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Authors	Donnelly, Mary;Murray, Claire
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UCC
University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

The Role of Family in Mental Health Law: A Framework for Transformation*

Mary Donnelly and Claire Murray

Abstract:

This article explores the role of family in mental health law and aims to contribute to a better understanding of this role in two ways. First, it places the current treatment of family in mental health legislation within a temporal and narrative context. In this, the article focuses on two jurisdictions, England and Wales, and Ireland, which provide an interesting contrast in approach. In England and Wales, the current treatment of family in the Mental Health Act 1983 is centred on the figure of the 'nearest relative' while the Irish Mental Health Act 2001 adopts a highly individualist approach, affording a very limited role to family. Secondly, the article develops a normative context for ongoing debates regarding the appropriate place for family in mental health law. It argues that the legislative frameworks in both jurisdictions discussed are outdated and inadequate and advocates an approach based on conceptions of relational autonomy and vulnerability which, it argues, offers more potential both in respect of people with mental illness and in respect of their family. It also argues that this approach is in line with emerging jurisprudence under the European Convention on Human Rights and with the requirements of the United Nations Convention on the Rights of Persons with Disabilities.

Introduction

Across the developed world, mental health services have changed fundamentally in recent decades as the process of deinstitutionalization has moved the delivery of services away from the traditional 'asylum' and into the community.[1] This shift in focus has contributed to

* We are grateful for reviewers' helpful comments.

[1] See P Bartlett and R Sandland, *Mental Health Law*, *Policy and Practice* (3rd Ed) (Oxford: Oxford University Press, 2007), pp 82-95; V Yeates, 'Ambivalence, Contradiction and Symbiosis: Carers' and Mental Health Users' Rights' (2007) 29 *Law & Policy* 435, 438-39. Similar patterns emerge in the United States see: J Petrila, 'Rights-based Legalism and the Limits of Mental Health Law: The United States of America's Experience' in B McSherry and P Weller eds, *Rethinking Rights-Based Mental Health Laws* (Oxford: Hart Publishing, 2010) and Australia: see T.

the development of a recovery-based model within which mental health is seen as more than relief of symptoms and the 'multiple residential, vocational, educational, and social needs and wants' of people with mental illness are recognized.[2] However, the shift also takes place within the 'hollowed out state', where the practical implementation of neo-liberal ideologies has led to decreased state involvement and established instead a sharing of responsibility for welfare between the state and non-state actors, including families and voluntary services.[3] Thus, the realities of community-based mental health care have also included ongoing reduction in funding and reduced hospital beds, leading to limited access to services and treatment, including effective early stage intervention.[4] Inadequate social support and continuing stigmatisation also mean that people with mental illness continue to suffer disproportionate levels of social marginalisation; unemployment; poor housing and homelessness.[5] The impact of this is, very often, felt not just by the individual but also by his or her family.

Current service delivery models have important consequences for people with mental illnesses and for their families. They also produce new challenges for mental health law. The classic paradigm of mental health law, focused solely on the relationship between the State and the individual, clearly fails to take account of the complex context in which services are now delivered. Given that, in many instances, families (and others) are also actors in the process of service delivery, the need for appropriate legal mechanisms to address their role in this respect must be addressed. Yet, it is not a simple matter to write families into mental health legislation. Family relationships are complex and families are

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Carney,'The Mental Health Service Crisis of Neoliberalism: An Antipodean Perspective' (2008) 31 *International Journal of Law and Psychiatry* 101.

[2] W Anthony, 'Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s' (1993) 16 *Psychosocial Rehabilitation Journal* 11, 12.

[3] T Carney, 'The Mental Health Service Crisis of Neoliberalism: An Antipodean Perspective' (2008) 31 *International Journal of Law and Psychiatry* 101, 102.

[4] See S Ramon, 'Neoliberalism and its Implications for Mental Health in the UK' (2008) 31 *International Journal of Law and Psychiatry* 116; on the similar consequences in Australia and the United States, see Carney *ibid* and J. Petrila 'Rights-based Legalism and the Limits of Mental Health Law: The United States of America's Experience' in B McSherry and P Weller eds, *Rethinking Rights-Based Mental Health Laws* (Oxford: Hart Publishing, 2010).

[5] See P Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2012) 75 MLR 752, 760. On the pervasive effect of stigmatisation, see G. Thornicroft, *Shunned: Discrimination Against People with Mental Illness* (Oxford: Oxford University Press, 2007); S. Hinshaw, *The Mark of Shame: Stigma of Mental Illness and an Agenda for Change* (Oxford: Oxford University Press, 2007).

infinitely varied. Family life inevitably involves balancing different needs, desires and concerns of family members and this is not always to the advantage of the family member who has mental health difficulties.[6] Addressing the role of family in mental health law therefore requires finding ways to deal with this complexity.

This article aims to contribute to a better understanding of the role of family in mental health law in two ways. First, it places the current treatment of family in mental health legislation within a temporal and narrative context, thus contributing to a better understanding of the origins of current legal approaches. Secondly, it develops a normative context for ongoing debates regarding the appropriate treatment of family. The article focuses on mental health legislation in two jurisdictions, England and Wales, and Ireland, which provide an interesting contrast in approach. In England and Wales, the current treatment of family in the Mental Health Act 1983 (MHA 1983) is centred on the figure of the 'nearest relative'. This focus derives from the 1957 report of the Percy Commission,[7] which sought to address the legal implications of the nascent move from institutional to community-based care. In Ireland, for reasons discussed below, the Mental Health Act 2001 (MHA 2001) adopts a classic individualist legal framework, with family being largely absent from the legislative framework. In both jurisdictions, mental health legislation applies only to people who have been formally made subject to compulsion. In England and Wales, this is initiated either by 'formal' admission to a psychiatric hospital or by being made subject to a Supervised Community Treatment (SCT) order while, in Ireland, compulsion requires 'involuntary' admission to an 'approved facility'.[8]

[6] On the complexity of family relationships and the potential for abuse, see evidence given to the House of Lords Select Committee on the Mental Capacity Act 2005 *Inquiry on the Mental Capacity Act 2005* (uncorrected transcript, Tuesday 25 June 2013)

[7] *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency* Cmnd 169 (London: MHSO, 1957).

[8] In England, in 2011/12, there were 48, 631 detentions under the MHA 1983 and 4,220 uses of SCT orders: NHS Information Centre *Inpatients formally detained in hospitals under the Mental Health Act 1983 and patients subject to supervised community treatment orders, Annual Figures, England, 2011-12* (NHS, 2012). In Ireland, approximately 10% of first admissions to an approved centre are involuntary (2,057 admissions): see A Daly and D Walsh *HRB Statistics Series 18: Activities of Irish Psychiatric Units and Hospitals 2011* (Dublin: HRB, 2012), p 15 and Mental Health Commission *Annual Report 2011* (Dublin: MHC, 2012), p 29.

The article chooses to focus on the concept of 'family' rather than that of 'carer' (although, of course, family members will frequently fulfill the role of carers).[9] This is in part because of the particular narrative status accorded to the 'myth' of the family in the discourse of mental illness and in the shaping of societal and legal responses to mental illness[10] and also because we want to address the range of relationships within families which would not necessarily be categorized as involving a carer.[11] In the description of narratives in the first part of the article, we are working with the traditional form-based definition of 'family' as social unit based around marriage and blood ties.[12] However, in the normative discussion undertaken in Part II, we utilise a more inclusive definition of family, grounded in a functional approach. Thus, in this part of the article we recognise that a relationship can be a 'family' relationship even in the absence of ties of blood or marriage if it is characterized by 'emotional and economic interdependence, mutual care and concern and the expectation of some duration'.[13]

'Family' in Mental Health Legislation

In order to understand the choices that have been made about the role of family in mental health legislation, it is instructive to consider first the different narratives of family in the discourse of mental illness.[14] By identifying these narratives, our goal is to look beyond the

[9] Several authors have addressed the role of carers in mental health law: see in particular, K Keywood 'Gatekeepers, Proxies, Advocates?: The Evolving Role of Carers under Mental Health and Mental Incapacity Law Reforms' (2003) 25 *Journal of Social Welfare and Family Law* 355; V Yeates, 'Ambivalence, Contradiction and Symbiosis: Carers' and Mental Health Users' Rights' (2007) 29 *Law & Policy* 435, 438-39. For a broader evaluation of the position of carers within the law, see J Herring, *Caring and the Law* (Oxford: Hart, 2013).

[10] See D. Jones, *Myths, Madness and the Family: The Impact of Mental Illness on Families* (Basingstoke: Palgrave, 2002), p 12.

[11] The meaning of the term 'carer' is itself open to debate: see J. Herring 'Carers' in L Gostin *et al* eds, *Principles of Mental Health Law* (Oxford: OUP, 2010), p 348-49. In formal policy documents, the most widely used meaning of the term is a person providing care and support to a relative or friend because of age and/or disability and excluding parents of minor children and paid carers: see J Herring, 'Where are the Carers in Healthcare Law and Ethics?' (2007) 27 *Legal Studies* 51, 52.

[12] See L Glennon, 'Obligations between Adult Partners: Moving from Form to Function' (2008) 22 *International Journal of Law, Policy and the Family* 22, 23-24.

[13] In this we reflect the diversity of relationships in contemporary society: see Law Commission of Canada, *Beyond Conjugality: Recognising and Supporting Close Adult Personal Relationships* (Ottawa: Law Commission of Canada, 2001), p 114.

[14] On the various roles played by narratives and story-telling within the law, litigation and legal scholarship, see J Baron, 'The Many Promises of Storytelling in Law' (1991) 23 *Rutgers Law Journal* 79; J Baron, 'Intention, Interpretation and Stories' (1992) 42 *Duke Law Journal* 630; D Farber and S Sherry, Telling Stories Out of School: An Essay on Legal Narratives (1993) 45 *Stanford Law Review* 807.

overt or express policy underpinnings for the legislation (although we also acknowledge these) and to consider also the pervasive beliefs and unstated influences which underpin the legal provisions.[15] Although within real families relationships are complex and are rarely, if ever, reducible to any single narrative, separating out different narratives is helpful because the competing narratives reflect inevitable tensions which mental health law must confront. Narratives are especially interesting in this context because, as David Jones argues, in the mental health context, 'myths about the power of families to do great harm - or to heal and make all things well – sweep through policy assumptions, the models used by professionals and academics *and* through the lives of ordinary people.'[16] Narratives are also important for the discussion in this article because, as described by Robert Cover, narrative provides not just the context for law but also its 'nomos' or 'normative universe'. Thus, 'every narrative is insistent in its demand for its prescriptive point, its moral.'[17] Recognising the underlying narratives, therefore, is valuable in attempting to establish a normative context for the role of families in mental health law.

