/he would have if the patient were detained under section 3. In *MH*, the mother of a young woman with a learning disability (MH) was subject to displacement proceedings in the County Court following the conclusion of the RMO that she had acted unreasonably when directing the discharge of the section 2 to which her daughter was subject. In *MH* the displacement proceedings lasted for more than two years. Despite the entreaties of Hale LJ in *R(S) v City of Plymouth (2002)* where she said “applications under section 29 have to be dealt with quickly”, in this case it clearly was not. Throughout, neither the patient nor the nearest relative had the power to make an application to the tribunal (although it should be acknowledged that there was a tribunal hearing early in the life of the displacement proceedings as a consequence of the then Secretary of State being persuaded to exercise his power within section 67 of the MHA to refer the case of an ‘unrestricted’ patient at any time). In the unanimous opinion of the Court of Appeal the patient’s lack of direct access to the tribunal was incompatible with the right to speedy review of the lawfulness of detention demanded by the provisions of Article 5(4). Subsequently on 20th October 2005, the House of Lords²² (the sole judgment being given by Lady Hale) ruled otherwise, not least because of the Secretary of State’s section 67 power.

(ii) Detention for treatment under section 3

Nearest relatives’ rights are much more extensive in relation to detention for treatment under s. 3 of the 1983 Act. Section 11(4) provides that an application may not be made under s.3 by an Approved Social Worker if the nearest relative has notified the ASW or the local social services authority that he objects to the application being made. Furthermore, the subsection imposes a duty on the social worker, before making the application, to consult the person appearing to be the nearest relative,²³ unless it appears that ‘in the circumstances such consultation is not reasonably practicable or would involve unreasonable delay’, reasonable and practicable being interpreted so as to give effect to the service user’s Article 8 rights, as held in the *Bristol* case.²⁴

The obligation to consult the nearest relative is seen as so important that consultation with a person who could not reasonably appear to be the nearest relative might invalidate the detention as held in *Re S-C (Mental Service user: Habeas Corpus)*.²⁵ The Richardson Committee, whilst according ‘the highest priority’ to the identification of ‘such a person’ saw consultation as dispensable, considering that ‘the consequences of there not being such a person at any particular stage in the compulsion process should not be sufficient to interfere with the validity of that process.’

3. The Power to order Discharge

A nearest relative may order the discharge of a service user²⁶ detained under section 2 or section 3. This right can be blocked by the issue of a barring certificate by the RMO who certifies the service user would, if released, be a danger to self or others.²⁷ The barring certificate is subject to review by the managers, who may overrule the RMO and the nearest relative also has recourse to a MHRT²⁸

22 [2005] UKHL 60

23 *D v Barnet Health Care Trust* [2001] 1 F.C.R. 218 The obligation on a social worker is to ‘act in a common sense manner’ when determining who is the nearest relative

24 *Administrative Court* [2005] All ER (D) 57 (Jan) 13 January 2005. Consultation means ‘the communication of a genuine invitation to give advice, and a general

consideration of that advice. *R v Secretary of State for Social Services ex parte Association of Metropolitan Authorities* [1986] 1 All ER 164.

25 [1996] 1 All ER 532.

26 *Mental Health Act 1983*, s 23.

27 *Mental Health Act* s.25

28 *Ibid*, s.66

In *R(O) v West London Mental Health Trust*²⁹ where managers reviewed a decision to impose a barring certificate, they continued detention in the hope of the service user acquiring insight into his illness. Collins J held that the managers had failed to specifically consider the issue of dangerousness to self or others, which if absent should lead to discharge.

The importance of the power of discharge and the fact that carers often have a much better perception than professionals of the needs of service users, is poignantly demonstrated by the case of Andrew Taylor, a young man with autism for whom no placement was available when he left school at 18.³⁰ Because of the uncertainty created by the fact that no suitable specialist placement was available, Andrew became disturbed and was detained in a psychiatric unit. Twice over an 18 month period a MHRT criticized Andrew's placement on the psychiatric ward, but he was able to leave only when his mother gave up work to care for him and exercised her power as his nearest relative to discharge on the basis that he would be in her care, and would not be a danger to himself or to others. Since discharge it seems he has made tremendous progress. Without intervention from the nearest relative he might still be inappropriately placed in hospital, despite the availability of review by the Tribunal.

