



**Anglia Ruskin
University**

Cambridge & Chelmsford

Reflections

on

'A Relative Affair'

**The Nearest Relative under the Mental Health Act
1983**

**A qualitative study conducted on a part-time basis at Anglia Polytechnic (now
Anglia Ruskin) University between 1995 and 2002**

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Written by Dr Joan Rapaport

In memory of William Bingley and Neil Foster who both in their different ways made incisive contributions to the nearest relative study.

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Joan Rapaport qualified as a social worker in 1967 and holds a Home Office Letter of Recognition. She worked as a Child Care Officer for several years and later managed a team of generic social workers. Whilst bringing up her children, Joan was actively involved in a local MIND association and worked alongside service users, carers and other volunteers to develop community projects such as a drop-in centre and befriending scheme. This work deepened her understanding of service user and carer experiences of mental health services and marked her transition from child care to mental health interests.

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Introduction

To enhance their practice, social workers are exhorted to engage in critical reflection, of which there are many confusing strands (D’Cruz *et al*, 2007). However, so far official attempts to encourage practitioners to undertake research have been at best light touch. This is disappointing given the opportunities to contribute to professional knowledge, policy and practice that derive from research and its potential to broaden minds, deepen understanding and pave the way for innovation and new developments. The Professional Capabilities Framework (PCF) developed by the Social Work Reform Board and adopted by the College of Social Work has identified ‘research’ as a core activity in its ninth domain, albeit for advanced practitioners, in recognition of its importance in personal professional development and the profession as a whole. This is a welcome and arguably long overdue development.

Whilst the ‘rapid academisation of social work education’ in the EU has facilitated an increase in research activities in schools of social work, ‘some critical social workers’ contend that ‘real’ practice has suffered because of other funding priorities (Zavirsek, 2009; 220). As a highly under-researched discipline over the last couple of decades, this concern points to a practice vacuum and a pressing need to explore accessible modest research options to develop the theoretical foundations on which social work is based. However, on a positive note, certain research methods (almost inevitably qualitative) and social work practice can sometimes be very similar (Atkinson, 2005) and where successfully combined, may be relatively economical to implement. As one example, ‘Action Research’ is founded on a relationship in which all those involved are participants in the process of change (Bond and Hart, 1995) and readily lends itself to social work practice. Winter and Munn-Gidding (2000) also highlight that it is a strategy for inquiry and development closely linked to practice which can be undertaken by both practitioners and service users. Its characteristics of being educative, accessible to individuals and groups, problem-focused, bent on improvements and based on a cyclical process in which research, action and interaction are interlinked (Bond and Hart, 1995), if faithfully implemented, pulsate the social work ideal of user empowerment.

As an example of another approach, Winter *et al* (1999; 180) lament the ‘strange’ absence of creative imagination in professional education and point to the potential of drawing on participants’ artistic and imaginative processes by way of story-telling, to enhance the power and subtlety of thinking and expression. In this approach fiction and fantasy have an important place in deepening understanding of people’s formative experiences and inner worlds, which inevitably impact on behaviour. As an added bonus, it has the potential to shape and sharpen creative writing skills in approaches where literary rather than scientific style may better evoke the experiences of the research participants and even be a vital part of a particular research method (such as ‘constructivist grounded theory’, Charmaz, 2000; 2001). However, social workers have long been required to be creative in their practice. Imagination is no less important in research where new approaches may need to be devised to explore the experiences and circumstances of service users with diverse complex needs. Significantly, qualitative research is an area that continues to develop and social care researchers are fortunate in having access to a wide range of qualitative methodologies from which to choose (Moriarty, 2011). The examples above but also others, provide scope for innovation and opportunities to devise techniques customised to the needs of particular client groups which social

workers, by dint of their training and experience, are arguably well equipped to do. However, this said, social work research should also research social workers and not only clients.

For pragmatic reasons I have boldly assumed that certain qualitative rather than quantitative methods are the most likely point of first entry for social workers into the research arena. However, the two are often used in complementary ways and should not be seen as diametrically opposed or as one better than the other. It is simply that some qualitative research and also methods, such as interviewing and running groups, are particularly close to social work practice. This suggests that with just a little tweaking, social workers should be able to contemplate engaging in research activity to advance the professional base and their own practice development. The task is urgent as social work perspectives need greater prominence. With the advent of the College of Social Work and the Professional Capabilities Framework it is therefore to be hoped that greater numbers of social workers than before will seek higher degrees, not only for the academic accolade but also expressly 'to better understand the context under which they practice' (Malcolm, 2009;5) and to assert with confidence, the social insights on which their work is based.