Narratives of 'Family' in the Discourse of Mental Illness

Three different narratives of family are explored here. In the first narrative, families are presented as a cause of mental illness and/or as contributors to an inappropriate medical and societal response to the illness. Thus, within this narrative, family is regarded as a threat to the mentally ill individual. In the second narrative, families are portrayed as victims, suffering emotional distress and placed at physical and emotional risk because of one member's mental illness. Within this narrative, the mentally ill individual can sometimes be seen as a threat to the family. A third narrative sees families as protectors, providing support and facilitating recovery and/or survival. Although these narratives resonate differently in contemporary social contexts, understanding the origins of the narratives is important both because it provides insights into the unspoken policy drivers of the legislative frameworks explored in this article and also because these narratives

[15]Although there is no 'bright line' dividing narratives from other policy material, narratives may be characterized by their 'development, pervasiveness and the confidence with which they are asserted': J Benjamin, 'The Narratives of Financial Law' (2010) 20 OJLS, 787, 788.

[16] D. Jones, *Myths, Madness and the Family: The Impact of Mental Illness on Families* (Basingstoke: Palgrave, 2002), p 5, original emphasis.

[17] R Cover, 'Nomos and Narrative' (1983) 97 Harv L Rev 4, 5.

expose, albeit at times in a caricatured way, some of the tensions that still have to be dealt with in modern mental health law.

Two formulations of the narrative of family as threat may be identified. In the first, the narrative is that of family as a cause of, or contributor to, mental illness. This narrative has long been prevalent within the discourse of mental illness. Within nineteenth/early twentieth century eugenicist discourse, families were seen as providing a direct genetic cause of mental illness.[18] The concern that 'degenerate' parents (a category which included people who were mentally ill as well as people who were intellectually disabled and those who had criminal tendencies) would pass on these genes to their children provided the basis for widespread sterilization programmes in several jurisdictions.[19] With the growth of psychoanalysis and the Freudian focus on early childhood experience, parents again assumed a pivotal role in the attribution of causes of certain forms of mental illness.[20] The 1950s and 1960s saw the growth of the family therapy movement and a focus on the dysfunctional (or 'skewed') family as a cause of schizophrenia.[21] At around this time also, and alongside the growth in the feminist movement, family dynamics, and in particular the gendered roles within families, was identified as a cause of mental illness in women.[22]

[18] See in particular, Benedit-Augustin Morel's work on 'degeneration': see T Millon, *Masters of the Mind: Exploring the Story of Mental Illness from Ancient Times to the New Millennium* (New Jersey: John Wiley & Co, 2004) and R Huertas, 'Madness and Degeneration, I: From "Fallen Angel" to Mentally Ill' (1992) 3 *History of Psychiatry* 391.

[19] See RL Burgdorf and MP Burgdorf, 'The Wicked Witch is almost Dead: Buck v Bell and the Sterilization of Handicapped Persons' (1977) 50 *Temple Law Quarterly* 995, 997-99.

[20] See in particular the work of Frieda Fromm-Reichman who postulated that male schizophrenia developed in the context of the combination of the 'schizophrenogenic mother', whose personality and mothering style was cold, domineering and guilt-inducing, and an ineffectual father : 'Notes on Development of Treatment of Schizophrenics by Psychoanalytic Psychotherapy' (1948) 11 *Psychiatry* 263.

[21] See the work of Theodore Lidz on schizophrenogenic parents and the' skewed' family environment (one which is seemingly harmonious but where one spouse passively accedes to the strange concepts of the other spouse regarding child rearing and family dynamics) : see R Lidz and T Lidz,'The Family Environment of the Schizophrenic Patient' (1949) 106 *American Journal of Psychiatry*332; T Lidz, A Cornelison and S Fleck *Schizophrenia and the Family* (International Universities Press, 1965). See also the work of Murray Bowen, 'A Family Concept of Schizophrenia' in D Jackson ed, *The Aetiology of Schizophrenia* (Oxford: Basic Books, 1960).

[22] See Broverman et al, "Sex-role stereotype and Clinical Judgements of Mental Health" (1970) 34 *Journal of Consulting and Clinical Psychology* 1; P Chesler, *Women and Madness* (New York: Doubleday, 1972). See also Charlotte Gilman's short story depicting female's mental illness, 'The Yellow Wallpaper' (1892), which is interpreted by some feminist commentators as an early evocation of the way in which gendered roles within family and society can drive some women to madness.

A second formulation of the narrative of family as threat sees family less as a direct cause of mental illness but instead presents family as a contributing factor in the inappropriate labeling of certain people as mentally disordered. Leading figures in the anti-psychiatry movement, RD Laing and Aaron Esterson, drew on their study of eleven women who had been diagnosed with schizophrenia to argue that the behaviour displayed by these women was, in fact, a rational response to an impossible family situation.[23] Feminist theorists have also identified the role of family in the inappropriate labelling of women as mentally disordered and in the inappropriate detention of women in psychiatric facilities.[24] It was argued that women who deviated from societal expectations regarding their role within the family were more likely to regarded as mentally ill and to be detained (often at the behest of husbands or fathers).[25]

A second narrative is that of family as victim, suffering alongside (and at times because of) the family member with a mental illness. Literary representation of this narrative may be seen in the unsympathetic portrayal of Mr Rochester's 'mad' wife, Bertha Mason, in Charlotte Brönte's *Jane Eyre*.[26] The narrative of family as victim is also seen by some historians as a contributor to the widespread growth of asylums in the nineteenth century. Medical historian, David Rothman, argues that, while initially reluctant to commit family members to asylums, 'once the family's tolerance was exhausted, they gave their burden over to the asylum, grateful for the relief it provided'.[27] Rothman argues that the idealized view of the family also provided the model for nineteenth century asylums which sought, at least in theory, to mimic the order and discipline found in the ideal family.

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[23] *Sanity, Madness and the Family* (Harmondsworth: Penguin, 1970).

[24] See P Chesler *Women and Madness* (New York: Doubleday, 1972); E Showalter, *The Female Malady, Women, Madness and English Culture 1830-1980* (London: Virago Press, 1985); J Ussher, *Women's Madness - Misogyny or Mental Illness?* (London: Wheatsheaf Harvester, 1991).

[25] See F Boland and J Laing, 'Out of Sight and Out of Mind? A Feminist Perspective on Civil Commitment in Britain and Ireland [1999/2000] *Contemporary Issues in Law* 257, 261.

[26] Bertha Mason (the first Mrs Rochester) is portrayed as violent and insane (although the nature of her illness is not clear) and a cause of distress and danger both to her husband and to the heroine.

[27] D Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Toronto: Little, Brown.1971) (rev'd Ed,1990), p xlvi.

The move towards de-institutionalisation led the narrative of families as victim to assume a different tenor. Families were increasingly required to take the place of the asylum and the respite which the asylum offered was no longer available. 'Burden research', which came to prominence at around this time, seeks to investigate the impact of one family member's mental illness on the family as whole. Here, the focus is less on the view of family as a victim of the family member with a mental illness; instead, the concern is to investigate the 'presence of problems, difficulties or adverse events which affect the life (lives) of the psychiatric patient's significant others (e.g. members of the household and/or the family)'.[28] Researchers have developed different burden scales which provide mechanisms for the measurement of burdens on families.[29] While there are variations at a level of detail,[30] the extensive empirical data which has been collected indicates that, in many instances, family members of people with mental illness experience burdens and pressures which vary in extent and, in some cases, are very significant.[31] There is also evidence that families can experience a substantial degree of stigmatization because of one member's mental illness.[32]

A third narrative is that of families as supporter and protector of the interests of the family member with a mental illness. This narrative may encompass family members acting as carer/s or being involved to some degree in the provision of care.[33] The relationship narrative of the family member and the person with a mental illness can often be a complex

[28] S Platt, 'Measuring the Burden of Psychiatric Illness on Family: An Evaluation of Some Rating Scales' (1985) 15 *Psychological Medicine* 383, 383.
[29] See J Grad and P Sainsbury, 'Mental Illness and the Family' [1963] *The Lancet* 544.
[30] Some scales differentiate between objective burdens which are verifiable and observable, such as financial burdens, disruption of family life and social isolation, and subjective burdens, which relate to the emotional impact and distress which family members feel: see J Hoenig and MW Hamilton, 'The Schizophrenic Patient in the Community and His Effect on the Household' (1966) 12 *International Journal of Social Psychiatry* 165.
[31] See G Faden *et al* 'The Burden of Care: The Impact of Functional Psychiatric Illness on the Patient's Family' (1989) 150 *British Journal of Psychiatry* 285; E Kuipers 'Needs of Carers' in G Thornicroft ed, *Measuring Mental Health Needs* (RC Psych Publication 2001); N Sartorius *et al*,. *Families and Mental Disorder: From Burden to Empowerment* (Chicester: John Wiley & Sons, 2005).
[32] P Corrigan and F Miller, 'Shame, Blame and Contamination: A Review of the Impact of Mental Illness Stigma on Family Members' (2004) 13 *Journal of Mental Health* 537.
[33] The question of what constitutes 'care' is open to debate, in particular the question of whether care can be defined on the basis of a relationship alone or whether action is required: see Jonathan Herring's argument that there is no bright line test but that certain markers can provide the basis for an understanding of care: Herring, *Caring and the Law* (Oxford: Hart, 2013), p 14. The markers of care suggested by Herring are: meeting needs; respect; responsibility and relationality, pp 14- 25.

one. It is frequently marked by bonds of love and affection but also at times by duty, shame and resentment.[34] Additionally, as Janet Henderson describes, the dyad is not always simple; Henderson notes that 'instead, the identity of "cared for" and "carer" may be shared, with partners experiencing both identities at the same time'.[35] Henderson also points out that both parties in a relationship 'may not always, or indeed ever, agree about the nature of care or the need for it.'[36] The care relationship may also have a temporal and intermittent quality. As Henderson describes, '[o]ne of the challenges to both people in the relationship is the watching or waiting'.[37] She notes that this a key difference between care relationships in the context of mental illnesses such as manic depression and in the context of physical illnesses. While the latter illnesses are generally either short-term or constant, the former may involve periods of distress separated by months or even years. For people in this kind of relationship, 'the emotional component of the experience of care can be intense'.[38] Yet, as Henderson notes, most participants in this kind of relationship would not classify this emotional engagement as emotional labour and nor would they describe what they are doing as care.[39]

As will be seen in the discussion below, the impact of some of these narratives may be identified in the legislation. In very general terms, Irish mental legislation predominantly reflects the first narrative, with family being seen as a threat to the individual while the legislation in England and Wales fits more closely with the second and third narratives.