4. The Right to apply to a Mental Health Review Tribunal

Nearest relatives have rights to apply to the MHRT if a service user detained for treatment is reclassified, if a certificate barring discharge of a section 3 detention is issued under s 25, or if the nearest relative has been displaced by the county court under s 29.³¹ The nearest relative may also apply for the ending of supervised discharge to which the service user is subject, once within every period for which the supervised discharge is renewed, and once following any reclassification of the service user as suffering from a different form of mental disorder.³² These will be replaced under the 2004 Draft Bill by a single right to apply to the Mental Health Tribunal (MHT) for discharge³³, but it should be remembered that MHT hearings in such circumstances will take some time to organise and in that sense will not be as effective as the existing right to direct discharge.

Displacement of Nearest Relatives

There are two ways around the objection of a nearest relative to detention for treatment: 1. a displacement order; and 2. an interim displacement order

1. Displacement Order

The grounds of displacement include that the nearest relative unreasonably objects to the application for admission for treatment, or has unreasonably attempted to exercise the power of discharge³⁴. The unreasonableness of a nearest relative's objection is to be judged according to the standard of whether a reasonable nearest relative would object?³⁵ This test almost raises a presumption of unreasonableness where there is disagreement with the professional judgment of the doctors and the social workers as to what is in the interests of the service user. Bartlett and

29 16 March 2005 Collins J.

30 Local Government Ombudsman, *Report on an Investigation into Complaint No 02/C/17068 against Bolton Metropolitan Borough Council* 30 November 2004. Thanks to Richard Jones for pointing out this report

31 *Mental Health Act 1983*, s 66(1)(d), (g), (h).

32 *Ibid.*, s 66(1)(ga), (gb), and (gc).

33 *Mental Health Bill 2004*, cl. 54(2).

34 *Section 29(3)(c)&(d) MHA 1983*

35 *W v L* [1974] QB 711, per Lord Denning at 717–718.

Sandland refer to 'an approach of extreme sympathy to medical opinion at trial' and conclude that 'it is difficult to see that s 29 applications do not in the end collapse into a question of the court's view of the best interests of the service user, and the courts are loath to take a view divergent from the service user's medical officers.'³⁶

2. Interim Displacement Order

In *R v Central London County Court ex parte London*³⁷ the Court of Appeal held that an interim order can be made displacing the relative and an application for admission under s 3 may be made during the currency of such an order if there are cogent reasons for doing so. The application for the interim order had been made *ex parte*, so the nearest relative was not heard. During the currency of such an order the displaced nearest relative loses their right not only to veto detention under s. 3, but also the right to seek the discharge of the service user under s. 23.

Displacement applications require judges to choose between professional medical expertise, acquired from clinical practice, and the increasingly recognised expertise born out of the carer role. It is now common in health care (including mental health) to speak of the 'Expert Carer' in recognition of the invaluable role of carers in maintaining the health of family members over prolonged periods of time. Carers are 'experts by experience', often able to assess a service user's needs more accurately than professional members of the care team by virtue of their in depth knowledge of how illness presents in their family member, and their active participation in care decisions should be encouraged.³⁸

Hence a clash between the clinicians and the family or carer(s) about what action is in the best interests of the mentally ill service user, inevitably brings into play a conflict between these two types of expertise. When a subjective test such as 'What would the reasonable nearest relative do?' is applied in relation to displacement, judges are more likely to defer to professional expertise, even when it may be wrong and damaging to the service user. Judges who deal with these applications ought to receive training to apprise them of the vital role played by carers, and to be able to think themselves into the shoes of someone caring long term for a mentally ill person. The 2004 Bill proposes that these issues should be dealt with by the Mental Health Tribunal rather than by the county court. Whatever forum is chosen, the important thing is for carers, and those they care for, to feel confidence in a decision making process which directly affects one's status as a member of society in a most acute way.