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Before you go further, a few words of advice! If contemplating undertaking research, do contrive to ensure that the topic overlaps with your work. This will not only save you time and some expense but may also encourage your employers to help finance all or part of your studies. Do make sure that your life is on a steady course and all is well with your nearest and dearest. It is not a good idea to embark on a major study if moving house or going through a divorce or separation. I think it is ill advised to take on such a big undertaking if having a baby or even twins, although this apparently does not hold for all! These are all major life stressors and you will be unlikely to perform your best at such times. If a PhD or Masters seems like a huge step, why not do some initial revving up by, for example, investigating the possibility of carrying out exploratory surveys or audits on particular issues of interest? This is exactly what I did before I embarked on my PhD, although at the time I had no idea of where I was heading! There was no cost involved apart from my time and that of those who responded with such enthusiasm. Alternatively, you may find a role in a local Action Research project, or perhaps you could initiate interest in developing one? Finally, if you are a newly retired social worker with time on your hands, why not try your hand at researching an issue you feel passionate about? Your experiences and learnt lessons are valuable and should be put to good use. As has been said and oft variously quoted:

'Those who fail to learn from history are doomed to repeat it' (Winston Churchill); 'History repeats itself, the first time as tragedy, the second as farce' (Karl Marx): provided by Don Brand in an email dated 19.4.12.

PROLOGUE: *Author's motivation*

In 1995 I embarked on my PhD studies, initially at the LSE and subsequently transferred to Anglia Polytechnic University (now Anglia Ruskin University) where my principal supervisor had obtained a professorship. However, my interest in the chosen topic, the 'nearest relative' under the Mental Health Act 1983 of England and Wales, had started about five years earlier when I encountered a detained patient in a long stay hospital who had no relatives or friends outside the institution. He had been born illegitimate during World War II and had been brought up in a series of children's homes. On leaving local authority care he had joined the Army but had been discharged soon afterwards for committing an offence. He was admitted to a psychiatric hospital soon afterwards where he had remained as a long stay patient. When I became involved in his care, I was concerned about his extreme isolation. Unsurprisingly, given his personal history, the patient had problems forming trusting relationships. Events were to demonstrate that it was not possible to link him to befrienders or advocates, as close nearest relative equivalents, which my managers had wanted me to do.

The nearest relative is officially identified as a patient safeguard (DHSS, 1976; DH, 1999) and as such potentially has influential powers governing a close relative's detention in hospital. The designation is identified from a hierarchy of relatives similar, though not identical, to that of the laws of inheritance. An accompanying set of ground rules exist to ensure that the relative closest to the patient by virtue of 'kindred and affinity' (N.K.H., 1959; Hewitt, 2007) is identified to carry the functions of the nearest relative role. Where a detained patient appears to be without any of the legally eligible relatives, the local authority has discretionary powers to apply to the court to appoint an 'acting nearest relative' (now, since the Mental Health Act 2007, patients have similar powers). It was my view that the appointment of an acting nearest relative would have been appropriate in the case of the patient I was supervising as it would, at the very least, have provided him with an official safeguard. However, support from senior managers and the local authority legal department was required before any such action could be taken. After eighteen months of abortive attempts to engage both legal and policy officials in discussion, I was no further forward. It was clear to me that no one in the departmental hierarchy had any interest in even considering the factors relating to the particular case.

My frustrations were contained a little when I chose the nearest relative as the topic for my Approved Social Work (ASW) course undertaken between 1991 and 1992. I carried out a brief survey of all the psychiatric hospitals in England and Wales to find out whether any patients existed elsewhere who were isolated and had no identified nearest relative. I was surprised by the commitment and interest of many hospitals in my enquiry and the concern that many Mental Health Act administrators felt about such patients. As a result of this survey, I discovered that there were small but not insignificant numbers of patients who had no identified nearest relative and that a sizeable proportion fell into the younger age brackets. This finding fuelled my interest in pursuing the topic further, although the focus of my PhD research was to take a very different turn because of more burning ethical issues of the day.