The Individualist Model: The Role of Family in Irish Mental Health Law

The MHA 2001 provides a good example of an individualist approach to mental health care. Family and carers play almost no role in this legislative framework, other than being afforded a particularly divisive role in respect of admission.

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[34] See Jones, *Myths, Madness and the Family: The Impact of Mental Illness on Families* (Basingstoke: Palgrave, 2002). Similar kinds of complexities are also evident in narratives of carers more generally: see Herring, *Caring and the Law* (Oxford: Hart, 2013), pp 5-7.

[35] J Henderson, 'He's not my Carer – He's my Husband: Personal and Policy Constructions of Care in Mental Health' (2001) 15 *Journal of Social Work Practice* 149, 154.

[36] *Ibid*, 155.

[37] *Ibid*, 156.

[38] *Ibid*, 156.

[39] *Ibid*, 157.

Under the MHA 2001, a person (referred to as 'the patient') may be admitted to an 'approved centre' on the basis that s/he suffers from a 'mental disorder'.[40] An application for admission may be made by a spouse or (same sex) civil partner;[41] by a relative; by an authorised officer (generally, a social worker); a member of the Garda Síochána (Irish police force); and, finally, by any other person.[42] A 'relative' is extremely broadly defined[43] and there is no statutory hierarchy of relatives, with all having an equal right to apply for admission. In addition, the final 'catch all' category means that essentially any person (with some limited exclusions[44]) may initiate an application.[45] In practice, the majority of involuntary admissions in Ireland are initiated by the spouse or relative of the person admitted.[46] There is a practical reason for this. There is a very limited number of authorised officers in Ireland and, therefore, this route to admission is effectively not available in most situations. The reality for most patients and families therefore is that a family member must take the initial formal step towards involuntary admission, something which can be profoundly undermining of family relationships.[47]

Although family members play a significant role in having a person admitted, once the admission has taken place, family members (and carers) have no role.[48] There is no

[40] For the criteria for admission, see MHA 2001, s 3: see D Whelan *Mental Health Law and Practice* (Dublin: Round Hall, 2009), pp 75-80.
[41] MHA 2001, s. 9 as amended by the Civil Partnership and Certain Rights and Obligations of Cohabitants Act 2010, s. 98. A 'spouse' is defined (MHA 2001: s 2) as including a man or a woman who is cohabiting with a person of the opposite sex for a continuous period of not less than 3 years. The category of 'spouse' does not include a spouse of a person who is living separately and apart from the person or in respect of whom an application or order has been made under the Domestic Violence Act 1996: MHA 2001, s 9(8).
[42] MHA 2001, s 9(1). Note that cohabitants for less than three years and same-sex cohabitants fall within the 'any other person' category.
[43] MHA 2001, s. 2(1) defines a 'relative' as a parent, grandparent, brother, sister, uncle, aunt, niece, nephew, or child of the person or of the spouse of the person, including relatives of the whole blood, the half blood or by affinity.
[44] MHA, s 9(3); the excluded categories are primarily concerned with avoidance of conflicts of interest.
[45] However, when an application is made by 'any other person', the applicant must include a statement of the reasons why it is so made and of his or her connection with the person: MHA 2001, s 9(5).
[46] In 2011, 57% of admissions (839 admissions) were initiated by the spouse or relative; 24% (354 admissions) by a member of the Garda Síochána; 8% (116 admissions) by an authorized officer and 11% (162 admissions) by another person: Mental Health Commission *Annual Report 2011* (Dublin: MHC, 2012), p 30. This represents a fall from a high of 69% of applications for admissions by a spouse or relative in 2007.
[47] See text to n 85 below.
[48] The only reference to family members beyond the application for admission comes in the context of ensuring that the medical professionals who determine admission (and carry out oversight functions in this regard) are not the spouse or relative of the person admitted: MHA 2001, ss 10 and s 24.

mechanism in the MHA 2001 to permit family members or carers to act on behalf of the patient. Nor is there any provision requiring that family members or carers be consulted or given any information in respect of the patient, even where the patient consents to or indeed requests that this should happen. Reference to family and carers is omitted even where the patient lacks capacity. There is a requirement under s. 4(2) of the MHA 2001 that patients should be provided with notification of proposed recommendations or treatment and that they must be entitled to make representations in relation to the proposals. However, there is no legislative requirement to notify family members or carers where the patient lacks capacity and family members/carers have no statutory entitlement to make representations on behalf of the patient. As a result, the legislation effectively leaves patients lacking capacity without any provision for support structures, whether derived from their family or otherwise. The absence of a role for family continues through to discharge. Family members have no statutory entitlement either to apply for discharge of the patient or to be informed in respect of the decision to discharge or of the discharge itself. At a sub-statutory level, the picture is somewhat different. The Code of Practice on Admission, Transfer and Discharge, developed by the Mental Health Commission, refers regularly to the importance of consultation with the resident (of the approved centre) and the resident's "family/carer or chosen advocate, if appropriate (i.e. with the consent of the resident)."[49] This is particularly emphasized in the context of discharge from an approved centre. However, the MHA 2001 does not impose a legal duty on those working within the mental health services to comply with the provisions of codes of practice and it is unclear to what extent this is adhered to in practice.

The individualist approach to family under the MHA 2001 is evident even in respect of children who have been admitted under the legislation.[50] The only mentions of parents in the MHA 2001 are to ensure that parents, or persons acting in loco parentis, are not

[49] Mental Health Commission, *Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre*, available at www.mhcirl.ie. See also the Mental Health Commission *Rules Governing Seclusion and Mechanical Means of Bodily Restraint* and the *Rules and Code of Practice on Electro-Convulsive Therapy* both of which include reference to discussions with next of kin/representative.

[50] The vast majority of admissions of children (statutorily defined in the MHA 2001, s 2 as persons under the age of 18 years) are 'voluntary' admissions where consent to admission is provided by the parents.

permitted to refuse consent for a child to be examined[51] and to prevent parents from removing a child who has been admitted as a voluntary patient if staff at the approved centre consider that the child has a mental disorder.[52] Parents are afforded no statutory consultative role in respect of the kinds of treatment provided to their children.[53]

The limited role accorded to family in the MHA 2001 may be explained in part by the social context within which the Act was introduced. Ireland has a history of very high levels of admission to/incarceration in psychiatric institutions where patients were held in, at times, appalling conditions.[54] The MHA 2001 (which did not come into operation until 2006) replaced the Mental Treatment Act 1945, which had afforded family an extraordinary degree of latitude in respect of admission and ongoing detention of patients with extremely limited scope for review.[55] Several high profile cases before the courts had shown inappropriate use of detention initiated by spouses in the context of marital difficulties.[56] These cases also made evident that the Mental Treatment Act 1945 (where a valid admission could be made solely on the basis of a certificate by a general practitioner) had been ineffective in preventing this.[57] There was also evidence from studies conducted under the 1945 Act regime that some family members had used certification and admission to psychiatric hospitals as a response to difficult or challenging behaviour by the person admitted[58] or to lack of compliance with traditional marital roles[59] and that this use of

[51] MHA 2001, s. 25(3).
[52] MHA 2001, s. 23(2).
[53] This is surprising given the elevated status of parental rights under the Constitution of Ireland at the time of the MHA 2001: see M Donnelly, 'Treatment for a Mental Disorder: The Mental Health Act 2001, Consent and the Role of Rights' (2005) 40 *Irish Jurist* 220, 257.
[54] See P Prior ed, *Asylums, Mental Health Care and the Irish: Historical Studies 1800-2010* (Dublin/Portland, Oregon: Irish Academic Press, 2012). For a literary representation, see S Barry, *The Secret Scripture* (London: Faber, 2008).
[55] See AM O Neill, *Irish Mental Health Law* (Dublin: FirstLaw, 2005), pp 113-14.
[56] See *O'Reilly v Moroney* [1992] 2 IR 145 (High Court); unreported Supreme Court 16th November 1993, where a woman who was experiencing marital difficulties had, at the instigation of her husband and father, been admitted on the basis of a certificate by a General Practitioner who had not spoken to her and had merely observed her reaction to her husband's arrival from a position in the front garden; *Bailey v Gallagher* [1996] 2 ILRM 433 where the appellant was admitted by his wife in the midst of considerable marital and business difficulties and was detained notwithstanding the absence of any evidence of mental disorder.
[57] See F Boland, 'Compulsory Detention and the General Practitioner in Irish Mental Health Law: Armour or Weapon in Wrongful Committals?' (2001) 52 *Northern Ireland Law Quarterly* 205.
[58] See T Carey and J Owens, 'Involuntary Admissions to a new District Mental Health Service- Implications for a new Mental Treatment Act' (1993) 10 *Ir J Psychol Med* 139.

certification had been supported by general practitioners.[60] As described by one politician in the debates preceding the introduction of the MHA 2001, '[w]e all remember families dumping people in institutions in previous decades'.[61] Thus, a strong feature of the context for the introduction of the MHA 2001 was a perceived need to address the lack of protection for people with mental illness from the threat posed by their families.

Given this context, it seems odd that, while family are effectively written out of the legislation once a person has been admitted, they (and any other persons) retain extensive powers at admission stage. There is no indication in the Dáil (parliamentary) debates on the MHA 2001 that this matter was considered and no reason is offered as to why it was considered appropriate to allow such a wide range of people the power to initiate the involuntary admission process. Clearly, however, this constituted a low-cost alternative to the introduction of a comprehensive system of authorised officers and it is likely the tribunal review system, which the MHA 2001 introduced into Irish law for the first time,[62] was considered sufficient to avoid any difficulties in terms of inappropriate admission.

