Family in Mental Health Law: Responding to Relationality

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Abstract

This chapter explores evolving responses to family (broadly defined to include family of choice) in mental health law. Recognising the complex dialectic at the heart of discussions of family in mental illness, the chapter traces changing views of family in a post-carceral era. Using the example of the 'Nearest Relative' framework in the Mental Health Act 1983 (UK), the chapter identifies flaws in responses to family in 'traditional' mental health legislation. Some of these flaws are being addressed by recent law reforms which expand the scope for the exercise of individual choice, both through allowing the person to nominate their own supporter/s and through legally enforceable Advance Healthcare Directives. These reforms offer positive options for many people with mental illness and their families. However, there are limits to what these kinds of reforms can deliver. For this reason, the chapter turns to the Report of the Royal Commission into Victoria's Mental Health System (VRC Report, 2021) which, it argues, offers potential for a more expansive vision of the role of mental health law and new ways of engaging with family.

Introduction

'Dearest, I feel certain I am going mad again. I feel we can't go through another of those terrible times. And I shan't recover this time.'
Final letter from Virginia Woolf to her husband, Leonard, 28 March 1941

Leonard Woolf was Virginia's carer during her periods of mental illness (with what might now be described as bi-polar disorder). But their relationship was so much more than this. Leonard was also Virginia's publisher, manager, husband and companion (Lee, 1997). Her letter continues 'I don't think two people could have been happier till this terrible disease came.' This poignant letter provides just one entry point to a consideration of family in situations of mental illness. Spouses and partners, parents and children, siblings and grandparents, friends and lovers may all respond in different ways where someone in their circle has a mental illness. Given this infinite variety, it is no surprise that mental health legislation has struggled to identify the most appropriate way to address the role of family in situations of involuntary admission.

There is a complex dialectic at the heart of discussions of family in mental illness. On the one hand, family are often best placed to provide support for the person with mental illness and to influence his or her recovery. Yet, family may sometimes also (often without intending to do so) undermine resilience and impede recovery. It is essential that we attend to this dialectic and that we recognise that while the needs of individuals and of families will often overlap, they do not always do so. This has implications for how we evaluate legal frameworks and how we think about mental health law reform.

The chapter begins by exploring the complexities of relationality in mental illness, recognising the different roles which family assumes and is assigned across different cultural and temporal contexts. It then examines the treatment of family in 'traditional' mental health legislation, using the example of the Mental Health Act 1983 (UK) where the Nearest Relative framework can be traced back to the early days of de-institutionalisation. This is followed by an analysis of some recent law reform efforts which stay within the traditional model but seek to expand individual choice of support options. Having identified traditional (albeit developing) responses to the role of family and some of the limitations of these, the chapter then turns to broader reform possibilities. Here, it draws primarily on the Report of the Royal Commission into Victoria's Mental Health System (VRC Report, 2021). This offers a more expansive vision of the role of mental health law, which also involves new ways of engaging with family.

Before beginning the substantive discussion, a brief note is required on the meaning of 'family' in this chapter. Sometimes, when speaking about specific legal provisions, family is understood as the particular legal formulation at issue, which is usually based on the traditional ties of blood or marriage (sometimes described as 'family of origin'). However, in general, 'family' is used as a shorthand to encompass 'family of choice' (i.e. people in a close relationship which is not based on blood ties or marriage) as well as family of origin (Smart, 2007).

Relationality and Mental Illness

There is no single narrative of the role of family in mental illness (Donnelly and Murray, 2013). As well as the infinite range of human relationships, there are broader differences between competing accounts of the role of family across times and cultures (Gilbar and Miola, 2014; Gopalkrishnan, 2018). The discussion below is primarily focused on the role of family in the West (although recognising that there are different responses to mental illness among different ethnic communities in the West (Szmukler and Bloch, 1997; Lefley, 1998; 2000)). It begins by considering the evolution of views of family in mental illness. This is followed by discussion of how the role of family maps onto conceptual understandings of relationality and then by an exploration of contemporary experiences of family in situations of mental illness.

Evolving Views of Family in Mental Illness

One common temporal division in mental health law scholarship distinguishes between the pre-carceral, carceral and post-carceral eras (Unsworth, 1991: 255). Family features in a different way in each. Property concerns dominate in the pre-carceral era with the primary focus being the transfer (whether to the State or to family) of the benefits and responsibilities of property ownership in situations of mental illness (Unsworth, 1991: 258-259). Although some responsibilities to provide care were imposed on those in authority, for example through the *parens patriae*

jurisdiction (Seymour, 1994), most of the time, care of people with mental illness was left to their families. Where families did not provide this, almshouses and other religious institutions provided some respite, but for many, the result was almost inevitably destitution and homelessness: what Brendan Kelly describes as the 'wandering lunatic' (2016: 18). Asylums, workhouses and other sites of incarceration were, in the first instance, an attempt to address this problem (Kelly, 2016). The steady growth in asylums which took place during the carceral era derived in no small way from families' enthusiasm to hand over the care of family members with mental illness. As David Rothman describes (in a United States context), 'once the family's tolerance was exhausted, they gave their burden over to the asylum, grateful for the relief it provided' (1990: xlvi). And for at least some of those admitted, this was the end of the matter, even in cases where the asylum attempted discharge into family care (Kelly, 2016: 4).

