The Nominated Person and carer

Current law

The term "nearest relative" was introduced in the Mental Health Act 1959 and modified in the Mental Health Act 1983. It is defined in Section 26 which provides a list of people considered to be nearest relative, who are ranked in order of priority. This inflexibility has caused problems and been upheld, in different decisions[1], contrary to Article 8 in the Human Rights Act. The nearest relative may not necessarily be the person identified as next of kin. Nor is the nearest relative always the best person to take on these powers, either from a patient's point of view or from their ability to fulfill the role. The patient has no right to seek the displacement of an abusive or unsuitable nearest relative.

The Act gives the nearest relative the following main rights and powers:

- to apply for admission to hospital (Sections 2, 3 and 4) and for guardianship under Section 7;
- to be informed of an admission for assessment and to be informed of their right to discharge a patient;
- to be consulted before a Section 3 admission for treatment and to block the admission if he or she objects, although this objection can be overridden by a court displacing him or her and appointing a substitute ;
- to require a local authority to direct an approved social worker to consider the need for admission to hospital and to be given written reasons if an application is not made;
- to discharge the patient from either an assessment or a treatment section or guardianship. This can be blocked by the RMO only if there is evidence that the patient is a danger to himself and/or others;
- the right to apply to the Mental Health review Tribunal if discharge is blocked; and
- to be given 7 days notice of the intended discharge of a patient and to be involved in aftercare planning unless the patient objects.

The Government's White Paper of December 2000 stated: *"New legislation will [introduce] provisions for nomination of a person to be consulted by the clinical team in all cases where a patient is subject to care and treatment under compulsory powers. The process of nomination will, in the first instance, be the responsibility of the social worker/other mental health professional responsible for co-ordination of action following the decision to apply compulsory power."*[2]

Draft Mental Health Bill 2004

The draft Mental Health Bill 2004 states that the patient must be given a reasonable opportunity to select a nominated person, and that if the patient is capable of making a selection and selects a person who is suitable and eligible, then the appointer must appoint that person. The Government expects that in the majority of cases the nominated

[1] SSG v Liverpool City Council, *October* 22 2002. The judgment clarified that Section 26 must be read as giving equal status to gay unmarried couples and heterosexual unmarried couples.

[2] *Reforming the Mental Health Act 1983- Part I,* Dec 2000, p.43, para 5.6

person will in fact be the patient's nomination. Legally, though, it is the mental health professional and not the patient who, in the proposed new legislation, will appoint the nominated person.

Persons under 16 cannot choose their own nominated person but must be consulted before any appointment is made and their wishes and feelings must be taken into account.

The nominated person has the right to:

- be consulted at different stages of the process when a person is put under compulsory powers;
- apply to the Mental Health Tribunal on behalf of the patient, usually only with leave of the Tribunal; and
- visit the person at any reasonable time

In short the draft Bill provides that individuals will be able to choose a "nominated person" and they will perform a similar but diminished role to the nearest relative.

Alliance position

The Alliance is concerned that this draft Bill involves a significant loss of powers for the family members of people with mental disorder, and in particular that the nominated person lacks the powers of the nearest relative. Neither carer nor nominated person can adequately safeguard the interests of the patient. Indeed we question whether the role as set out in the draft Bill warrants the degree of regulation and bureaucratic requirements that are promised.

We support the replacement of the nearest relative with the nominated person; the nominated person is likely to be someone in whom the patient has trust and confidence, someone who s/he believes will safeguard his/her interests and someone who can provide emotional support at a time of crisis. However, the Alliance feels that the provisions need to be strengthened to protect this choice. Unless the role carries with it real powers, it is unable to act as a counterweight to the powers over service users given to professionals under the draft Bill.

The power to object to the use of compulsion or to discharge the patient is a vital safeguard; this can draw the attention of busy professionals to a changed situation and make them think critically about their decisions. They are a check on a misuse of discretion or a failure to act and may prevent unnecessary compulsion. They are useful in assisting a person's discharge without recourse to a Tribunal.

The Alliance also believes that the rights of carers should be enshrined in any Mental Health Act and calls for a clearer definition of the term 'carer' in relation to rights under the Mental Health Act, which takes into account first time assessments and, in ongoing situations, allows for fluctuations in providing care.