Two further reasons can be identified for the the omission of reference to family (and carers) in the MHA 2001. First, the Act is entirely focused on institutional or hospital-based care. Although the provision of community-based care became a cornerstone of Irish mental health policy with the publication of the policy paper, *A Vision for Change*[63] in 2006, the MHA 2001 pre-dated this policy development. Accordingly, the Act does not make any attempt to address issues which arise where mental health care is delivered in a community, rather than an institutional, context.[64] Thus, the legislative position is clearly distinct from the policy position advocated in *A Vision for Change* which recognises 'the

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[59] See F Boland and J Laing, 'Out of Sight and Out of Mind? A Feminist Perspective on Civil Commitment in Britain and Ireland [1999/2000] *Contemporary Issues in Law* 257.
[60] See T Carey and J Owens, 'Involuntary Admissions to a new District Mental Health Service- Implications for a new Mental Treatment Act' (1993) 10 *Ir J Psychol Med* 139.
[61] Dáil Debates, Mental Health Bill 1999, Second Stage, Thursday 6 April 2000, Vol 517 Col 1021.
[62] On the review system introduced in MHA 2001, see D Whelan, *Mental Health Law and Practice* (Dublin: Round Hall, 2009), pp 211-256.
[63] *A Vision for Change: Report of the Expert Group on Mental Health Policy* (Dublin: Stationary Office, 2006).
[64] The process of de-institutionalisation has also proceeded more slowly in Ireland than in other developed jurisdictions. In 2006, 32.3% of patients in Irish 'approved centres' had been resident there for more than five years: Mental Health Commission, *Annual Report 2006* (Dublin: MHC, 2007).

need to formally recognise and support through practical means the crucial role of family care in mental health service provision.'[65]

Secondly, a striking feature of the MHA 2001 is the scope of the role of the 'consultant psychiatrist' who is responsible for the care and treatment of the patient. Under the MHA 2001, the consultant psychiatrist is established as effectively the sole decision-maker in respect of involuntary patients. There is no legislative provision for consultation with other professionals involved in the care and treatment of the patient.[66] The lack of a role for family might therefore also be seen as part of a heavily medicalised/clinician-centred model of care and treatment with little room for any perspectives other than those of the consultant psychiatrist.[67]

A Restricted Role for Family: The 'Nearest Relative' under the MHA 1983

As mentioned previously, the legal treatment of family in the MHA 1983 derives from the recommendations of the Percy Commission in 1957.[68] The Commission had sought to address the emerging shift from institutional to community care which began in England and Wales in the years after World War II. In this context, the Percy Commission recognised that relatives had a vital role to play and, while it accepted that some relatives might take advantage of family members with mental disorders, it considered that such occurrences would be rare.[69] Although parliamentarians were somewhat less sanguine,[70] the Mental Health Act 1959 largely reflected this narrative of family. With relatively limited

[65] *A Vision for Change: Report of the Expert Group on Mental Health Policy* (Dublin: Stationary Office, 2006), p 28.

[66] Contrast the position under MHA 1983 as amended by the Mental Health 2007 where the 'responsible clinician' for the patient's care and treatment is an 'approved clinician' and may be drawn from a number of healthcare professions. Additionally, the oversight mechanism under the MHA 1983 imposes a requirement on the second opinion clinician to consult with at least two other professionals involved in the patient's care: MHA 1983, s 58(4).

[67] On the inferior role afforded to 'lay' knowledge within the mental health system (in England and Wales), see K Keywood 'Nearest Relatives and Independent Mental Health Advocates: Advocating for Mental Health?' in L Gostin *et al*, *Principles of Mental Health Law* (Oxford, Oxford University Press, 2010), pp 330-31.

[68] *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency* Cmnd 169 (London: MHSO, 1957).

[69] D Hewitt, *The Nearest Relative Handbook* (2nd Ed) (London: Jessica Kingsley Publishers, 2009), p 15.

[70] *Ibid*.

changes introduced by the MHA 1983 and the Mental Health Act 2007, the model proposed by the Percy Commission continues in place to the present day.[71]

The scheme for including family under the MHA 1983 is centred on the figure of the 'nearest relative' of the 'patient' (who has been formally admitted or is subject to an SCT order). The nearest relative is determined in accordance with a statutory hierarchy beginning with husband, wife, civil partner (and in certain circumstances, co-habitant[72]); son or daughter; father or mother; brother or sister; grandparent; grandchild; uncle or aunt; nephew or niece.[73] A relative is precluded from being categorised as the 'nearest relative' where s/he is not resident in the United Kingdom, Channel Islands or the Isle of Man; where s/he is the patient's spouse or civil partner and is permanently separated from, or has/has been deserted by, him or her; or where s/he is under the age of 18 years.[74] A degree of special treatment is afforded to family members who are carers. If the person admitted ordinarily resides with or is cared for by one or more of his or her relatives, this relative will take priority over all other relatives, including a spouse or civil partner.[75] In addition, a non-relative with whom the patient ordinarily resides for a period of not less than five years (or resided prior to admittance to hospital) is treated as if s/he were a relative.[76] However, s/he comes last in the hierarchy in determining the nearest relative and may not be treated as the nearest relative of a married/civil partnered patient.[77] Thus, the MHA 1983 is very clear in privileging blood ties over more broadly defined care relationships.

[71] P Bartlett and R Sandland, *Mental Health Law, Policy and Practice* (3rd Ed) (Oxford: Oxford University Press, 2007), p 159.
[72] A husband, wife or civil partner is defined as including a person who is living with the patient as the patient's husband, wife or civil partner for a period of not less than six months: MHA 1983, s 26(6) as amended by MHA 2007, s 26. However, a person may not be treated as the nearest relative of a married patient on this basis unless the patient is permanently separated from or has been/has deserted their husband, wife or civil partner: MHA, s 26(6).
[73] MHA 1983, s.26(1).
[74] MHA 1983, s 26(5).
[75] MHA 1983, s. 26(4).
[76] MHA 1983, s. 26(7).
[77] MHA 1983, s. 26(7).

A patient may apply to the County Court to have the person who is the nearest relative under the statutory hierarchy displaced from this role.[78] Applications for displacement may also be made by any relative of the patient; by any other person with whom the patient is residing (or was residing prior to admission to hospital) or by an Approved Mental Health Professional (AMHP) (formerly an Approved Social Worker).[79] An application to displace the nearest relative may be made on the basis that a nearest relative 'unreasonably objects to the making of an application for admission for treatment or a guardianship application' or where s/he has 'exercised without due regard to the welfare of the patient or the interests of the public his power to discharge the patient … or is likely to do so'.[80] Kirsty Keywood suggests that, in applications to displace brought by AMHPs, where there is a dispute between professional views and those of the nearest relative, the views of the professional almost inevitably dominate.[81]

The nearest relative has a range of statutory functions which, as Keywood explains, can, broadly speaking, be divided into gatekeeper and support/advocacy functions.[82] Gatekeeper functions centre on admission and discharge. The nearest relative may initiate an application for admission for assessment and treatment and for guardianship.[83] Although it was the intention of the Percy Commission that most applications for admission would be made by the nearest relative, in modern practice most applications are made by an AMHP.[84] This approach has clear policy advantages. As recognised in the *Mental Health Act 1983 Code of Practice*, the AMHP is usually the most suitable applicant because of his or her professional training and knowledge of the legislation and local resources and also because of the potential adverse effect which an application by the nearest relative might

[78] MHA 1983, s. 29(2)(a) inserted by MHA 2007, s. 23(4)(a). This inclusion followed the judicial finding that the absence of a statutory right to make an application for removal of a person as nearest relative was incompatible with Art 8 of the European Convention on Human Rights: see *R(M) v Secretary of State for Health* [2003] EWHC 1094; note also the friendly settlement reached in *JT v United Kingdom* (2000) 30 EHRR CD 77.
[79] MHA 1983, s 29(2).
[80] MHA 1983, s. 29(3).
[81] K Keywood 'Nearest Relatives and Independent Mental Health Advocates: Advocating for Mental Health?' in L Gostin *et al*, *Principles of Mental Health Law* (Oxford, Oxford University Press, 2010), p 331-32.
[82] K Keywood 'Gatekeepers, Proxies, Advocates?: The Evolving Role of Carers under Mental Health and Mental Incapacity Law Reforms' (2003) 25 *Journal of Social Welfare and Family Law* 355.
[83] MHA 1983, s. 11(1).
[84] Bartlett and Sandland, *Mental Health Law, Policy and Practice* (3rd Ed) (Oxford: Oxford University Press, 2007) p 159.

have on that person's relationship with the patient.[85] As described earlier, the Irish position which requires family members to make applications for admission is profoundly undermining of family relationships (and the patient's prospects of recovery).

The nearest relative is also central where the application for admission has been initiated by an AMHP. An AMHP must not make an application for admission unless s/he has first consulted the person (if any) appearing to be the patient's nearest relative (unless it appears to the AMHP that consultation is not reasonably practicable or would involve unreasonable delay).[86] An AMHP is also precluded from making an application where the nearest relative has notified the AMHP or the local authority that s/he objects to the application being made.[87] Several cases have reinforced the significant role played by these requirements in protecting patients' right to liberty.[88] It is clear both from the *Mental Health Act 1983 Code of Practice*[89] and from relevant case law[90] that the obligation to consult requires more than simply informing the nearest relative of the AMHP's intention. The Code states that, in consulting nearest relatives, AMHPs should, where possible, ascertain the nearest relative's views about the patient's needs and the nearest relative's own needs in relation to the patient; inform the nearest relative of the reasons for considering an application for detention and what the effects of such an application would be and inform the nearest relative of his or her role and rights under the legislation.[91] There is evidence that the nearest relative's need for respite can play a significant role in

[85] Rev'd ed (2008), para 4.28.
[86] MHA 1983, s. 11(4)(b).
[87] MHA, s 11(4)(a). In order to facilitate the nearest relative's role in this regard, there is a statutory obligation on the AMHP to 'take such steps as are practicable to inform' the person (if any) appearing to be the nearest relative in respect of admission for assessment 'before or within a reasonable time' after an application for admission: MHA1983, s. 11(3).
[88] See *TMM v London Borough of Hackney* [2011] EWCA Civ 4 where the Court of Appeal upheld the applicant's *habeas corpus* application on the basis the AMHP had failed to meet the statutory requirements; see also *CX v A Local Authority* [2011] EWHC 1918 (Admin); *GD v Hospital Managers of the Edgeware Community Hospitals* [2008] EWHC 3572 (Admin).
[89] Rev'd ed (2008).
[90] See *R v South Western Hospital Managers, ex parte M* [1994] 1 All ER 162; *Re Briscoe* [1998] EWHC 771 (Admin); *GD v Hospital Managers of the Edgeware Community Hospitals* [2008] EWHC 3572 (Admin); *CX v A Local Authority* [2011] EWHC 1918 (Admin).
[91] Rev'd ed (2008), para 4.64.

the AMHP's decision to apply for admission.[92] There is also evidence that the nearest relative's objection to admission can lead the AMHP to try to negotiate an alternative to admission.[93] Thus, in both a legal and a practical sense, the nearest relative acts as an important gatekeeper around admission, both in allowing/enabling admission and in stopping admission from happening. In the latter context, however, it should be recalled that the AMHP may apply for removal of a person as nearest relative thus limiting the powers of the nearest relative in this regard.