While these family responses to mental illness may seem incomprehensible to modern eyes, it is important to remember the broader social context in which they took place. Mental illness was a source of profound stigma and shame, both for the person who was mentally ill and for their family (Scull, 1993; 2015) and this created a compulsion to hide this shame by whatever means possible. This was reinforced by the shift to a capitalist, production-focussed society which placed new pressures on relationships with economically non-productive family members (Series, 2022: 34). Nonetheless, it is no surprise that the 'legalism' of early mental health legislation was premised at least in part on the need to protect mentally ill people from their families (Unsworth, 1991). This view of family as inherently dangerous was exacerbated by other factors, including the attribution of mental illness to genetics or upbringing and the linkages drawn, especially in psychotherapy, between family failings and individual mental illness, for example, Frieda Fromm-Reichmann's cold and domineering 'schizophrenogenic mother' (1948) and Phyllis Chesler's patriarchal family structures (1972).

There were many reasons for the move away from incarcerating people with mental illness. Writing in respect of the UK, Lucy Series points to the role of scandals, sociological critiques (including Erving Goffman's coruscating analysis of 'total institutions' (1961)), the development of independent living and disability rights pressure groups (some of which were led by family members), the anti-psychiatry movement, and the growth in theories of normalisation and person-centred care (2022: 55-65). The development of new pharmacological treatments also held out the promise that mental illness could be cured or at least managed outside of an institutional setting (Gronfien, 1985). In this new policy environment, family came increasingly to be seen less as 'the enemy' and more as necessary allies in the provision of appropriate care. This changing approach is exemplified in the Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1957) (the Percy Report), which provided the policy underpinnings for the shift to care in the community and was given legislative effect in the Mental Health Act 1959 (UK).

The Percy Commission consulted extensively, including with people with lived experience of mental illness and their families (Rapaport and Manthorpe, 2009: 254). The final Report presents families as having a vital role to play in delivering the new model of community care (Hewitt, 2009; Rapaport and Manthorpe, 2009: 260). This emerging understanding led to a new focus on 'burden' research, which sought to investigate the impact of one family member's mental illness on broader family health and wellbeing (Grad and Sainsbury, 1963; Hoenig and Hamilton 1966; Platt, 1985; Faden, 1989; Sartorius et al, 2004). While criticisms can be levelled against some of the earlier research, which was often insufficiently cognisant of broader social factors, one very clear finding across all studies was that a family member's mental illness did not just affect the person themselves, but also

had a negative impact on their broader family, especially if the family was involved in the person's care.

Recognising Relationality

The recognition of family in the shift to community care reflects a broader philosophical turn towards recognising relationality and connectedness. Contemporary thinking reflects a move away from an individualist perspective and a greater recognition of the inherently social context in which people live their lives and the defining influence of relationships with others (Harding, 2017). The foundations for this shift lie primarily in feminist philosophy, which fundamentally challenged individualist conceptions of the self, emphasising instead the inevitability of dependency, connectedness and relationality (Baier, 1986; Fineman, 2005; Kittay, 1999; see also MacIntyre, 1999). Various ways of responding to the realities of relationality have been proposed. One is the elevation of an ethic of care (Noddings, 1994; Kittay, 1999; Herring, 2013); a second is the identification of relational autonomy (Mackenzie and Stoljar eds. 2000) and a third is the recognition of the normative force of vulnerability as a universal aspect of the human condition (Goodin, 1985; Fineman, 2008; Mackenzie et al eds., 2013).

Each of these approaches have something to offer in conceptualising the role of family in mental illness (Donnelly and Murray, 2013). The contribution of care (and of carers) has long been neglected in philosophical discourse, notwithstanding the fact that, as Eva Kittay has argued, the ability to give and receive care is as fundamental to human dignity as the ability to reason which has so preoccupied philosophers (Kittay, 2011: 52). As discussed below, care can be an essential part of recovery from mental illness and, without care, the only alternative for some people with serious mental illness is homelessness and destitution. However, an ethic of care alone cannot provide an adequate conceptual framework to address the role of family in mental illness (Donnelly and Murray, 2013: 398). This is because the relationship between a person with a mental illness and their family does not always fit neatly within the contours of 'care' (Henderson, 2001). Moreover, a focus on care alone risks obscuring the 'cared-for' person, including failing to respect their autonomy and dignity. This is especially problematic in mental illness, which has long been characterised by the denial of these rights (whether through societal or legal strictures or indeed because of the impact of the illness itself (Gergel, this vol)).