Purpose of this script

Using the nearest relative study as an example, the purpose of this paper is to promote the interest of social workers in undertaking research and to support the argument that research methods and social work practice can sometimes be very similar. A prime objective is to demonstrate that research is an essential tool not only to promote policy and practice but also to empower social workers to engage in debate and consultations about matters that are of central importance to their role. The nearest relative study comprised historical and contemporary parts. The underpinning philosophical, theoretical and methodological elements of the nearest relative study will be briefly described with an emphasis on the contemporary section. Reference will be made to the historical section and nearest relative functions in outline to provide sufficient context to help orientate the reader. However, readers should note the importance of the historical perspective in providing continuity and reciprocal links with the past, and understanding historical and contemporary realities (Braudel, 1980).

This piece provides an overview of a small qualitative study about a social work topic and is an example of what can be achieved. Given the centrality of **role theory** to this research, it is arguably of particular relevance to social work at a time when the profession is struggling to regain recognition, in spite of its recent recognition in law and advent of the College of Social Work. Warnings have long been sounded regarding the diminution of social work in adult and mental health services in the United Kingdom because of trends to employ less qualified workers in their place (MHAC, 1995; Dawson, 2012). Given these competing, but perhaps sometimes also complementary forces, the need for social workers to evidence the benefits of their role and interventions in comparison with those of others, must surely be a timely imperative.

A *glossary of terms* used in this study is provided to help readers with the theoretical and methodological sections which may otherwise deter those who are, as yet, unfamiliar with research language and phraseology. It may be of comfort to some to know that the author started from a very humble academic base. The sections may be read out of turn if this allows for an easier introduction to the overview of theoretical and research aspects. Indeed, I would advise newcomers to research to read '**Social Work Imperatives**' under '**Comments and Conclusion**' first to help demystify the intricacies of the analytic and data collection processes. As much understanding develops in the course of active engagement, readers should not feel discouraged if they do not fully understand the research sections. Once again, with the intention of helping readers familiarise themselves with the process, the PhD format has been broadly followed. However, if I have fallen short in my endeavours, would-be students should take heart that acquiring a sense of what is involved plus commitment and perseverance will carry them a long way.

Readers seeking a wider range of explanations and examples of qualitative studies are referred to (Malcolm, 2009) and Moriarty, 2011).

Which Mental Health Act?

It is important to note that since the period of study, the Mental Health Act 1983 in England and Wales has been amended by the Mental Health Act 2007 (the 2007 Act) and the nearest relative (having narrowly survived the reform) has undergone some long overdue and necessary changes (described in Hewitt, 2007). The social work role, with which the nearest relative is historically deeply intertwined, has also experienced change. The Approved Social Worker (ASW) which was introduced under the 1983 Act has been replaced by the Approved Mental Health Professional (AMHP), a qualified mental health professional who may not necessarily be a social worker. This position contrasts with that of Scotland where, under the Mental Health (Care and Treatment) (Scotland) Act 2003, the social work role of Mental Health Officer has been retained but the nearest relative replaced by the roles of 'named person', appointed by the patient, and 'carer'. The nearest relative hierarchy now only features in a default capacity if the patient has been unable to choose his or her named person. However, of significance to the reader, the focus of study is on the Mental Health Act 1983 in England and Wales prior to the amendments of the 2007 Act. Steps towards legislative reform were only in their early stages during the latter part of the period of research.

THE NEAREST RELATIVE

Overview of socio-political scene

The role of relatives in mental health has deep roots and springs naturally from family ties and propinquity. Their role first appeared as a formalised legal entity under the Madhouses Act 1774 and was later further developed under lunacy legislation from which the nearest relative was crafted. The designation's evolution, development and implementation have been influenced by socio-political trends. The Percy Commission (1958) and associated reformers were clearly guided by the principles of 'kindred and affinity' and safeguarding when devising the role. Paternalism prevailed. Patients (the term of the day) were not consulted about the new initiative, even though they would be those most directly affected by its use or abuse. During the ensuing decades, with the contraction and eventual closure of the large asylums, community care policies and localised service re-provision, though somewhat patchily, gathered momentum. Whilst progress was unfortunately marred by sensational media coverage of a small number of psychiatric homicides, community care trends continued. Lay advocacy, service user empowerment and patient autonomy became buzzwords and outwardly at least (Basset, 2000; Ramon, 2000), held as socially desirable. Given the fixed nature of the nearest relative, by the 1990s, absence of patient choice regarding the identity of the nearest relative was at odds with socio-political trends and longstanding principles of beneficence (do good) and nonmalificence (do no harm), fundamental to healthcare ethics.