Appointment of the nominated person

There should be no suitability clause

The Bill requires the nominated person to be *"suitable"*- a term which will be interpreted in the Codes of Practice. We do not accept that there should be any other criterion for *"suitability"* than the relationship or connection with the patient which is already within the Bill. Giving the appointer (a mental health professional) discretion over the "suitability" of the nominated person will reduce the likelihood that the patient's choice is respected.

As the Mental Health Act Commission states:
"*Although the Bill leaves the 'suitability' of a patient's preferred 'nominated person' to the discretion of the professional who acts as appointer, regulations are also promised that will set out 'certain categories of people' who will be automatically disqualified from being eligible for appointment as nominated persons. It would appear that Government wishes to establish beyond doubt certain legal categories of unsuitable person so that their exclusion from the role of nominated person would not rely upon the exercise of the professional discretion that the Bill provides. We are not at all convinced that it is easy to establish categories of such unsuitable persons that will not arbitrarily discriminate against people who might be categorised as unsuitable due to, for example, their having a criminal record of a certain kind. It will be vital, not least to ensure that the law relating to the appointment of a patient's nominated person is not in breach of Article 8 of the ECHR, that genuine and appropriate nominations are not fettered by arbitrary constraints of law.*"[3]

Incapacity to act as a nominated person should follow the definition of capacity set out in the Mental Capacity Act 2005

A person is also disqualified to act if *"he appears to the appointer to be incapable because of illness or mental disorder.*" A patient may wish to choose someone with a mental disorder – indeed, people who have direct experience of mental disorder and of the mental-health system might be particularly effective nominated persons. It needs to be clear that a person can only be incapable if s/he lacks capacity according to the definition set out within the Mental Capacity Act 2005: *"A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain."*

The criteria for appointment should be willingness, capacity and relationship with the patient

Three criteria are needed:

- that the person chosen by the patient to be the nominated person is willing to perform the function,
- that that person has capacity, as defined in the Mental Capacity Act 2005; and
- that a person who is not related or connected to the person should not be appointed

[3] Mental Health Act Commission, November 2004. *Report of the Joint Committee on the Draft Mental Health Bill: Volume II,* Ev.28-29, para.4.8. The Mental Health Act Commission adds: "*The Bill's Explanatory Notes on how "certain categories of people" are to be defined as disqualified gives as an example "a convicted child abuser in the case of a child patient" (para 414).[…] The Government's example is relatively sensible, but very specific. We do not see how the principle that appears to underlie it can easily be extended to adult patients and their relationships with other people in their lives. We would be very concerned if, as has been mooted during the development of this policy, conviction of any serious criminal offence automatically disqualified a person from nomination by a patient."*

The nominated person should have a role where possible at the examination stage

The Government has said that it would be impractical to appoint the nominated person before or during the initial examination because, "*An initial examination often needs to take place very quickly, particularly in emergency cases.*"[4] This is true in some cases but not all. For example the patient may already be an informal hospital inpatient. Even in the case of emergencies the draft Bill nevertheless states that if practicable the examiners should consult the patient's carer. We agree with this provision, and believe that if it is possible to consult the patient's carer it should also be possible to appoint a nominated person – after all, in many cases the nominated person may be the patient's carer.

Where there is no nominated person, the carer should assume the role of default nominated person.

A person's carer is often the best informed source of advice and assistance during that person's mental health crisis and as such has an independent role. S/he also has a vital interest in the person's welfare and recovery. The draft Bill acknowledges the carer's role by requiring consultation with carers during the process of applying compulsory powers. However, the draft Bill fails to give adequate recognition to the position and expertise of carers, and to their key role in a person's recovery. While carers must be consulted at the examination stage, they are not formally a substitute for the nominated person. However, in the absence of a nominated person, that role should default to the carer.

If there is neither a nominated person nor a primary carer, the Approved Mental Health Professional(AMHP) should appoint any other person who s/he considers to be the most suitable. The patient could appeal against either the appointment of the carer as nominated person or the AMHP's choice of nominated person a Mental Health Tribunal.