A focus on relational autonomy provides something of a counterweight to these concerns. Although this concept is variously defined (Christman, 2004), at its core, it attempts to address the realities of relationality while remaining grounded in respect for individual autonomy (Mackenzie and Stoljar eds. 2000). Autonomy has been a foundational norm in disability rights advocacy 'where it provides a necessary counterweight to centuries of paternalist presumptions' (Donnelly, 2022: 23). Yet, traditional liberal conceptions of autonomy cannot address the range of factors (structural, societal, cultural and educational as well as capacity-related) which prevent a person from being able to make autonomous decisions. Relational autonomy provides a helpful way of thinking about family in situations of mental illness because it recognises that autonomy is not a given but rather, 'is made possible by constructive relationships' (Nedelsky, 2011: 118). Thus, it provides a conceptual basis for support-based legal frameworks which seek to assist a person with mental illness to make autonomous decisions, including during times of crisis. At the same time, a key feature of relational autonomy is that it does not presume that all relationships are positive or 'constructive'. Thus, the 'relational project' is 'intrinsically evaluative and aimed at transformation' (Nedelsky, 2011: 32). In

respect of mental illness, this requires that a person with mental illness must also be supported to extricate themselves from relationships which diminish autonomy.

Vulnerability theory adds another helpful layer when thinking about mental illness. This theory begins from the premise that vulnerability is universal and inevitable (Fineman, 2008; Mackenzie et al eds., 2013). This in turn draws attention to the actions which a state can take to respond to vulnerability, including an obligation to build resilience (Fineman, 2008). The contribution of vulnerability theory in responding to mental illness is that it addresses both the vulnerable individual and those, including family, who are placed in a position of 'derivative dependency' because of their efforts to care for and support their family member (Fineman, 2008: 117). In practical terms, this focus requires asking 'what can be done to create or enhance frameworks in which both individuals *and* families can contribute to mental health and recovery' (Donnelly and Murray, 2013: 401).

Some of these conceptual understandings are reflected in the United Nations Convention on the Rights of Persons with Disabilities (CRPD). Article 12(3), which requires States Parties to 'take appropriate measures to provide persons with disabilities with the support they may require in exercising their legal capacity', reflects a relational understanding of autonomy (Bach and Kerzner, 2010). There is also a reference in the Preamble to family as 'the natural and fundamental group unit of society' and an affirmation that 'persons with disabilities and their family members should receive the necessary protection and assistance to enable families to contribute towards the full and equal enjoyment of the rights of persons with disabilities' (2006, para 24). This might be seen as reflecting elements of vulnerability theory. However, beyond this, the role of family is largely ignored by the CRPD. As Rosemary Kayess and Phillip French point out, this downplaying of the role of family was a deliberate choice; following a keen argument among members ofthe Ad Hoc Committee, it was concluded that there should not be any overt recognition of family because, in most societies, family needs tend to be privileged above those of the person with disability and family members are sometimes principally responsible for, or collude in, the breach of rights of persons with disabilities (2008, 25-26).

Leaving aside the question of whether this was an appropriate call for the Ad Hoc Committee to make, its effect is that the CRPD is of limited use in trying to conceptualise, or advance, the role of relationality in situations of mental illness. Bearing this in mind, we now turn to the contemporary experiences of family in situations of mental illness.

Family in Contemporary Context

Although there is no single or simple narrative of family in contemporary context, some themes emerge. In the West, we are now well over half a century into the post-carceral era and the long-term institutional admission which grounded traditional mental health law is largely consigned to history (except in forensic settings). The vast majority of people receive care in the community or through short-term hospital admission. In Ireland, for example, the average length of stay for discharges from inpatient mental health services in 2021 was 55.6 days, while the median length of stay was 14 days (Daly and Craig, 2022: 8). This is not intended to diminish the importance of protection against wrongful involuntary admission; respect for the rights to liberty, autonomy and equality require that these protections be robust and meaningful. However, it is also the case that, for many people living with mental illness, the primary difficulty is no longer incarceration, but an absence of services and support, both in terms of direct access to health services and in respect of all the other elements, such as housing, income, employment and the social structures that make life

liveable and recovery possible (Carney, this volume). Thus, for many, the reality is that 'community care' is either family care or homelessness, isolation and neglect.

For those who do have access to family support (in its broadest sense), it is now widely recognised that these relationships can play an important role in recovery and preventing relapse (Onken et al, 2002; Tew et al, 2012; Ward, 2017). This has led to an increase in family therapy/recovery interventions and there is a body of evidence which suggests that these can be highly effective (Ward, 2017). Family and carer involvement is also encouraged in professional guidance and Codes of Practice (eg. Code of Practice to the Mental Health Act 1983 (2015)). There is, however, also evidence that family relationships can adversely impact recovery (Ward, 2017) and that the person with a mental illness may sometimes have quite a different view of the role their family members play in their recovery (Waller, 2019).