The nearest relative also plays a role at the discharge stage, although his or her actual powers in this respect are substantially restricted. The nearest relative can discharge a patient from detention, guardianship and from an SCT order.[94] However, s/he must give 72 hours' notice in writing to the hospital managers of the intention to discharge and if, within this time, the responsible clinician furnishes a report to the hospital managers (typically referred to as a 'barring certificate') certifying that, in his/her opinion, the patient if discharged would be likely to act in a manner dangerous to other persons or to him or herself, the discharge by the nearest relative has no effect.[95] The nearest relative is then also restricted from making a discharge order for the next six months[96] although s/he can make an application for a tribunal review of the patient's detention during this period.[97] S/he is also at risk of having an application made to have him or her discharged from acting as nearest relative.[98] The person appearing to be the nearest relative is also entitled to be informed, seven days in advance, if practicable, if the patient is to be discharged,[99] although

[92] L Bowers, 'Reasons for Admission and their Implications for the Nature of Acute Inpatients Psychiatric Nursing' (2005) 12 *Journal of Psychiatric and Mental Health Nursing* 231.
[93] J Rapaport 'A Matter of Principle: the Nearest Relative under the Mental Health Act 1983 and Proposals for Legislative Reform' (2004) 26 *J Social Welfare and Family Law* 377, 389.
[94] MHA 1983, s 23(2) as amended by MHA 2007.
[95] MHA 1983, s 25(1).
[96] MHA 1983, s 25(1).
[97] MHA 1983, s. 66(1)(g) as substituted by the Transfer of Tribunal Functions Order 2008, SI 2008/2833 (which established the Health Education and Social Care Chamber of the First-Tier Tribunal to replace the Mental Health Tribunal).
[98] See text to n 80 above.
[99] MHA 1983, s.133(1).

the patient may object to this information being given and in this case, the obligation to inform does not apply.[100]

The second role of the nearest relative is one of support. The MHA 1983 contains several measures which enable the nearest relative to assume a support/advocacy role, although, as Keywood argues, the Act does not actually mandate the nearest relative to act in this way.[101] In order to facilitate the support role, the hospital manager of the facility where the patient is admitted is required to provide the person appearing to be the patient's nearest relative with a copy of the statutory information which must be given to the patient (provided that the patient does not object to this happening).[102] The nearest relative must also be informed of the renewal of a patient's detention; the extension of an SCT order and the patient's transfer to another facility.[103] The nearest relative may also request an Independent Mental Health Advocate (IMHA)[104] to visit and interview the patient for the purpose of providing help to the patient 'in accordance with the arrangements'[105] and the IMHA is required to comply with any 'reasonable' request in this regard.[106] There is limited empirical data on how effectively the support aspects of the nearest relative role operate in practice. Joan Rapaport's study (which was conducted between 1995 and 2002) suggests that, while there were some instances in which the nearest relative was able (together with social work professionals) to provide valuable support to the patient,[107] the more common experience was a lack of knowledge among both service users and nearest relatives of the powers and role of the nearest relative.[108]

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[100] MHA 1983, s. 133(4).
[101] K Keywood 'Nearest Relatives and Independent Mental Health Advocates: Advocating for Mental Health?' in L Gostin *et al*, *Principles of Mental Health Law* (Oxford, Oxford University Press, 2010), p 327.
[102] MHA 1983, s. 132(4). Note, however, that these rights do not apply to a restricted patient who enters compulsory mental health care through the criminal justice system: Keywood *ibid*, p. 338.
[103] Code of Practice Rev'd ed (2008), para 2.30.
[104] The Independent Mental Health Advocacy service was introduced by the Mental Health Act 2007 and applies to 'qualifying patients' which include any patients detained under the MHA 1983 and any patient subject to a supervised community treatment order.
[105] This is defined as providing help in obtaining information about the various legal measures in the Act and about any rights that may be exercised by the patient under the Act and help (by way of representation or otherwise) in exercising those rights: MHA 1983, s. 130B(1) and (2).
[106] MHA 1983, s. 130B(5)(a).
[107] See J Rapaport, *Reflections on a 'Relative Affair': The Nearest Relative under the Mental Health Act 1983* (London: Social Care Workforce Unit, 2012), p 34.
[108] *Ibid*, p 31.

The Percy Commission was prescient in recognising that delivery of mental health services in the community requires family support. However, the nearest relative model, which has, by and large, remained unchanged since 1957, can be criticised on a number of grounds. First, the existence of the statutory hierarchy to determine the nearest relative effectively denies the patient any kind of real choice as regards who should act in this regard. Although a patient may now apply to court to displace a person from acting as his or her nearest relative, s/he does not have the right to choose who should act in his or her place. Additionally, as Keywood notes, the right to apply to court is a 'rather weak advocacy tool' because it places the onus on the patient (who is already in a vulnerable and disempowered position) to take the steps necessary to activate the process.[109] The possibility that the figure of the nearest relative would be replaced by a 'nominated person' (nominated by the patient and approved by the AMHP)[110] was identified in the law reform process leading to the introduction of the MHA 2007. However, significant flaws in the proposed model were identified[111] and ultimately no significant changes were made to the existing position.

Secondly, by focussing on formal family ties rather than relationships of care, the MHA 1983 downgrades the significance of care relationships which are not blood relationships. As Jonathan Herring notes, 'the preference for the blood relationship over the caring relationship is difficult to justify' given that 'a blood tie is no guarantee that the person has the best interests of the other at heart or knows them well.'[112] Thirdly, the dual role of gatekeeper/supporter creates inevitable tensions in the relationship between patients and nearest relatives. As Victoria Yeates describes, the 'mix of nearest relative powers both to apply for, and to resist, compulsion creates considerable potential for ambivalence in

[109] K Keywood 'Nearest Relatives and Independent Mental Health Advocates: Advocating for Mental Health?' in L Gostin *et al*, *Principles of Mental Health Law* (Oxford, Oxford University Press, 2010), p 328. Note additionally the difficulties with the relevant standard for removal, that the person 'not a suitable person to act.'
[110] For description of the proposed model, see J Rapaport, 'A Matter of Principle: the Nearest Relative under the Mental Health Act 1983 and Proposals for Legislative Reform' (2004) 26 *J Social Welfare and Family Law* 377, pp. 383-84.
[111] See V Yeates, 'The Death of the Nearest Relative? Carers' and Families' Rights to Challenge Compulsion under Current and Proposed Mental Health Legislation' [2005] *Journal of Mental Health Law* 123, 133-135.
[112] J Herring, *Caring and the Law* (Oxford: Hart, 2013), p 172.

relationships between family members and care recipients'. [113] Yeates argues that this ambivalence is increased in the context of compulsory community care where a new expectation is placed on family carers to monitor patients 'and ensure compliance with medication regimes'.[114]

Finally, and of particular relevance to the discussion in this article, the nearest relative model can be criticised for failing to address the 'web of relationships' within which most people, with and without mental illness, live their lives. The nearest relative provides a neat focus for professional engagement with family and, as such, has the benefit of simplicity. Professionals only have to deal with one person and can avoid having to engage in potentially messy family disagreements.

This has some benefits[115] but it represents a very restrictive view of patients and their families and makes no attempt to address the range of relationships within and outside families. In contrast to the legislative approach, the Code of Practice to the Mental Health Act 1983 recognises a much broader conception of family and there are several references throughout the Code to the support role of family (and others). The Code notes that the involvement of friends, relatives and other supporters may have significant benefits for the care and treatment of the patient, including reassurance to the patient, knowledge of the patient and practical assistance in helping the patient communicate information and views.[116] On this basis the Code states that a patient may nominate a relative, friend or other informal supporter (as well as the formal IMHA) and recommends that professionals should 'normally' agree to a patient's request to involve relatives, friends and other informal supporters.[117] However, the Code also states that it is not appropriate to involve another person as requested by the patient where this would result in delay that would not be in the patient's best interests, where the involvement of the person is contrary to the

[113] V Yeates, 'Ambivalence, Contradiction and Symbiosis: Carers' and Mental Health Users' Rights' (2007) 29 *Law & Policy* 435, 443.
[114] *Ibid*.
[115] One benefit (as described by J Rapaport and J Manthorpe, 'Family Matters: Developments concerning the Role of the Nearest Relative and Social Worker under Mental Health Law in England and Wales' (2008) 38 *British Journal of Social Work* 1115, 1125) is that the nearest relative's powers 'legitimized the nearest relative's involvement in wider service processes, as co-workers'.
[116] Rev'd ed (2008), para 2.36.
[117] *Ibid*, para 2.37.

patient's best interests or where the person has requested that s/he should not be involved. Thus, while expanding the category of people who can play a supportive role, the Code falls short of allowing for family members (or other nominated supporters) to serve as full-scale advocates.[118] Furthermore, because it lacks the force of legislation, questions arise regarding the extent to which the Code is delivered upon in practice.[119]

Finding a Place for Family?: The Normative Context

The preceding discussion shows that, in the two jurisdictions discussed, current legislative responses to the role of family emerged in particular social and temporal contexts. It is also clear that, in both jurisdictions, the treatment of family and carers by mental health legislation is outdated. Of course, the fact that the legislation is outdated does not necessarily mean that practices on the ground are similarly outdated. As noted in the previous section, the Code of Practice to the MHA 1983 is a good deal more inclusive than the legislation itself and, in many situations, it may well be the case that suitable accommodations are reached between patients, their families and mental health professionals. However, even if this is the case, the legislative framework remains important. This is both because of what it mandates in a practical sense and because it constitutes a concrete representation of underlying values.

This final part of the article develops a normative context for engagement with family in mental health law. We begin by identifying the important role played by the traditional individualist liberal rights of autonomy and liberty in the development of modern mental health law. We then outline a number of reasons why this approach fails to meet contemporary needs (although we also acknowledge the ongoing importance of these norms in the context of mental health law). We argue that an approach based on conceptions of relational autonomy and vulnerability offers more potential both in respect

[118] *Ibid*, para 2.37.

[119] On the legal status of the Code, see *R (on the application of Munjaz) v Mersey Care NHS Trust* [2005] UKHL 58, [21] where the House of Lords affirmed that the Code is 'guidance and not instruction'. However, the Court also affirmed that the Code was 'much more than mere advice which an addressee is free to follow or not as it chooses.'

of individuals and in respect of family. We also argue that this approach is in line with emerging jurisprudence in respect of the European Convention on Human Rights (ECHR) and with the requirements of the United Nations Convention on the Rights of Persons with Disabilities (CRPD).[120]

Mental Health Law and Liberal Norms

Baroness Hale, writing extra-judicially, describes mental health law as an ongoing attempt to reconcile 'three overlapping but often competing goals: protecting the public, obtaining access to the services people need, and safeguarding users' civil rights'.[121] As Genevra Richardson has pointed out, the dominant policy in mental health legislation has been the reduction of risk to the public.[122] Within this context, the traditional terrain for normative discussion of the law's treatment of mental illness involved the inter-play between the individual's rights of autonomy and liberty and the State's powers to restrict these rights in the case of people with mental illnesses. Given the substantial levels of discrimination endured by people with mental illness,[123] the contribution made to the development of mental health law by arguments based on traditional liberal rights cannot be underestimated. When operating within a risk-based policy agenda, individual rights such as liberty and autonomy are contested in ways which are clearly unacceptable in other contexts.[124] In both the jurisdictions discussed in this article, mental health legislation

[120] United Nations General Assembly, 13 December 2006, A/RES/61/106, Annex I. The CRPD entered into force on 2 May 2008 on receipt of its twentieth ratification. As of May 2013, the CRPD has been signed by 155 states and ratified by 130. The CRPD has been ratified by the United Kingdom but not by Ireland although there is a political commitment to ratify following the proposed enactment of capacity legislation which is likely to occur in 2014.