They need, in Wexler and Winick's words:

'[H]earings in which they can participate, in which they are treated with dignity, and in which they believe that they are dealing with trustworthy authorities who are motivated to be fair to them'.³⁹

36 P. Bartlett and R. Sandland, *Mental Health Law: Policy and Practice*, Oxford, University Press (2nd edition) 2004, 207.

37 [1999] 3 WLR 1.

38 See the development of the Institute of Psychiatry 'Expert Carers Initiative' to train carers

www.iop.kcl.ac.uk/Departments/PsychMed/EDU/ExpertCarers.shtml, following the speech by Stephen Ladyman MP Parliamentary Under-Secretary for Community Care of 6 October 2003.

39 David B. Wexler and Bruce J. Winick, *Law In A Therapeutic Key*, Carolina Academic Press 1996, 14

Displacement and Human Rights

Whilst social services authorities may apply for displacement of an unsuitable nearest relative, the one person with no power in this regard is the service user. In *JT v United Kingdom*⁴⁰, this was held to breach the right to respect for privacy under Article 8. Under the statutory formula JT's nearest relative was her mother, who was living with a man who JT alleged had abused her in the past, and she had no power to apply to the court for displacement. The judgment of the Strasbourg Court noted that a friendly settlement was reached whereby the government undertook to introduce reform proposals to (1) enable a service user to make an application to the court to have his nearest relative replaced where the service user objected on reasonable grounds to a particular individual acting in that capacity, and (2) prevent certain persons from acting as the nearest relative of the service user. Almost five years later, no legislation has been introduced, as acknowledged by the Government in *R (M) v. Secretary of State for Health*⁴¹ where Maurice Kay J. declared that ss 26 and 29 of the Mental Health Act are incompatible with the ECHR. The decision in *JT v United Kingdom* could have been complied with by remedial order amending the 1983 Act to entitle a service user with capacity to nominate someone to exercise the functions of nearest relative and to seek displacement of an unsuitable nearest relative, without abolishing the important powers and rights which go with the nearest relative role.

The reason why the Government has not chosen this path is that the Draft Mental Health Bill 2004 proposes to abolish the nearest relative in favour of a new 'nominated person' regime, and in the process undermine the floor of rights of families and carers to question the use of compulsory powers. The nominated person provisions in the 2004 Bill partially reflect proposals in the Richardson Committee Report.

The Richardson Committee and the Mental Health (Care and Treatment) (Scotland) Act 2003

1. The Richardson Committee

The Richardson Committee heard strong criticism of two key aspects of the nearest relative provisions: first the person identified as the nearest relative under s 26 may be unacceptable to the service user; and second the service user has no power to apply for displacement of an unsuitable nearest relative. The Richardson Committee responded to these concerns by recommending the removal of the nearest relative *altogether*, to be replaced by the nominated person, who 'should not have the powers of application and discharge currently possessed by the nearest relative.' **From service users' point of view, the main problem was not the extent of the nearest relative's rights, but their inability to exclude an abusive relative from exercising this role.** The Richardson Committee concluded that implementation of their proposals to introduce greater 'independent decision-making' (by authorization of compulsory in-service user or out-service user treatment by a Mental Health Tribunal (MHT)), would mean that the powers of such a statutory figure as the nearest relative 'should be reduced'⁴² The Tribunal may be independent of the hospital, but the Draft Mental Health Bill proposals also state that a service user can be subject to assessment as a resident user or non resident user for up to 28 days on the say-so of the Approved Mental Health

40 (2000) 30 E.H.R.R CD 77.

41 [2003] E.W.H.C. 1094.

42 *Review of the Mental Health Act 1983 November 1999 paras. 12.17 – 12.18.*

Professional (AMHP) and two doctors, subject of course to the service user's and the nominated person's appeal to the Tribunal.