The position can become more complex in situations of chronic mental illness or during an acute phase of an intermittent illness. Here, family members may be required to act as carer. This shifts the relationship to a different register, which may continue for a short or a longer time, depending on the circumstances (Henderson, 2001). This in turn may give rise to tensions. As Henderson describes, the parties to the relationship 'may not always agree, or indeed ever [agree], about the nature of care or the need for it' (2001: 155). These tensions are heightened in situations of involuntary admission/use of coercion. In such situations, families report ambivalence and discomfort, but also feelings of relief (Jankovic, 2011; Norvoll, 2018; Stuart et al, 2020). For the person who has been admitted, there may be feelings of betrayal and/or abandonment, especially where their family members have been instrumental in initiating the admission (McGuinness, 2018; Akther, 2019; Sugiura, 2020).

There is also a strong body of evidence across a wide range of jurisdictions which suggests that the structures of mental healthcare pose significant challenges for families. Stuart et al's systematic review of carers' experience of involuntary admission identifies several key concerns (2020). A prominent theme was the absence of support from mental health services. Carers identified how, in the period prior to admission, they were 'overwhelmed by too much responsibility, isolated from sources of support, and expected to manage situations they were ill-equipped to deal with, including self-harm and threats of suicide, until assistance became available' (Stuart et al, 2020: 4). This problem was especially challenging for carers who were new to the mental health system or for younger and less experienced carers (Stuart et al, 2020: 5). Carers also described their frustrations in their relationships with health professionals and their distress at the quality of care provided (Stuart et al, 2020: 6).

A notable concern which emerges from most studies is carers' lack of access to information and involvement in care decisions, something which becomes especially acute around plans for discharge (Jankovic, 2011; Stuart, 2020). Sometimes, this lack of information reflects a systems-level failure to engage properly with families or confusion about the scope of health professionals' legal duties (Hansson et al, 2022). However, these concerns also reflect an ongoing ethical tension regarding the role of confidentiality where the person with mental illness does not wish information to be shared with family members (Hansson et al, 2022). This is not easy to resolve. On the one hand, confidentiality is a long-established foundational principle of the clinician/patient relationship and basic equality principles indicate that confidentiality should be no less important just because a person has a mental illness. Moreover, confidentiality can be an essential element in building and sustaining trust within a therapeutic relationship. On the other hand, family members who act as carers are directly and personally affected by their family member's mental illness (Szmukler and Bloch, 1997: 404; Stuart, 2020: 6). It can be argued that this requires some degree of reformulation

of the scope of the ethical duty of confidentiality (Hansson et al, 2022). Szmukler and Bloch argue that an ethical duty to share information with carers may be appropriate in some circumstances, based on 'the seriousness of the risk to the family's well-being, available alternatives, the patient's capacity to recognise actual and potential harms, and pre-existing family values' (Szmukler and Bloch, 1997: 404-405). Other relevant factors might include the pre-existing relationship between the person and their carer/s and any harm that would be caused to the person by sharing the information. As we will see below, finding ways to resolve this ethical tension is an ongoing challenge for mental health law.

All of the problems identified above are exacerbated for young carers (i.e. carers under 18), who are sometimes overlooked in mental health research, policy and law (although almost one third of young carers provide support in situations of mental illness (Dharampal and Ani, 2020: 113)). Studies suggest that tasks undertaken by young carers include housework, healthcare and emotional support. (Dharampal and Ani, 2020: 113). Young carers report being confused by the legal system, being ignored by mental health professionals, and being left without supports or even basic information about medical changes following their parent's discharge from hospital (Dharampal and Ani, 2020: 117-118). It is also clear that the health and well-being of young carers is often substantially diminished by their caring role (Martinsen et al, 2019; Dharampal and Ani, 2020; Lacey et al, 2022).

Bearing in mind this complex picture, we turn now to the ways in which family is treated in traditional mental health legislation.

Family in Mental Health Legislation

'Traditional' mental health legislation typically emerged during the carceral era and is principally concerned with regulating non-consensual admission to psychiatric facilities and non-consensual treatment for a 'mental disorder' which, depending on the jurisdiction, may be in hospital or in the community. This basic framework is replicated in many jurisdictions across the world (WHO, 2020). Within this, there is a good deal of variation in treatment of the role of family (Mullen et al, 2006; Donnelly and Murray, 2013). The discussion here focusses on the nearest relative provisions in the Mental Health Act 1983 (UK) (MHA 1983). These remain largely unchanged from those recommended by the Percy Report in the very early days of the move to community care.

The 'Nearest Relative' Framework

The nearest relative framework is based on the identification of a single point of contact – the patient's[1] 'nearest relative' (NR) – who is invested with authority by law. The NR (who must be over 18 years and living in the UK) is determined in accordance with a set statutory hierarchy with spouse/civil partner/cohabitant (for more than 6 months) at the apex (MHA, s. 26(4)).[2] An

[1] While recognising the difficulties with the term 'patient', I adopt it in discussion of the MHA 1983 to reflect the wording of the Act.