[121] B Hale, 'Justice and Equality in Mental Health Law: The European Experience' (2007) 30 *International Journal of Law and Psychiatry* 18, 19.

[122] G Richardson, 'Balancing Autonomy and Risk: A Failure of Nerve in England and Wales?' (2007) 30 *International Journal of Law and Psychiatry* 71, 75-76.

[123] See T Campbell and C Heginbotham**,** *Mental Illness: Prejudice, Discrimination and the Law* (Aldershot: Dartmouth, 1991); M Perlin, '"Half-Wracked Prejudice Leaped Forth": Sanism, Pretextuality, and Why and How Mental Disability Law Developed as it Did' (1999) 10 *Journal of Contemporary Legal Issues* 3; M Perlin, '"Where the Winds Hit Heavy on the Borderline": Mental Disability Law, Theory and Practice, "Us" and "Them"' (1998) 31 *Loyola of Los Angeles Law Review* 775.

[124] Justifications for this level of differential treatment are generally unpersuasive: see the summary of arguments in M Donnelly, *Healthcare Decision-making and the Law: Autonomy, Capacity and the Limits of Liberalism* (Cambridge: Cambridge University Press, 2011), pp 242-46.

permit deprivations of liberty and the overriding of autonomous decisions on the basis of mental illness.

Philosophically, the antecedents of the traditional liberal approach to rights derive from the classic Millian vision of the individual as autonomous, independent and self-directed.[125] The subject as construed within this debate is 'antecedently individuated' in the sense of 'standing always at a certain distance from the interests it has'.[126] Thus, family (or others) do not feature. Instead, within the divide between public and private spheres of activity which has 'long informed dominant Western ways of knowing and being,'[127] family is very clearly located in the private sphere. Family is 'a sanctuary of privacy into which one can retreat to avoid state regulation.'[128] In this way, family is rendered invisible and outside of the ambit of State involvement.

There are a number of reasons why this conception of the rights subject is inadequate within contemporary mental health law. First, the very existence of the individuated subject can be disputed on metaphysical grounds. Arguing from a broadly communitarian perspective, Michael Sandel recognises the significance of community, not merely as 'an attribute but a constituent of identity,'[129] while feminist theorists argue that conditions of dependency, which are inevitable in childhood, are key in the creation of one's moral personality.[130] Thus, subjects are inevitably 'socially embedded'.[131] Secondly, there are normative reasons why the traditional liberal rights subject is not an appropriate construct around which to build a moral theory. As described by Daniel Callahan, this approach 'elevates isolation and separation as the necessary starting point of human

[125] JS Mill, *On Liberty* (London, 1859) (from ed Grey *On Liberty and Other Essays* (Oxford: Oxford University Press, 1991).
[126] M Sandel, *Liberalism and the Limits of Justice* (2nd Ed) (Cambridge University Press, 1997), p 62.
[127] S Boyd, *Challenging the Public/Private Divide: Feminism, Law and Public Policy* (Toronto: University of Toronto Press, 1997), p8.
[128] F Olsen, 'The Family and the Market: A Study of Ideology and Legal Reform' (1983) 96 *Harvard Law Review* 1497, 1504.
[129] M Sandel, *Liberalism and the Limits of Justice* (2nd Ed) (Cambridge University Press, 1997), p 150.
[130] A Baier, *Postures of the Mind: Essays on Mind and Morals* (Minneapolis: University of Minnesota Press, 1985), p 85.
[131] C Mackenzie and N Stoljar, 'Autonomy Reconfigured' in C. Mackenzie and N. Stoljar eds *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (New York: Oxford University Press, 2000), p 4.

commitments'.[132] It fails to recognise the moral responsibilities which an individual owes to others, the weight of which responsibilities is 'conditioned by the individual's personal circumstances'.[133] Theorists arguing from a feminist perspective also point out that somebody has to do the work of caring, that this person is often female,[134] and that the liberal focus on the individuated subject obscures the work of care and fails to recognise the uneven distribution of the burden of care.[135]

Thirdly, the focus on the individuated rights subject is simply less helpful and effective as a protective mechanism in the context of contemporary models for mental health service delivery.[136] Within the contemporary environment, the fear of patients being locked up for long periods in psychiatric hospitals no longer resonates.[137] Instead, for many patients and their families, the primary problem is negotiating the bureaucracy involved in accessing both community and hospital services and even in obtaining basic information about available services.[138] The most pertinent risk for the patient may be the collapse of the family support network leading to social consequences such as homelessness, isolation and deteriorating mental and physical health.

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[132] 'Autonomy: A Moral Good not a Moral Obsession' (1984) 14 *Hastings Center Report* 40, 41. See also M Sandel, *Liberalism and the Limits of Justice* (2nd Ed) (Cambridge University Press, 1997), p. 179, who contends that '[t]o imagine a person incapable of constitutive attachments [is] to imagine a person wholly without character, without moral depth.'

[133] M Brazier, 'Do no Harm - Do Patients Have Responsibilities too?' (2006) 65 *Cambridge Law Journal* 397, 402.

[134] While this assertion is borne out in both jurisdictions discussed in this article, the differential is not so stark as might perhaps be expected: the most recent statistics show that in Ireland, 62% of carers are women: Carers' Association, *Carers in Ireland: A Statistical and Geographical Overview* (2009) available at www.carersireland.com while in the United Kingdom 58% of careers are women: *Facts about Carers 2012* available at www.carersuk.org.

[135] R West 'Jurisprudence and Gender' (1988) 55 *University of Chicago Law Review* 1.

[136] See J Petrilla 'Rights-based Legalism and the Limits of Mental Health Law: The United States of America's Experience' in B McSherry and P Weller eds, *Rethinking Rights-Based Mental Health Laws* (Oxford: Hart Publishing, 2010); M Donnelly 'Community Based Care and Compulsion: What Role for Human Rights?' (2008) 15 *Journal of Law and Medicine* 783.

[137] See T Carney, 'Involuntary Mental Health Treatment Laws: The 'Rights' and Wrongs of Competing Models' in McSherry and Weller eds, *Rethinking Rights-Based Mental Health Laws* (Oxford: Hart Publishing, 2010).

[138] This is borne out by evidence from families: see Faden *et al* 'The Burden of Care: The Impact of Functional Psychiatric Illness on the Patient's Family' (1989) 150 *British Journal of Psychiatry* 285; L Hallam, 'How Involuntary Commitment Impacts on the Burden of Care of the Family' (2007) 16 *International Journal of Mental Health Nursing* 247.

Alternative Approaches

There is increasing recognition of the need to take account of the socially embedded subject in developing law and policy. A number of ways of doing this have emerged from the literature. One argument advanced is the development of an alternative normative framework centred on an 'ethic of care'.[139] As Jonathan Herring notes, there is 'no complete agreement over what an ethic of care means'.[140] Herring sets out a number of central principles which underpin this approach.[141] In brief, these are, first, a recognition that care is part of being human and that it is something which should be valued; secondly, a view that emotions are ethically significant; thirdly, an acceptance that people are relational and that their interests are intermingled; fourthly, a recognition of the importance of responsibilities; and, finally, a rejection of abstract moral rules. Aspects of the normative approach which we advocate below are consistent with some of these principles, in particular, the view that people are relational and that interests are intermingled.

However, we would be concerned about the (further) elevation of a responsibility-based approach in the context of mental health law. Responsibility to others is already used as a basis to justify compulsory detention and treatment under mental health legislation. In its exploration of the policy basis for differential legal treatment of people with mental illnesses, the *Expert Committee Review of the Mental Health Act 1983* identified a belief that 'the consequences of untreated mental disorder may impact more directly and significantly on carers and relatives than do the consequences of untreated physical disorder.'[142] We would be concerned that any legal extension of a responsibility-based approach, especially when this kind of approach is not a part of healthcare law in other respects,[143] would lead

[139] Early work in this respect focussed primarily on the ethics of care as a gendered phenomenon: see C Gilligan, *In a Different Voice: Psychological Theory and Womens' Development* (Cambridge, Mass: Harvard University Press: 1982); N Noddings, *Caring: A Feminine Approach to Ethics and Moral Education* (Berkeley: University of California Press, 1984); V Held, *Feminist Morality: Transforming Culture, Society and Politics* (Chicago: University of Chicago Press: 1994).
[140] J Herring, *Caring and the Law* (Oxford: Hart, 2013), p 49.
[141] See Herring *ibid*, pp 49-64.
[142] *Expert Committee Review of the Mental Health Act 1983* (London: Department of Health, HMSO, 1999), para 2.9.
[143] See M Donnelly *Healthcare Decision-making and the Law: Autonomy, Capacity and the Limits of Liberalism* (Cambridge: Cambridge University Press, 2011), p 245. On the limited role of responsibility in current healthcare law, see Brazier 'Do no Harm - Do Patients Have Responsibilities too?' (2006) 65 *Cambridge Law Journal* 397.

to further erosion of the rights of people with mental illness. Accordingly, we argue that a more promising response to the challenges in finding a place for family in mental health law is based around conceptions of relational autonomy and vulnerability.