The right to be consulted over the need for compulsion gives the family standing to advocate on behalf of the prospective 'patient' and put the case against compulsion if they feel it necessary *before compulsion has been imposed*. In order for this to happen there needs to be someone who has status by virtue of an emotional or caring relationship to make objections, without having to wait until after compulsion for such a person to be appointed, although the nominated person would have the right to apply for discharge to the MHT. Reasonable objections to compulsion are best dealt with by way of prevention rather than cure given the potentially traumatising experience of compulsion.⁴³

The important recommendation in terms of service user autonomy was that where possible, they should be empowered to appoint their own nominated person, and that this could be done by advance statement. 'Such a person might be a relative, friend, carer or advocate.'⁴⁴ Where there is no family, spouse or partner, it would be beneficial for the service user to be able to nominate a nominated person, and the Committee strongly recommended that 'the identification of a nominated person should be a central focus especially for those who are likely to be assessed for compulsion on future occasions.'⁴⁵ However, many people with a mental health problem do not foresee the possibility of compulsory powers being imposed, or may lack capacity to do so, and may not have had the foresight to appoint a nominated person in advance. The Richardson Committee considered this useful but decided against proposing a default provision based on s 26 of the 1983 Act to address the situation where a service user has not nominated anyone in advance. Again they felt such a provision would be unnecessary, particularly in relation to assessment, because of the rights of access to the MHT to appeal against compulsory assessment.⁴⁶ This ignores that fact that carers and relatives may provide safeguards which cannot be provided by the tribunals, by being in a position to offer care to the service user, to advocate against compulsion, and to discharge the service user from detention. The other problem is that there is no-one to act for the service user at the point where compulsory powers are being considered.

2. The Mental Health (Care and Treatment) (Scotland) Act 2003

The Mental Health (Care and Treatment) (Scotland) Act 2003 provides a framework to solve these problems. It creates a presumption in favour of a capable service user's choice of 'named person' and specifically provides for recognition of nominations made by a capable service user, including advance nominations⁴⁷, with the first default position being the primary carer. The second default position is the nearest relative, defined in a way which reflects modern family forms including same sex partnerships.⁴⁸ This system accords with the view of the Parliamentary Joint Committee on Human Rights on the 2002 Draft Mental Health Bill that service users with capacity to do so should have a fuller role in selecting their nominated persons, so as to ensure compatibility with the Convention.⁴⁹ It also enables the service user who has not nominated someone in advance to have a supporter prior to the imposition of compulsion rather than after it.

43 *No Force Campaign (DMH 44) House of Lords, House of Commons, Report of the Joint Committee on the Draft Mental Health Bill Session 2004–2005 HL Paper 79(1), HC Paper 95(1)*

44 *Richardson Committee Report, op. cit., para. 12.21*

45 *Ibid., para. 12.21.*

46 *Richardson Committee Report, op. cit., para. 12.22.*

47 *Mental Health (Care and Treatment)(Scotland) Act 2003, s 250.*

48 *Ibid., cl 254(2)(b) and (7).*

49 *Draft Mental Health Bill: Twenty Fifth Report of Session 2001–02, HL Paper 181, HC 1294; London, HMSO, para. 84.*

The Mental Health Bill 2004

Under the 2004 Bill regime the nearest relative role is replaced by two figures, the carer and the nominated person, and the floor of rights is substantially diminished. Whereas in many instances one person will wear both hats, the carer will not necessarily also be the nominated person. This possible divergence of roles and functions provides the framework for potential confusion and conflict within the family. The person who performs the caring role may find themselves without the nominated person rights, diluted though they may be compared with the existing rights of the nearest relative, a clear case of responsibilities without commensurate rights.