[2] This is followed by the patient's child, parent, sibling, grandparent, grandchild, uncle or aunt, nephew or niece (MHA, s. 26 as am by the Mental Health Act 2007, s. 26) with priority given to the eldest person in each class. However, where the patient ordinarily resides with, or is cared for by one or more relatives, this relative/s is given priority over other relatives (MHA, s. 26(4)). A person who is not a relative but with whom

application to displace the NR may be made to the county court by another relative or by an Approved Mental Health Professional (AMHP) and, subsequent to an amendment introduced by the MHA 2007, by the patient him or herself (MHA, s. 29(2)).

The NR plays an important gatekeeper role (Laing et al, 2018). S/he may initiate an application for admission for assessment or treatment (MHA, s. 11(1)) or request an AMHP to carry out an MHA assessment (MHA, s. 13(4)).[3] The latter will typically happen where the NR considers that community mental health services are not being sufficiently responsive to their relative's situation (Laing et al, 2018: 39). The NR may also object to an application for admission by the AMHP (MHA, s. 11(4)(a)).[4] Where this occurs, the only way an admission can proceed is through an application to the county court to have the NR removed. The NR also has a gatekeeper role around discharge. S/he may make an order to have the patient discharged from detention, guardianship or a community treatment order (CTO) (MHA, s. 23(2)). However, this power is restricted where the responsible clinician certifies that the patient, if discharged, would be likely to act in a manner dangerous to him or herself or to others (MHA, s. 25(1)).[5] Where this happens, the NR is prohibited from making another discharge order for a six-month period (MHA, s. 25(1)).

The NR is statutorily entitled to designated information, including the information about legal rights which must be provided to the patient (MHA, s. 132(4)).[6] S/he is also entitled to information about the patient's discharge (MHA, s. 133(1)).[7] This information may help a NR to support the person by identifying and explaining relevant information (although there is no express statutory linkage between the requirement to provide information and a requirement to provide support)(Keywood, 2010: 327). In respect of both statutory requirements, the patient may object to the information being shared and this objection prevents any sharing.

For its time, the NR framework was a considered and innovative response to relationality. However, as recognised by the Independent Review of the Mental Health Act 1983 (the Wessely Review), it is now 'outdated, variable and insufficient' (2018: 85). The most immediate problem is the imposition of a statutorily designated NR without meaningful patient involvement in the appointment. This was somewhat improved by an amendment allowing the patient to apply to court to have their nearest relative removed (MHA 1983, s. 29(4)(za) as ins by MHA 2007, s. 23).[8] However, as Kirsty Keywood identifies, court application is a 'rather weak advocacy tool', placing the onus on the already disadvantaged patient to instigate and follow through (Keywood, 2010: 328). The lack of choice has been identified as problematic by NRs who indicate that the responsibilities imposed by the role may

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the patient has been ordinarily residing for more than 5 years at the time of admission is treated as a relative, although they come last in the hierarchy and cannot be treated as the nearest relative of someone who is married or has a civil partner (MHA, s. 26(7)).

[3] In such circumstances, an assessment must be carried out and if the AMHP determines that an application for admission should not be made, they must inform the NR of the reasons for this in writing (MHA, s. 13(4)).

[4] So as to facilitate the exercise of this right, the AMHP must consult with the person appearing to be the NR where an AMHP proposes to make an application for admission unless it appears to the AMHP that the consultation is not reasonably practicable or would involve unreasonable delay (MHA, s. 11(4)(b)).

[5] In order to facilitate this, the NR must give 72 hours' notice in writing of his or her intention to order a discharge: MHA, s. 25(1).

[6] Under MHA, s. 132, the manager of the hospital must take such steps as are practicable to ensure that the patient understands: the provision of the MHA under which the person is detained and the effect of this provision and the tribunal rights that apply; and various of the other statutory protections which apply.

[7] If practicable, this must be given at least seven days prior to discharge: MHA, s. 133(1).

[8] This followed judicial recognition that the statutory framework as it stood was incompatible with the European Convention on Human Rights: *R(M) v Secretary of State for Health* (2003); *JT v United Kingdom* (2000).

sometimes be unwelcome and/or assumed only because of a sense of duty (Yeates, 2007; Dixon, 2022). There is a dearth of studies of patients' experiences of the NR framework and so there is limited data capturing patient views. However, it is highly likely that, for many patients, the NR is not the optimal person to provide support.

Looking beyond the lack of patient choice in appointment, various studies over an extended time-period identify systemic failures in the NR framework. NRs experience dissatisfaction and confusion around their role which in turn substantially impedes their capacity to support their family member (Yeates, 2007; Shaw et al, 2018; Dixon et al, 2022). Dixon et al identify both subjective and objective burdens experienced by NRs. Subjective burdens include experiences of 'distress, relief, of feeling conflicted and frustrated with mental health services and staff' (2022: 13-14). Objective burdens included NR's 'accounts that their concerns were ignored or minimised, that services failed to share information, and did not offer adequate support' (2022: 14).