Role and functions

The nearest relative is defined under Section 26 of the Mental Health Act 1983 to influence the hospital compulsion of a close relative or other identified person. The legal hierarchy of relatives is as follows:

Husband or wife

Son or Daughter

Father or Mother

Brother or Sister

Grandparent

Grandchild

Uncle or Aunt

Nephew or Niece

A person who has been living with the patient for five years or more (introduced in 1983)

The highest relative in the hierarchy who has reached the age of majority (eighteen) is in most cases the identified relative. However, additional rules also apply. As but a few examples, where the patient has been residing with or is cared for by one of the above relatives, that relative jumps to the top of the list and is appropriately identified as the nearest relative. 'Husband or wife' includes cohabiting relationships of six months and over. Relationships of the 'whole' blood take precedence over those of the 'half' blood. Divorce and permanent separation end the nearest relative connection.

A nearest relative has several discretionary rights and powers. The main ones are:

- To ask the local authority to send an Approved Social Worker (ASW, now since the 2007 Act the Approved Mental Health Professional (AMHP)) to carry out an assessment of the patient with a view to hospital admission (S 13(4));
- To make an application for the patient's compulsory admission or reception into guardianship (a community provision);
- To object to a section for treatment (Section 3) being made;
- To seek to discharge the patient from hospital;
- Since the introduction of the Carers Act 2005, if also the patient's main carer, the right to ask for an assessment of his or her own needs to enable him or her to continue to provide care.

These are august powers for a lay role. However, the nearest relative is under no obligation to act. Furthermore, the nearest relative does not have unfettered rights. For example, the application for admission, unless an emergency, must be accompanied by two medical recommendations. If it is deemed that a nearest relative 'unreasonably objects' to the patient's hospital admission or guardianship, an application can be made to the county court (usually instigated by the ASW, now AMHP) to displace him or her from the role (29(3)(c)). The patient's doctor may take action to prevent the nearest relative from seeking discharge from section where the relative has acted

without due regard for the patient's welfare or public interests (S29(3)(d)). However, although 'useful' (HC 1981 – 1982; C293) statistics on nearest relative activity were and apparently never have been collected, official reports (HL 426; DHSS, 1976) suggest that by the mid-1970s most applications for compulsory admission were made by the Mental Welfare Officer (the forerunner of the ASW and now, AMHP).

The Mental Health Act 1983 confirmed the preference for the social work applicant and introduced the role of the ASW, who was to be specially trained in mental health and the operation of the Act. Significant to the study, as illustrated by the pre-Act debates and documentation in which the British Association of Social Workers (BASW) played a prominent part, the newly instituted nearest relative power to ask social services for an assessment (Section 13(4)), instead of, as was customary, the patient's doctor, intentionally boosted the roles of both ASW and nearest relative. This diversion potentially enabled the social worker to carry out an early social assessment of the patient's circumstances, before the problems had been medically determined, to ascertain whether or not viable alternatives to hospital could be provided. This was a time when theories to enhance the social recognition of people using services, such as normalisation and social role valorisation (SRV), were in the air and the lay advocacy movement was starting to take shape. The nearest relative's advocacy (HC 562: 1696-7) and guardianship (Percy Commission, 1958) potential had already been identified in the pre-1959 Act debates.

The nearest relative powers were drawn from a range of lunacy legislation and first introduced under the Mental Health Act 1959. Since its inception there have been concerns about the potential for the role to fall in the wrong hands (HC 698; 736). Although criteria for displacement were instituted, they focused on the ability of the nearest relative to carry out legal functions and disregarded the quality of the relationship. They were thus generally considered to be notoriously weak especially where abuse was known or suspected. Given their legal duties, ASWs had first-hand experience of problems with the role which were reported to the erstwhile Mental Health Act Commission (MHAC) in its capacity to oversee the operation of the Act (the MHAC was abolished in 2009 when its functions were transferred to the Care Quality Commission (CQC)). Recommendations to change the displacement criteria to allow inappropriate relatives to be removed (MHAC, 1991; 11.3 (d)) were ignored by government. It was not until two cases, involving sexual abuse of both patients by family members, taken to the European Court of Human Rights (ECHR) (JT v UK (1997) and FC v UK (1999)) that the nearest relative role was found to breach of Article 8 of the European Convention on Human Rights (right to private and family life) and the government finally conceded the case for change within the context of Mental Health Act reform.