The appointment should not lapse on discharge

The appointment of a nominated person ceases when the patient is discharged (242(4)). As a result, the whole process (including a possible delay in appointment at the assessment stage) has to be started again in the event of a further need for compulsion. The Alliance proposes that a nominated person should remain in post after discharge from an order, subject to the agreement of the patient, though their powers would be held in abeyance. If s/he requires a different nominated person next time s/he could be permitted to specify a person at the point of discharge. That person's name would be included in the patient's records or in an Advance Statement. This proposal has been strongly supported by user groups who are members of the Alliance and who have surveyed their members on the issue.[5]

Patients should also be given the option to state the name of their primary carer in an advance statement.

The patient should be able to revoke the appointment which s/he has made

There will remain the need for a displacement process, a power to change the nominated person in certain circumstances. At present, arrangements for replacing a "nearest relative" involve going to a county court, which will be generally unfamiliar with the circumstances and which does not allow the patient to be represented. This is unsatisfactory.

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[4] Department of Health,2004. *Improving Mental Health Law – towards a new Mental Health Act,* para. 4.10, p. 37.
[5] Survey by JAMI of their members in 2002.

The Alliance proposes that a displacement process should only be considered by a Tribunal. The application may be made by the clinical team or the patient. Patient, nominated person and clinical team would be able to put their views to the Tribunal, which would need to be satisfied with the reasons for displacing the current nominated person and the suitability of the proposed new nomination. In deciding these questions, there should be an emphasis on those who have most daily contact with the patient and those who have existing responsibilities in respect of the patient. As with the original nomination, the patient's choice of replacement would be accepted unless there were exceptional circumstances.

Despite a recommendation to this effect in the Joint Committee on Human Rights (JCHR) Report it has not been taken up in this Bill.[6]

To ensure a patient did not make too frequent applications to change their nominated person, we suggest setting a minimum limit of three months between applications unless there are urgent reasons for a more immediate hearing.

Rights and powers of the nominated person/ carer

The White Paper states:
"Patients with serious mental disorder often need the help of someone who knows them well to represent their views and wishes in discussions with the clinical team. This is important if, particularly in the early stages of assessment under compulsory powers, a patient is too ill to participate fully in decisions about his or her care…"[7]

This makes clear that the nominated person's role is to act as proxy for the patient, putting forward the patient's views, or what they believe are the patient's views. The role is <u>not</u> about the nominated person's own views of what would be *"in the best interests of the patient."* The Alliance agrees with this approach.

The nominated person is likely to be someone in whom the patient has trust and confidence, someone who s/he believes will safeguard their interests and someone who can provide emotional support at a time of crisis. It also needs to be someone who has personal knowledge of the patient (so that completely uninformed choices are not made) and who is able to represent the patient's views and wishes.

This principal role of the nominated person should be on the face of the Bill

The Alliance believes that the principal role of the nominated person should be enshrined in primary legislation, to give confidence to service users that, should they fall subject to the Act, their views about treatment will be fully taken into account. Under the 1983 Act the nearest relative has a significant role (see above). However, in the draft Bill those *"nearest relative"* powers have been significantly curtailed. The net effect of this is to diminish the patient's protection at the critical times, when compulsory powers are first being considered and at the point of discharge.

As the Institute of Mental Health Act Practitioners puts it:
"*These powers recognise the importance of the family in people's lives, and the need to limit the circumstances in which the state may interfere with individual and family life. A balance is achieved between the state's claim to provide protective compulsory care and*

[6] Joint Committee on Human Rights, November 2002. *25th report of the Joint Committee on Human Rights, Session 2001-02: Draft Mental Health Bill,* 11, HL 181, HC 1294, para 64
[7] *Reforming the Mental Health Act 1983- Part I,* Dec 2000, p.43, para 5.4

the right claimed by families to care for their loved ones, and to cope with and manage behaviour that mostly affects only them."[8]

The nominated person and the carer should have a right to apply for an assessment of the patient and a right to written reasons for a failure to detain

The right for a nominated person to request a decision as to whether "*examination"* will take place is much weaker than the nearest relative's right to require the local authority to direct an approved social worker to consider an application for admission. This removes an important safeguard. The carer and the nominated person should both have the right to apply for assessment and the right to a justification if they are not successful.