Reforming the Traditional Model

The past decade has seen widespread mental health law reform. In part, this has been because of the impetus provided by the CRPD, although the movement for reform has also emerged from evident deficiencies in the operation of the traditional model (Donnelly, 2023). Perhaps the most obviously relevant reform for the discussion in this chapter is increased provision for individual choice of representative. The recommendations of the Wessely Review in England and Wales provide a useful example of this shift. The Review recommends replacing the NR by a 'Nominated Person' (NP) who is appointed (and may be removed) by the patient 'either prior to detention, at the point of assessment for detention or whilst detained' (2018: 85). The Review also recognises that not everyone will be able to identify an NP and so it also makes provision for a fallback Interim Nominated Person (INP), who is to be appointed by the AMHP in accordance with guidelines (to be developed) aimed at ensuring that the INP is the most suitable person for the role (2018: 86). Once the patient regains capacity, s/he may replace the INP (and any objecting family member may go to court to seek replacement) (2018: 86). The Review is also clear that a person with capacity should be able to use the nomination process to opt out of having either a NP or an INP (2018: 86).

Alongside better choice, the Wessely Review proposes enhanced status for the NP/INP. This includes expanding the scope of consultation with the NP to include an obligation to consult on transfers between hospitals and on care plans (the latter with the patient's consent) and a right to appeal clinical treatment decisions where the patient is unable to do so and where the NP/INP believes that the patient would not agree to the treatment or that the treatment is not in the patient's best interests (2018: 87). The latter recommendation reflects the Review's recognition that 'closest family and friends will often be an invaluable source of information about the patient's wishes and preferences, as well as what treatment does and does not work best for them' (2018: 97). The Review also proposes that a NP/INP who has been found to have inappropriately objected to admission should not be removed, but that the county court should be permitted to temporarily overrule the NP on this point alone while allowing them to continue to support the patient in all other ways (2018: 88). These recommendations are given effect in the Draft Mental Health Bill 2022 (EW) which is being progressed at the time of writing.

We are also seeing some jurisdictions buttress better choice through legislative provision for advance directives. These can operate alongside a nominated person model and can help reduce resort to coercion (Morrissey, 2022). In Ireland, for example, the Assisted Decision-Making

(Capacity) Act 2015 (ADMCA 2015) provides for advance healthcare directives (AHDs) which allow the directive-maker to make a legally enforceable treatment refusal (ADMCA, s. 84(2)) and to request treatment and to have this request taken into consideration if the treatment in question is relevant to the person's condition (ADMCA, s. 84(3)) (Donnelly, 2017). A notable feature of the ADMCA is that the directive-maker may appoint a designated healthcare representative (DHR) who is statutorily empowered to ensure that the person's AHD is complied with (ADMCA, s. 88(1)(a)). The directive-maker may also confer on the DHR the power to advise and interpret the directive-maker's will and preferences regarding treatment by reference to the AHD and/or to consent to or refuse treatment, up to and including life-sustaining treatment, based on the directive-maker's known will and preferences by reference to the AHD (ADMCA, s. 88(1)(b)). In some circumstances, the AHD remains operative even where a person has been involuntarily admitted under the Mental Health Act 2001 (ADMCA, s. 85(7) as am by Assisted Decision-Making (Capacity) (Amendment) Act 2022, s. 74).[9]

Mental health law reforms of the kind described above reflect the principles of relational autonomy. As well as enhancing personal choice, these reforms also increase the family's ability to advocate for their family member. By allowing the person to nominate and plan ahead, these reforms may also provide a way around some of the ethical dilemmas around confidentiality and information sharing which were identified above. The potential of these reforms is summarised by Margaret Sweeney, who has a diagnosis of paranoid schizophrenia and who plans to appoint her husband as her DHR:

> Having a vulnerability to psychosis makes me, at certain stages of my life, move from a position of capability, possibility and ability to a position of disability, dependency and mental confusion. This is why [the ADMCA] means so much to me. So that during those vulnerable periods of my life, my wishes are protected (Norton and Sweeney, 2022: 190).

Yet, it is also clear that these reforms will not address all of the challenges experienced by people with mental illness or the families who support them. A much broader and well-resourced system change is required if lack of early and ongoing support is to be tackled in a meaningful way (Laing 2021: 176). A broadly similar point may be made about AHDs. While potentially very beneficial for some people, a good deal of work needs to be done to facilitate uptake within an integrated and properly resourced care plan. It must also be recognised that AHDs are by no means a universal solution, especially for people experiencing serious mental illness for the first time, whose experience of involuntary admission may have a profound impact on their recovery, or for people whose lives are more chaotic. Ultimately, as Laing recognises, without a '[f]irm financial commitment to bolster the legal changes' we are unlikely to see the level of improvement which is needed to underpin law reform initiatives of the kind identified above (2021, 176). This then takes us to the last part of this chapter and the question of whether it is possible to use mental health law to create a better space for people with mental illness and their families.

Finding a Better Space?