Like the ethic of care, the concept of relational autonomy is variously defined.[144] John Christman argues that the factor which makes 'a conception of autonomy *uniquely* "relational" or "social" is that among its defining conditions are requirements concerning the interpersonal or social environment of the agent.'[145] Viewed from an ethics of care perspective, however, the distinctive feature of relational autonomy is the continued relevance of the principle of autonomy. However, autonomy is conceived differently to the liberal view. As described by Jennifer Nedelsky, under a relational approach, autonomy is not equated with independence. Instead, '[a]utonomy is made possible by constructive relationships'.[146] Under this view, autonomy is not static, a quality which one has (or does not have) but rather, a 'capacity whose realization is ever shifting'. [147] Nedelsky, who puts forward a detailed exposition of relational autonomy from a legal perspective, explains why relational autonomy is especially relevant in the context of the modern bureaucratic state. She argues that:

> The central problem in the modern administrative state is no longer the traditional liberal objective of protecting individual autonomy by keeping the state at bay. The problem is how to protect and enhance the autonomy of those who are *within* the (many) spheres of state power.'[148]

This reflects the contemporary context for the delivery of mental health services where, as described above, the primary challenge for people with mental illness (and their families)

[144] One relevant distinction is between 'procedural' and 'substantive' accounts, with the former being especially concerned with building autonomy capacities and the latter designating decisions made in certain circumstances as non-autonomous: see C Mackenzie and N Stoljar eds, *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (New York: Oxford University Press, 2000), pp 19-21. For a synthesis of key themes in relational autonomy, see J Herring, 'Relational Autonomy and Rape' in S. Sclater *et al* eds, *Regulating Autonomy: Sex, Reproduction and Family* (Oxford: Hart Publishing, 2009), pp 56-58.
[145] 'Relational Autonomy, Liberal Individualism, and the Social Construction of Selves' (2004) 117 *Philosophical Studies* 143, 147.
[146] *Law's Relations: A Relational Theory of Self, Autonomy, and Law* (New York: Oxford University Press, 2011), p 118.
[147] *Ibid*, p 119.
[148] *Ibid*, p 118.

is often negotiating bureaucracies and accessing appropriate treatment and services to promote recovery and enhanced quality of life.[149]

Relational autonomy is also a useful conceptual tool in the context of the current discussion because, although it accepts that humans must be viewed in a relational way, it does not presume that all relationships are benign.[150] Thus, Nedelsky argues, the 'relational project' must be seen as 'intrinsically evaluative and aimed at transformation.'[151] Relational autonomy is therefore not about maintaining existing relationships regardless of their nature. Nedelsky argues, '[p]art of the reason relational autonomy is so important is that it is part of what enables people to extricate themselves from bad relationships as well as to transform the structures that shaped those relationships'.[152] Thus, in the mental health context, a relational approach to law requires that people with mental illness must be enabled to extricate themselves from bad family relationships while, at the same time, supporting family relationships which enhance autonomy. This is something which the legislation in both of the jurisdictions discussed in this article fails to achieve. In England and Wales, the nearest relative framework makes it too difficult for a person with a mental illness to extricate him or herself from a bad family relationship[153] while legislation in both jurisdictions fails to support autonomy-enhancing relationships between people with mental illness and their families (and other significant people in their lives).

While we argue that a focus on relational autonomy provides an important conceptual tool in approaching the challenges of dealing with family in mental health law, this approach has limits in this situation. A focus on the development of autonomy-enhancing relationships does not address the range of difficulties which people with mental illness and their families must confront. During periods of serious mental illness, for some people at least, achieving autonomy may be difficult, if not impossible. If the law is to work effectively during these periods, other conceptual tools are needed. In this context, a

[149] See text to n 138 above.
[150] J Nedelsky, *Law's Relations: A Relational Theory of Self, Autonomy, and Law* (New York: Oxford University Press, 2011), p 32.
[151] *Ibid*, p 32.
[152] *Ibid*, p 32.
[153] See text to n 109 above.

conceptual framework which recognises the role of vulnerability may provide grounding for an appropriate legal framework.

A number of theorists, perhaps most notably in a legal context Martha Fineman, have identified the potential of a framework centred on the conception of vulnerability in reconceptualising the traditional liberal subject.[154] Fineman seeks to reclaim the term 'vulnerable' from the traditional way it is used in discussions of public responsibility to describe 'groups of fledgling or stigmatized subjects' (children, the elderly, people with HIV-AIDs).[155] Fineman recognizes that when vulnerability is conceived of as a condition experienced by a minority, it is possible to avoid engaging with the constant possibility of vulnerability and the need to allocate the resources required to address the consequences of this. Fineman argues that we should recognize that vulnerability is inherent in the human condition and that every human is, in some way, vulnerable and susceptible to harm. Thus, vulnerability is 'a universal, inevitable, enduring aspect of the human condition that must be at the heart of our concept of social and state responsibility'.[156]. Fineman argues that because we recognize that all subjects are, in one way or another, vulnerable, the concept of vulnerability is 'freed from its limited and negative associations'.[157]

While arguing that vulnerability should be recognised as a universal attribute, Fineman also recognizes that vulnerability is particular and is experienced uniquely by each person. Thus, '[b]ecause we are positioned differently within a web of economic and institutional relationships, our vulnerabilities range in magnitude and potential on an individual level.'[158].

[154] See M Fineman, 'The Vulnerable Subject: Anchoring Equality in the Human Condition' (2008) 20 *Yale Journal of Law and Feminism* 1 (reproduced in M Fineman ed, *Transcending the Boundaries of Law, Generations of Feminism and Legal Theory* (Oxford and New York: Routledge, 2011); M Fineman, '"Elderly" as Vulnerable: Rethinking the Nature of Individual and Societal Responsibility' (2012) 20 *The Elder Law Journal* 101. Other theorists who have worked with conceptions of vulnerability include J Tronto, *Moral Boundaries: A Political Argument for an Ethic of Care* (New York: Routledge, 1993); S Dodds, 'Depending on Care: Recognition of Vulnerability and the Social Contribution of Care Provision' (2007) 21 *Bioethics* 500.
[155] Fineman (2008) *ibid*, p 8.
[156] *Ibid*, p 8.
[157] *Ibid*, p 8-9.
[158] *Ibid*, p 10.

Fineman acknowledges that the State cannot eradicate vulnerability; however, she argues that 'it can and does mediate, compensate and lessen vulnerability through programmes, institutions and structures.'[159] At the core of Fineman's argument is the contention that recognition of the vulnerable subject requires a greater emphasis on the State's responsibility towards individuals and institutions, including family.[160] Thus, in contrast to some visions of the ethic of care, this model looks beyond allocating responsibility to the individual (in this case, the person with a mental illness) towards his or her carers/family members and asks instead whether, and how, the responsibility of the State and its institutions towards this person and towards his or her family network is being met. This kind of approach requires a reformulation of the traditional liberal response whereby care-taking is relegated to the family and operates within the private rather than the public sphere and is of limited concern to discourses developed around the individuated subject. . This narrative sees the patient as "vulnerable" but the family, comprised of traditional liberal subjects, is not susceptible to vulnerability and so can withstand the burdens associated with care-taking.

By relocating responsibility for care, the vulnerabilities approach rejects the dichotomy between public and private spheres. As described by Nicola Lacey , this dichotomy 'allows government to clean its hands of any *responsibility* for the state of the 'private' world and *depoliticizes* the disadvantages which inevitably spill over the alleged divide by affecting the position of the "privately" disadvantaged in the "public" world'.[161]Instead this approach recognises that the State is always a residual player in 'private' family arrangements.[162] In this way, this approach situates family at the intersection of public and private domains. It acknowledges that the situation in respect of each member of a family has an impact on the family as an entity and that this impact is enhanced in the context of care relationships within the family. Fineman describes family members providing care in this situation as

[159] *Ibid*.
[160] Fineman, *ibid*, p 161.
[161] N Lacey, 'Theory into Practice? Pornography and the Public/Private Dichotomy' (1993) 20 *Journal of Law and Society* 93, 97 (original emphasis).
[162] Fineman, 'The Vulnerable Subject: Anchoring Equality in the Human Condition' (2008) 20 *Yale Journal of Law and Feminism* 1 (reproduced in M Fineman ed, *Transcending the Boundaries of Law, Generations of Feminism and Legal Theory* (Oxford and New York: Routledge, 2011), p. 7.

being in a position of 'derivative dependency'. She argues that 'derivative dependency is not inevitable but is socially assigned as the responsibility of the private family.'[163]

In the context of mental illness, responsibility for care and support have long been placed in the hands of family. It is only when the family can no longer cope with the demands placed on it that the State assumes responsibility for care. At this point, there is a shift from the private to the public sphere and the legislative frameworks discussed in this article come into play. Under a vulnerabilities approach, this is far too late for State engagement. Instead, this approach obliges the State to be responsive to the need to develop greater resilience for people with mental illnesses and for their families. The approach changes the questions asked, shifting the focus away from individual sets of relationships with their inevitable flaws and complexities and looks instead at what can be done to create or enhance frameworks in which both individuals *and* families can contribute to mental health and recovery. From a legal perspective, this approach requires a sustained interrogation of how law should respond both to the needs of the individual and to the needs of the family unit within which he or she is situated.

Although there is little indication of this approach in the legislation discussed here, the beginnings of such an approach are evident in the *Mental Health Act 1983 Code of Practice*. In the context of admission, this states that it is important to identify all individuals who provide regular and substantive care for patients and to ensure that health and social services assess these carers' needs and 'where possible' that they provide services which meet these needs.[164] As noted earlier, however, a difficulty with the Code is its limited enforceability.[165] Additionally, a truly responsive framework would come into operation long before the need for compulsion became an issue and would, to the benefit of people with mental illnesses and of their families, work to avoid the need for the formal admission process to be engaged.

[163] M Fineman, '"Elderly" as Vulnerable: Rethinking the Nature of Individual and Societal Responsibility' (2012) 20 *The Elder Law Journal* 101, p 117.
[164] (2008) rev'd ed, para 2.39.
[165] See text to n 119 above.

The conceptual approaches advocated here shift the focus for analysis away from the old narratives which see family as a threat to the individual or the individual as a threat to family. Instead, the common needs of individuals and family are emphasised to, we would argue, the benefit of both.

Both approaches advanced here require more support from the State than is currently delivered under mental health law. Thus, the approaches fit more comfortably with conceptions of positive rights rather than with the traditional liberal rights to be free from the state interference. The final section develops the argument that a degree of support for this vision of mental health law can be found in the emerging jurisprudence of the European Court of Human Rights (ECtHR) and that it is also supported by the Convention on the Rights of Persons with Disabilities (CRPD).