The carer's role and rights

The carer's rights to be consulted are not automatic and are also limited to expressing views as to the likely impact of any medical treatment on the carer and service user, and to providing clarification as to the service user's wishes and feelings.⁵⁰ Therefore the main function of the carer is as provider of information to the clinical team, a useful but essentially passive role. The carer's right to be consulted will not be exercisable unless and until the service user's views have been sought and a determination is made by the AMHP that consultation is appropriate and practicable, appropriateness and practicability to be determined in the light of the *Bristol* case.⁵¹

The recommendation of the Joint Parliamentary Scrutiny Committee that the Bill should be amended to contain a presumption to consult a carer when examinations and assessments are being carried out unless the patient is expressly opposed to it has been rejected in the Government's response.⁵² The Government believes the patient will receive greater protection where an AMHP exercises discretion as the burden of expressing an objection will be removed from the patient. In cases of exploitative or inadequate carers this may be so but in families with able, ethical carers the scene may be set for disharmony where the 'expert carer' clashes with the professional.

The nominated person

Fifteen clauses of the Bill are devoted to the appointment and displacement of the nominated person.⁵³ Priority is given to the autonomous choice of a capable service user subject to the important qualification that in the view of the approved mental health professional (AMHP) the person nominated is eligible and suitable. There are various mechanisms for overriding the service user's choice, so it may be some time after compulsion is imposed before the nominated person is appointed, tying up professional time, and creating uncertainty. The obvious problem here is that, because of the absence of recognition of advance statements appointing a nominated person, the service user is being asked to make a choice in relation to their nominated person when their capacity is considered to be sufficiently impaired to warrant the use of compulsory powers under mental health legislation.

If the service user lacks capacity or the person chosen is unsuitable or ineligible, the appointer (in most cases, the AMHP) must appoint the most suitable eligible person or, if there is none, the local social services authority. The service user must be consulted over the appointment (unless inappropriate or impracticable) but does not have an absolute veto over appointments. The AMHP merely has to have regard to the service user's views in deciding whether the appointment is

50 *Mental Health Bill 2004*, cl 12.

51 *Administrative Court [2005] All ER (D) 57 (Jan) 13*
January 2005.

52 *Government Response to the Joint Committee's report on
the draft Mental Health Bill 2004* page 46

53 *Ibid.*, cls 232–246.

inappropriate, but is not bound by them.⁵⁴ This gives immense discretion to the AMHP.

The effect of these reforms will be to leave the service user unprotected at the point where s/he is most vulnerable, when compulsion is being imposed. The 2004 Bill provides that as soon as practicable *after* the person becomes liable to assessment, that is *after compulsory powers have been exercised*, the AMHP must appoint a nominated person for the service user, and notify the service user and the nominated person (also each person with parental responsibility for a service user under 16) of the fact that the service user is liable to assessment as a resident or a non-resident service user, of all the determinations made in his case and the reasons for them, and of the help available from Independent Mental Health Advocates.⁵⁵

The nominated person has rights to be consulted at various points after compulsion has been imposed, and to make applications to the Mental Health Tribunal on the service user's behalf. The matters about which a nominated person is consulted must include whether it appears to him that the service user's wishes and feelings about that step are known or can be ascertained and, if so, what appear to him to be those wishes and feelings.⁵⁶ A service user's nominated person is entitled at any reasonable time to visit the service user⁵⁷.

A service user with capacity may place restrictions on the role of the nominated person. A service user 'who appears to the appointer to have capacity' can notify the AMHP that the nominated person is not to be consulted, notified, provided with any document, or account is not to be taken of any representations or requests made by the nominated person on any matter.⁵⁸ This means that the nominated person role may become a matter for negotiation creating scope to erode further the rights of a 'stropky' carer or relative who may well be right, and have a fair case to put, like Mr and Mrs E in *HL v United Kingdom*⁵⁹ and Andrew Taylor's mother in the Bolton LGO case.⁶⁰

The 2004 Bill erodes the nearest relative's rights to act as supporter of the rights of the service user. Unless the service user has had the prescience to nominate a person in advance (remember the Bill has no provision for advance appointments) the nominated person would not be appointed until *after* the service user is subject to compulsion. The Bill cuts away the current nearest relative right to advocate for the least restrictive alternative at the crucial stage prior to compulsory powers being exercised, that is *before* the process of compulsion rolls forward with its own momentum. Supervision of the system would be transferred to the mental health tribunal from the county court. Within this labyrinthine system the service user has a limited right, with the leave of the MHT, to apply for the revocation of the appointment of his nominated person.⁶¹

It is a curious way to address the issue of service user autonomy by proposing a system which fails to recognise advance statements appointing a nominated person, which contains no fall back position, and which introduces a complex system where the very people whose decisions may be challenged by the nominated person are given immense discretionary power over who that person should be.