[9] There are two grounds for involuntary admission under the Mental Health Act 2001: s. 3(1)(a) provides for admission on the basis that the person is at risk of harm to him or herself or to others while s. 3(1)(b) provides for admission on the basis that the person's capacity is impaired and that the admission is likely to be of therapeutic benefit. Where a person is admitted under s. 3(1)(b), his or her AHD continues to have legal force; however, this is not the case for those admitted under s. 3(1)(a).

An emerging theme in the scholarship of mental illness/distress is that new paradigms are needed which are better attuned to the realities of contemporary life (Rose, 2019; Rose and Rose, 2023). A similar argument may be made about mental health law, where variations on the traditional model have dominated for almost 150 years and are looking increasingly out-of-touch with modern needs. Laing rightly identifies that '[p]ositive rights and resources must be at the heart of successful mental health law reform if it is going to lead to any lasting and meaningful improvements for people with mental illness and their families' (2021: 176). This requires a paradigm shift. A recent attempt to articulate such a shift can be found in the Report of the Royal Commission into Victoria's Mental Health System (VRC Report, 2021) and the subsequent legislative measures introduced in Victoria. The VRC Report is rich and multi-faceted with many lessons for mental health law reform (McSherry, this vol; Donnelly, 2023). The discussion here focuses on the VRC Report's response to the role of families. However, to put these in context, a brief outline of the broader elements of the reform is needed.

The Royal Commission was appointed in 2019 with the aim (in the words of the then Victorian Premier) of fixing a 'broken system' (VRC Interim Report, 2019: 11). A distinguishing feature of the Royal Commission's work is that it was authorised to undertake a whole system review, with law reform being just one part of a much broader engagement. The Royal Commission published an Interim Report in 2019 and a final Report, which runs to five volumes, in February 2021. This sets out 65 recommendations intended to deliver 'transformational reform' (Executive Summary, 2021: 18 *et seq*). Drawing on the work of Braithwaite et al (2013), the Royal Commission adopted a systems approach to its analysis. In this, the Royal Commission recognised both the interdependency and the complexity of the mental health system. This means that system change cannot be achieved by simply directing the system to produce an outcome (e.g., through legislative reform). Instead, change can only be achieved by 'shifting the underlying conditions that hold the most influence over how the system, and those people within the system, operate' (Report Vol. 1: 58). Reflecting this approach, the Royal Commission focused on the identification of 'systems levers' (i.e. parts of a system 'where a seemingly small or discreet shift in one part of the system produces big changes across the system' (VRC Report Vol. 1: 77)).

One key systems lever identified by the Royal Commission was the introduction of a Mental Health and Wellbeing Act to shift the legislative focus away from compulsion towards the delivery of treatment and the enhancement of wellbeing (VRC Report Vol. 4: 35-6). Thus, the primary objective of the proposed Act was the delivery of the highest attainable standard of mental health (RC Report Vol. 4: 36-37). Another systems lever was the establishment of the Victorian Collaborative Centre for Mental Health and Wellbeing, based on models from cancer and cardiac care (McSherry, this vol). The Centre was to provide 'adult clinical and non-clinical services, emphasise the participation and inclusion of people with lived experience, and conduct interdisciplinary research' (VRC Interim Report: 392) with 'a mandate to influence mental health treatment, care and support across Victoria, with a view to changing some of the "deeper" characteristics of the system' (VRC Report Vol. 1: 77).

Families, carers and supporters played a central role in the Royal Commission's approach, which started from the premise that 'most people live within relationships of care and support' and that this should be 'the starting point for the design of the future mental health and wellbeing system' (VRC Report Vol 3: 72). In developing this analysis, the Royal Commission was careful to distinguish between the lived experience of families and carers and the lived experience of consumers[10] of mental health services (VRC Report Vol. 3: 74). It noted that '[w]hile at times these groups may have shared interests, they speak from their own perspective and experiences, and at times they may

[10] This reflects the terminology used in the Report.

have conflicting views' (VRC Report Vol. 3: 74). This was an important methodological choice by the Royal Commission and is reflected in the Commission's recommendations (Donnelly, 2023).

Many of the concerns raised by the families who gave evidence to the Royal Commission were similar to those identified in the studies discussed above, including lack of information and support around admission and an absence of options in crisis situations. However, given the system-wide scope of the review, the Royal Commission also elicited feedback about a broader range of issues, including lack of housing options for their family member; lack of opportunities for respite; and lack of information about broader support options (VRC Report Vol. 3: 80). The VRC Report also includes powerful personal testimony from families, including young carers, on the impact of their caring role on their lives and on their own health and wellbeing.[11]

The Royal Commission found that caring for someone living with a mental illness is different to other caring roles for a variety of reasons, including:

> [T]he need to provide higher degrees of emotional support; managing crises; maintaining vigilance to prevent self-harm or suicide attempts; having strained relationships; dealing with the unpredictable and episodic nature of caregiving; and stigma and isolation (VRC Report Vol. 3: 81).