Human Rights Support for Relationality and Vulnerability Approaches

Article 8 of the ECHR protects the right to respect for private and family life. Article 8 has been important in enhancing protections for individual rights, including the right of autonomy[166] and the right to physical and psychological integrity,[167] and these aspects of Art. 8 have contributed to the development of a more rights-based mental health law. Article 8 has also been important in affording greater recognition to the role of family, both as a source of support and in its own right. The ECtHR has recognised that the individual's right of privacy includes the individual's right to foster and develop relationships.[168] The Court has also found that, in some circumstances, individuals have a right to family support and involvement in decisions about their care. Thus, in *Glass* v *United Kingdom*, the ECtHR found a breach of the right to physical integrity of a severely physically and mentally disabled 14 year-old boy by the implementation of medical decisions made about him without his mother's knowledge.[169] The ECtHR did not find that the mother's views should

[166] In *Pretty* v *United Kingdom* (2002) 35 EHRR 1, para 61, the ECtHR found that 'the notion of personal autonomy is an important principle underlying the interpretation of [ECHR] guarantees'.
[167] See *X and Y v the Netherlands* (1986) 8 EHRR 235; *Bensaid v United Kingdom* (2001) 33 EHRR 205; *YF v Turkey* (2004) 39 EHRR 34; *Storck* v *Germany* (2005) 42 EHRR 96.
[168] *Niemietz* v *Germany* (1993) 16 EHRR 97; *Botta* v *Italy* (1998) 26 EHRR 241.
[169] (2004) 29 EHRR 341, para 70. These included the provision of diomorphine and the placing of a do-not-resuscitate (DNR) order without parental consent/consultation.

have determined the matter but rather, that she should have been consulted and that, given that objections had been raised by the mother, the authorisation of the court should have been obtained.[170]

Glass concerned a minor and a close family relationship. The ECtHR expressly noted that the mother acted as the child's legal proxy and that, in this capacity, she had the authority to act on his behalf and to defend his interests.[171] Also, in his separate opinion, Casadevall J referred specifically to 'maternal instinct'.[172] Therefore, it is not clear how far an individual's Art. 8 based right to have his or her family consulted would extend. However, a case can certainly be made that some degree of consultation could be required in other situations where a patient lacked capacity. Thus, the case can be viewed as support for the essentially relational proposition that, in some cases at least, individuals have a right to have their families involved in decisions about their healthcare and there is no reason in principle why this should not include decisions about mental health care.

The decision in *Glass* was reached on the basis of the patient's right to have his family consulted and the ECtHR declined to offer a view on the argument, which had been put forward by the second applicant, that Article 8 gave rise to a parental right to be consulted.[173] However, the view that family members who are carers have rights on their own behalf was recently accepted by the ECtHR in *Dordević v Croatia*.[174] The applicants in this case were a son and his mother. The first applicant was a man with physical and learning disabilities who had been subjected to sustained harassment by pupils from a neighbouring school.[175] As a result of stress brought on by this harassment, the first applicant (who was described as 'a peaceful and benign person who could not and did not know how to defend himself from the abusers'[176]) became very distressed.[177]The second

[170] *Ibid*, para 88.
[171] *Ibid*, para 70.
[172] *Ibid*, separate opinion, para 2.
[173] *Ibid*, para 72.
[174] [2012] ECHR 1640. This position had, of course, been accepted by Munby J in *R (A and B, X and Y)* v *East Sussex County Council and the Disability Rights Commission* [2003] EWHC 167 (Admin).
[175] Incidents included shouting obscenities at the first applicant, calling him names, spitting at him and, on one occasion, burning his hands with cigarettes: *ibid*, para 8-12.
[176] *Ibid*, para 11.

applicant was the first applicant's mother and carer. She had informed the police of the ongoing harassment of her son on several occasions and had also informed the Ombudswoman for Persons with Disabilities. The ECtHR found that, although some efforts had been made, there had been no serious attempt to address the situation; no monitoring was put in place, social services were not involved and no counselling had been provided to the first applicant.[178]

The ECtHR found that the respondent state had breached the first applicant's Art. 3 right to protection from inhuman and degrading treatment.[179] The Court also found that there had been a breach of the second applicant's Art 8 right to private and family life even though she had not been subjected to 'any form of violence affecting her physical integrity'.[180] The Court found that there was no doubt that the continued incidents of harassment of her son 'for whom she has been taking care' had concerned her personally and had, 'even in their milder forms, caused disruption to her daily life and her routines' and that these had had an adverse effect on her private and family life.[181] The ECtHR then went on to note that the 'moral integrity' of an individual is covered by the concept of private life and that the concept of private life extends also to 'the sphere of the relations of individuals between themselves.'[182] The Court found that, '[w]hile the essential object of Article 8 is to protect the individual against arbitrary interference by public authorities,' there may also be positive obligations 'inherent in effective respect for private and family life'.[183] In certain circumstances, the State has a positive duty to protect the 'moral integrity of an individual from the acts of other persons' and to 'ensure respect for human dignity and the quality of life in certain respects.'[184] In the case in question, the State's failure to put in place adequate protections to prevent the abuse of the first applicant constituted a violation of the Art.8 rights of the second applicant.

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[177] On the evidence before the ECtHR, the first applicant often bit his lips and fists, developed a twitch in his left eye and developed psoriasis: *ibid*, para 60.
[178] *Ibid*, para 148.
[179] *Ibid*, para 150.
[180] *Ibid*, para 97.
[181] *Ibid*, para 97.
[182] *Ibid*, para 97.
[183] *Ibid*, para 151.
[184] *Ibid*, para 152.

The decision in *Dordević* is important both because of the ECtHR's recognition of rights in a relational context and because of the Court's preparedness to impose a positive duty on the State to extend rights protection in this context. The ECtHR was clear, however, that positive duties would be recognised only in limited situations. The Court acknowledged that 'operational choices' must be made in terms of priorities and resources and that the scope of the positive obligation in the case in question must 'be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities.'[185] Thus, the decision does not necessarily presage an ECHR-derived paradigm shift in the direction advocated in this article. Nonetheless, the approach of the Court might be argued to constitute the beginnings of support for this way of approaching the role of family in mental health law.

Support for the position advocated in this article may also be drawn from the CRPD. The Convention is regarded by many commentators as constituting a paradigm shift in the legal response to disability (including mental illness or psychosocial disability).[186] Two aspects of the CRPD are of relevance to the discussion here. First, the CRPD recognises both positive and negative rights and places clear obligations on States Parties to take positive steps to protect rights (both civil and political and social and economic rights) of persons with disabilities.[187] Article 19 expressly requires States Parties to recognise the equal right of all persons with disabilities to live independently and to be included in the community. Art. 19(b) includes a specific requirement that States ensure that persons with disabilities have access to a range of in-home, residential and other community support services needed to support living and inclusion in the community. As described by the Council of Europe Commissioner for Human Rights, Art. 19 'embodies a positive philosophy, which is

[185] *Ibid*, para 139.
[186] See A Lawson, 'The United Nations Convention on the Rights of Persons with Disabilities: New Era or False Dawn?' (2006-7) 34 *Syracuse Journal of International Law and Commerce* 563; R Kayess and P French, 'Out of Darkness Into Light? Introducing the Convention on the Rights of Persons with Disabilities' (2008) 8 *Human Rights Law Review* 1; P Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2012) 74 MLR. 752.
[187] See A Kampf, 'The Disabilities Convention and its Consequences for Mental Health Law in Australia' (2008) 26(2) *Law in Context* 10.

about enabling people to live their lives to their fullest, within society.'[188] It is difficult to see how a State can deliver on this right without engaging with the role of family (as well as the other people) insofar as this makes it possible for people with mental illness to live in the community. Thus, the CRPD mandates the kind of positive State engagement which we argued earlier is inherent in a vulnerabilities approach.

Secondly, the CRPD recognises that persons with disabilities operate in a relational context. This is especially evident (and important) in the context of legal capacity. Michael Bach and Lana Kerzner note that a 'relational understanding of autonomy is particularly important for those who require the support and assistance of others in communication, understanding and representing themselves to others; the case for many people with intellectual, cognitive and/or psychosocial disabilities'.[189] Article 12 requires States Parties to recognise that persons with disabilities enjoy legal capacity on an equal basis with others and to take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity. Thus, the CRPD mandates a new approach based on supported decision-making.[190] Family have a fundamental role to play in providing this support. In turn, the CRPD places clear obligations on States Parties to provide its own support to families and others so that they can fulfil the necessary support role for persons with disabilities.[191]

Conclusion: Finding a Place for Family

Narrative 'supplies law with its unreflecting assumptions'.[192] Understanding different narratives of family in the discourse of mental illness helps to provide a context for a normative evaluation of the law's response. We have identified three relevant narratives in

[188] Commissioner for Human Rights, *The Right of Persons with Disabilities to Live Independently and be Included in the Community* CommDH/Issue Paper (2012), 3 available at www.commissioner.coe.int.
[189] M Bach and L Kerzner, *A New Paradigm for Protecting Autonomy and the Right to Legal Capacity* (Ontario: Law Commission of Ontario, 2010), p 40.
[190] There is ongoing debate regarding whether the CRPD requires supported decision-making in all instances or whether there is still scope for substitute decision-making in some limited cases: A Dhanda, 'Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?' (2007) 34 *Syracuse Journal of International Law and Commerce* 429.
[191] See M Bach and L Kerzner *A New Paradigm for Protecting Autonomy and the Right to Legal Capacity* (Ontario: Law Commission of Ontario, 2010), pp 111-114.
[192] J Benjamin, 'The Narratives of Financial Law' (2010) 20 OJLS, 787, 788.

this article and examined ways in which these narratives underpin mental health legislation in England and Wales and in Ireland. The individualist approach taken in the Irish MHA 2001 derives in part at least from a narrative of family as a threat to the person with a mental illness. Accordingly, the MHA 2001 lacks any legal mechanisms to enable families to provide support to patients and fails also to provide support for families. Although the MHA 1983 affords some degree of recognition of the role of family, the legislation retains an individualist focus. Family is allowed a role but only if this role is mediated through the person of the nearest relative who is chosen not because of his or her closeness to the patient but because s/he comes at the top of a statutory hierarchy. Thus, the nearest relative becomes the public face of the private family and the sole point at which the interaction between the public world of mental health legislation and the private world of family care is allowed to take place. The resulting framework fails to address the real lives and needs of people with mental illness and their families. For this reason, we argue that the approach in both jurisdictions is outdated and should be the subject of a normative re-evaluation.

In developing a normative context for reconsideration of the role of family, we advocate moving away from the current individualist focus and instead towards a greater recognition of the relational or embedded nature of the subject. The conceptual tools provided by relational autonomy and vulnerability are, we argue, especially well-suited to the challenges faced by mental health law in addressing the role of family. Relational autonomy is helpful not just because it recognises that individuals are inherently relational but also because of its transformational potential. This approach requires that we ask what the law can do to develop (autonomy-enhancing) relationships and not simply how the law should respond to existing relationships. In the context of mental illness, where family relationships are undoubtedly complex and at times strained, this approach moves away from existing narratives and offers the potential to develop new narratives of family.

In order for new narratives to develop, both individuals and families need support and this support, we have argued, requires a more responsive State and a more sophisticated legal framework. There are, of course, enormous challenges in this. We have to identify how the

State (and the law) can support relationships and, of particular importance in the field of mental health, we need to find ways in which State support can be achieved without permitting ever greater levels of State control. Nonetheless, we believe that the conceptual tools we have discussed here provide the basis for productive ongoing engagement with the role of family in mental health law.