54 *Ibid.*, cl 233(6), cl 235, cl 236.

55 *Ibid.*, cl 19.

56 *Mental Health Bill 2004*, cl 238.

57 *Ibid.*, cl 238(3)

58 *Ibid.*, cl 239. *If the nominated person is notified s/he must not do the things specified in the notice, and the requirements of the Act to consult the nominated person in relation to that matter do not apply.*

59 *HL v United Kingdom Judgment of the European Court of Human Rights* 5 October 2004.

60 *Local Government Ombudsman, Report on an Investigation into Complaint No 02/C/17068 against Bolton Metropolitan Borough Council* 30 November 2004.

61 *Draft Mental Health Bill 2004*, cl 244.

The Convention case law clearly recognizes that mentally disordered people need support to exercise their rights, particularly if they lack capacity.⁶² It also recognizes that service users should have the right to sever legal ties with family members who have behaved abusively towards them in the past or are otherwise unsuitable to exercise the powers of nearest relative.⁶³ People with mental disorder sufficiently serious to warrant compulsion will stand a much better chance of doing well in the community if they have a carer. Any new legislation should contain proposals which enable relatives, nominated persons, or next friends, call them what you will, to have a firm footing of legal rights to advocate for the least restrictive alternative, and to look after non-dangerous family members in the community by discharging their compulsory detention. Instead the 2004 Draft Bill seeks to abolish these rights.

Whilst under the 1983 Act the carer will almost automatically be the nearest relative, the carer will not necessarily achieve nominated person status under the Draft Bill. This will potentially divide families and damage relationships where the carer bears responsibility for care, but may not even have the powers of the nominated person, limited as they are. Nearest relatives are often seen as an irritant or at best an irrelevance, and the proposed reforms pay little more than lip service to service user autonomy, except where it might be used to clip the wings of the nominated person, and can be seen as a somewhat unobvious attempt by the state to wrest back control from the private family arena by replacing the robust but flawed nearest relative concept with limited rights for nominated persons and carers. If the Government was serious about Article 8 compliance it would have introduced a remedial order by now.

The Joint Parliamentary Scrutiny Committee

The Joint Parliamentary Scrutiny Committee heard a considerable body of evidence recommending acceptance of the principle that the service user should have greater rights to choose who should be the nominated person, but it rejected the reduction in the floor of rights for such a person proposed under the Draft Bill.⁶⁴ The Committee recommended that the nominated person should have broadly the same rights as the nearest relative. Removing the rights of the nearest relative would in the Committee's view erode the position of families and carers to take responsibility for the care needs of the service user and to avoid admission to hospital. The nominated person should be able to make an order for the discharge of a service user detained in hospital. The clinical supervisor should be able to block discharge only on grounds of likely dangerousness to self or others, subject to appeal to the MHT by service user, carer or nominated person.⁶⁵

The Government has rejected these recommendations, arguing that they are unnecessary as the Bill provides 'a comprehensive package of additional safeguards' (namely, the clinical supervisor's on going review function, the review role of the MHT and the support provided by advocates and nominated persons). The Government states that compulsion should continue where treatment is

62 *HL v United Kingdom Judgment of the European Court of Human Rights of 5 October 2004.*

63 *JT v United Kingdom (2000) 30 E.H.R.R CD 77.*

64 *Yens Marsen-Luther of the Institute of Mental Health Act Practitioners, said 'We are terribly concerned that the proposals to get rid of the opportunity for the nearest relative to discharge the service user if they are not a*

danger to themselves or others. We think this is throwing the baby out with the bathwater.' (the origin of this phrase is German and means a Treatise for fools!) House of Lords, House of Commons, Report of the Joint Committee on the Draft Mental Health Bill Session 2004–2005 HL Paper 79(1), HC Paper 95(1) para 398