At the examination stage the nominated person (if already appointed) has no rights at all, the carer has a diminished role and the advocate is not included. If the person has no carer or does not want the carer to be involved s/he is completely unprotected. The nominated person should be included at this stage, as should the advocate if the patient requests him/her. The role of the nominated person is to act as a knowledgeable friend to give advice, information and an opinion about the patient; the advocate's is to explain the process and speak for the patient. We do not consider this to be unnecessary duplication of effort because it may calm a crisis and help to avert unnecessary use of compulsion.

The nominated person/carer should have a right to block an admission to hospital

The carer or nominated person should have the right to block admission. The person who knows the patient best is more able to assess the seriousness of a situation and its likely course than a busy professional unacquainted with the patient's case. It is a useful power for a caring friend or relative and assists professionals. Under current law the nearest relative can be displaced by an application to the county court if it appears s/he is not acting in the patient's best interest in blocking admission. This could be replicated under the new Bill, although the Tribunal would be the appropriate forum for this process.

The nominated person and carer should be able to attend the Tribunal

The nominated person should be able to attend any Tribunal hearing and to apply to the Tribunal on behalf of the patient for review of the use of compulsory powers. If the patient is not able, because of mental incapacity or for other reasons, to instruct a lawyer to represent him or her at the Tribunal, the nominated person should have the power to do so on his or her behalf.

The nominated person should have the power to make an order for a discharge, subject to 72 hours notice

Under the 1983 Act the nearest relative has the right to discharge a patient from formal powers subject to giving 72 hours' notice and the agreement of the responsible medical officer. This is not provided in the draft Bill which only allows a nominated person to apply to the Tribunal for a discharge. The Government's reasoning behind this change is that the Bill, "*provides a new legal framework with independent scrutiny by the Tribunal of all compulsion beyond initial assessment period providing, in every case, an important safeguard against the inappropriate use of formal powers*".[9] It is not clear, however, why the right to discharge a patient is incompatible with increased independent scrutiny. Nor do we believe the government understands that, under current law, it is also the case that clinicians must keep the status of the patient under review and discharge a patient who no longer meets the criteria – while not specified in the Act it is a duty arising from human rights law. Furthermore, a mechanism to discharge patients without recourse to the

[8] IMHAP, November 2004. *Report of the Joint Committee on the Draft Mental Health Bill,* Volume II. Ev.99.
[9] Department of Health, 2004. *Improving Mental Health Law – towards a new Mental Health Act*, para 4.16, p. 37

Tribunal would help to reduce the considerable demands on the Tribunal under this new law. Recent research suggests that discharge by the nearest relative against psychiatric advice is not associated with a poor clinical outcome.[10] This seems to indicate that patients' representatives can play a useful role in discharging patients who do not need to be treated under compulsory powers.

Carers should be given a separate right to be consulted on discharge of a patient

Given that the carer is likely to be the one most directly affected by a person's discharge they should be consulted on this issue.

There also is a wider point to be considered. Many carers would be delighted to have their loved ones back at home to care for them, but not under an NRO which brings an element of coercion to the relationship. The Act should enable the patient to be discharged home rather than obstruct it.

General issues

The roles of nominated person and advocate should be stated in primary legislation or the Code of Practice.

We believe that, perhaps in their concern to minimise confusion of roles, the Government has seriously weakened the role of the family (as carer or as nominated person). Even the duties to consult have limited force when they can be dispensed with wherever impracticable or inappropriate. In our view, in order to avoid confusion of roles the principal role of the nominated person and of the advocate, as a proxy for the patient, putting forward the patient's views or what they believe are the patient's views, should be clearly set out, preferably in primary legislation or in the Code of Practice.

There should be a statutory requirement on authorities to provide information for the nominated person and carer, about their legal role

It is crucial that the nominated person is fully aware of their powers, in language and in a format that he or she can understand, or those powers become pointless in practice. They also need to understand the role of others in the process, such as the tribunal, the clinical team and any carer or statutory advocate. There needs to be a statutory requirement on the authorities to provide this information to the nominated person.

[10] Shaw, P, Hotopf, M, and Davies, A, 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.