On this basis, the Royal Commission concluded that families, carers and supporters need support in their own right and that the particular needs of young carers must be recognised (VRC Report Vol. 3: 81). Although the Royal Commission did not explicitly use a vulnerability analysis of the kind described above, this aspect of its work can be regarded as an attempt to address the 'derivative dependency' of family members.

In proposing solutions, the Royal Commission recommended that families should be much more closely involved in the operation of the mental health system. It identified the following three key strategies to achieve this:

- ensuring that working with families, carers and supporters is an essential part of the commissioning of mental health and wellbeing services
- improving information sharing with families, carers and supporters, including developing standards for services and practitioners
- introducing system-wide training for the mental health and wellbeing workforce to facilitate working with families, carers and supporters (VRC Report Vol. 3: 96).

While these strategies stretch well beyond what law can achieve, they also influence key aspects of the legal framework. Thus, the Royal Commission recommended that recognition and promotion of the value of families, carers and supporters should be one of the guiding principles underpinning the Mental Health and Wellbeing Act (VRC Report Vol. 4: 37). While underpinning principles are an increasingly common feature of mental health law, an explicit reference to families is unusual. The Royal Commission approach may also be distinguished from more traditional approaches because the legislative principles are scaffolded by an explicit requirement that the Victorian Department of Health and Victorian mental health and wellbeing services must make decisions in line with the Act's objectives (VRC Report Vol. 4: 37) and by the establishment of new enforcement bodies.

The explicit statutory recognition of the needs of families, carers and supporters is based on ethical principles which favour a more deeply relational approach. This choice needs to be viewed

[11] A notable feature of the Royal Commission's approach is its wide-ranging consultation and the inclusion of detailed personal testimonies (Donnelly, 2023).

alongside other elements of the VRC Report, especially the recommendations that the consumer of mental health services must be central in all aspects of mental health policy and service delivery and that active steps must be taken towards the removal of all forms of coercive and restrictive practices in mental health (VRC Report Vol. 4: 300-301). Thus, the Royal Commission has tried to respond to the needs of families while also retaining an essential focus on the individual.

It remains to be seen whether the ambitious recommendations of the Royal Commission will achieve their goals. However, there has already been some progress. The Collaborative Centre is now established, with both carers and people with mental illness represented on the Board.[12] A Mental Health and Wellbeing levy came into effect on 1 January 2022 providing a steady income stream (in addition to State funds) for delivering on the Royal Commission's recommendations.[13] Finally, the Mental Health and Wellbeing Act 2022 has received Royal Assent, although it has not yet come into force at the time of writing.

Conclusion

For most people, mental health and mental illness are experienced relationally, with all the positive and negative aspects that this brings. Strong family relationships can help maintain mental health, assist in recovery from mental illness and provide necessary support during difficult times. Yet, relationality can also have a dark side. Some family relationships can be difficult or distant or may come under unbearable strain in situations of mental illness. Adding to this, all relationships (good and bad) are lived against a backdrop of a mental health system which is frequently under-resourced, unwieldy and restricted in the range of available options.

Mental health law has the challenging task of finding the best way to respond to relationality. A review of the Nearest Relative framework suggests that traditional mental health law has not been very good at this task. The increased choice being introduced through recent law reform projects should certainly improve the situation. Allowing each person to nominate their chosen supporter/s and to use advance healthcare directives to direct their choices during an acute phase should offer substantial improvements for both people with mental illness and their family members. However, as argued here, these improvements will not be sufficient to address the deep and structural problems that families encounter in trying to support their family member. A paradigm shift is needed to a mental health system that better serves the diverse needs of people with mental illness and their families. In imagining what this might look like, this chapter has drawn on the work of the Royal Commission into the Victorian Mental Health System (2019; 2021). Here we see an approach which looks at law as just one part of a broader system. We also see a normative shift towards delivering the highest attainable standard of mental health and away from the coercive practices which have characterised the traditional model. In this model, families, carers and supporters are recognised as separate rights-holders, although the Royal Commission also showed a good deal of ingenuity in trying to find ways to ensure that family interests do not become dominant over those of the person living with mental illness.

It is too soon to evaluate how the choices made by the Royal Commission around the role of families, carers and supporters will work in practice. It is certainly too much to expect that the new

[12] Under the Victorian Collaborative Centre for Mental Health and Wellbeing Act 2021, s. 11(6), two members of the Board (out of a maximum of 10) must be persons who identify as caring for or supporting, or as having cared for or supported, a person with mental illness or psychological distress and two must be persons who identify as experiencing, or having experienced, mental or psychological distress.

[13] The levy is paid as payroll tax surcharge by employers with national payrolls of more than $10 million per annum.

frameworks can resolve all of the tensions that arise in this space. Nonetheless, the inclusion of family (alongside consumers of mental health services) in researching, planning and structuring the mental health system offers the potential for innovation and the development of fresh perspectives which can better meet the needs of people with mental illness and the families who care for them.

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