65 *Ibid., para 398.*

deemed necessary even though there may be no issue of dangerousness.⁶⁶ The shift towards greater state power could hardly be made any clearer

The Committee also considered that the rights and interests of a service user would be better safeguarded if a nominated person was able to act at the point when compulsory powers are first used, to exercise his powers from the start of the examination stage, and was entitled to participate in the examination.⁶⁷ Additionally the Committee recommended that patients have the right to independent mental health advocates from the start of the initial examination period.⁶⁸ The Government response acknowledges concerns that patients should have adequate support from advocates/nominated persons/carers before compulsory powers are applied but disappointingly states it is to be left to codes of practice to determine how this will be achieved.⁶⁹ It is submitted that such a vital function should be enshrined in the primary legislation.

The Committee recommended that service users should be able in advance to appoint a nominated person either by an advance statement or by a simple free-standing instrument. If no prior appointment had been made the Committee recommended using the default system adopted by the Scottish legislation whereby the carer would be the nominated person, or if there was no carer, the nearest relative.⁷⁰

The Government response to the recommendation regarding advance statements is positive to the extent that there is a statement that they 'will carefully consider how this may be achieved in the Bill'.⁷¹ Whilst this is encouraging it does not amount to a firm commitment as to how, or indeed if, this recommendation will be followed. The response to the default provisions recommendation is less enthusiastic. The Government acknowledges the time consuming and complex nature of appointing a nominated person who is both suitable and eligible but feels clarification can, once again, be left to 'guidance'.⁷² It is submitted this is an inadequate response. Further, the Committee's proposals are rejected for 'not allowing scope for flexibility.' Reference is made to the patient who although lacking capacity, 'may still be able to indicate some preference and regard should be had to this' in deciding who is suitable and eligible. It is to be hoped that in practice this will translate in to a genuine process which facilitates patient autonomy rather than one that substitutes the predictability of a default system in favour of yet more state discretion.

Conclusion

A Mental Health Bill, even if enacted this session, is unlikely to come into force until 2008. In the meantime, if service users' human rights are not to be infringed, a simple remedial order should be introduced giving them the right, when capable, to make a statement about who they want to be their nearest relative (and who they do not want), and to enable them to seek to displace a nearest relative who is unsuitable (with the leave of the county court). Finally, in a case where the nearest relative is subject to displacement proceedings and detention under s.2 extended, the case should automatically be brought before a tribunal within seven days, and the relative should have standing to give evidence at that hearing.

66 *Ibid*, page 44

67 *Ibid.*, paras. 402–403.

68 *Ibid*, para 387

69 *Ibid* page 42

70 *Ibid.*, para 402.

71 *Ibid*, page 45

72 *Ibid*, page 45

The predominance of the risk-management/public safety agenda has led to the view that obstacles to the use of compulsory powers should be reduced, and objecting nearest relatives under existing legislation have the capacity to be obstacles. The Government view is that it is anachronistic for one person to play such 'a direct decision making role... simply by virtue of being the nearest relative.'⁷³ This says much about the proposed shift of power from the private to the public arena. Remarkable people like Mr and Mrs E and Andrew Taylor's mother were undoubtedly viewed by the professionals as misguided and obstructive. These carers were right, and they won their cases. Their expertise gained by experience as carers, and their close involvement in care had been set at naught by the decisions of the professional experts.

Enlightened mental health legislation should achieve a balance between respect for patient autonomy and empowering those who know and care for them to bring mental health professionals to the negotiating table to achieve the most appropriate outcome. Preserving nearest relative rights, regarding powers to challenge detention, is not destructive of patient autonomy but an essential ingredient in the often confusing and inexact process of coping with mental disorder and how best to manage it.

73 Annex 4: Schedule of detailed comments on the draft Mental Health Bill with responses from the Government, page 247