Although the Mental Health Act 1983 promoted the ASW's role to conduct an early social assessment, the nearest relative's power to request an assessment under S 13(4) was not publicised. Fears on the part of local authorities of misuse and abuse of the power are insinuated (Barnes et al, 1990). Unsurprisingly, evidence suggests that S 13(4), as with the other powers, was little used as relatives generally do not know their rights (Hart, 1998; Gregor, 1999; Rapaport, 2002). This suggests that most relatives continue to approach the patient's doctor and the concept of the early social assessment has lost ground. However, contrary to the above negative perceptions, Johnstone et al (1984) and Jones (2001) found that relatives rarely wanted their family member to return to hospital and only seek this recourse as a last resort. Indeed, the MHAC, in its eighth biennial report (MHAC;

1999), found that in one area nearest relatives were using their powers to object to detention for treatment because they were so appalled by the hospital environment. Yet bad news travels further than good and during its lifetime there is little evidence of any positive recognition of the value of the role or attempts to publicise its functions. By the late 1980s, an advice worker employed by the National Schizophrenia Fellowship ('NSF', now Rethink) had produced a pro forma letter for carers, who were concerned about a close relative who appeared to be mentally ill, to send to their respective local authorities to request an assessment under S 13(4). This arguably highlights the absence of available nearest relative information at national level.

By 1995, when the PhD commenced, the legal designation of nearest relative was forty-six years old. It had existed during a period of great change including the closure of the Victorian asylums, the focus on community care and a growing emphasis on professionalism and policies promoting social inclusion and patient autonomy. There had been many changes in family structures with implications for the nearest relative hierarchy. Divorce was more prevalent and many people were choosing to live in partnerships rather than marriage. There was greater social acceptance of same-sex relationships, as later confirmed by the Civil Partnerships Act 2004. Britain had become a multi-cultural society. The nearest relative hierarchy did not always accommodate the family traditions of some black and ethnic minority groups (Rapaport, 2002). Furthermore, the designation had been found to be in breach of Article 8 of the European Convention on Human Rights. Even so, it was still important in the eyes of the law and ASWs ignored their nearest relative duties at their peril (see for example *S-C (Mental Health Patient: Habeas Corpus)* [1996] 2 WLR 146; [1996] All ER 532; *R v Liverpool City Council ex parte F*; *Queen's Bench Division* 16.4.97; [Legal Action] Jan 1998).

The carer position

Whilst Twigg (1994; 295) identifies an 'encoded right' to certain information contained within the nearest relative powers, carers in mental health, by virtue of S26(4) often also nearest relatives occupy a difficult position. Although they are an important mainstay of community care, research suggests that many feel marginalised by services and have not received their carer entitlements (Rethink, 2003). Beliefs about the cases of mental illness are complex. Research evidence suggests that multiple social and physical factors are at play (Chua and McKenna, 1995; Wickham and Murray, 1997). However, theories such as those introduced by the 'anti-psychiatry' movement, implicating family dysfunction in the aetiology of schizophrenia, have lingered and cast a shadow over the carer role (Rapaport, 2005,a). Although *Untold Stories* was published after the completion of the PhD, Alan Bennett's perspective is here included as he describes the common carer plight so eloquently, in a nutshell:

'I was always nervous of discussing anything but the matter in hand with my mother's various psychotherapists for fear they were taking notes on me too, and that whatever I said, however, lightly, would be taken down and held in evidence against me; I was part of the equation'. (Bennett, 2005; 107).

However, changes in generic carer policy and legislation, such as the Carers Act 1995, have arguably benefited mental health carers and there has been a general shift of emphasis from relatives to carers in respect of entitlements, although identified needs are not always met (Rethink, 2003). An amendment to the Mental Health Act 1983 (Mental Health (Patients in the Community) Act 1995), driven by public safety concerns, introduced supervised discharge and community treatment. In

respect of supervised discharge, there was no nearest relative power to make the application. The ASW was also relegated to the role of making a recommendation for supervised discharge, the role of applicant here being given to a medical practitioner. These changes, together with the unpopularity surrounding the nearest relative role, because of the potential for vested interest and abuse, suggested that the designation was possibly under threat. Co-incidentally, the social work role was also experiencing erosion in respect of professional autonomy through fragmentation into many other occupations (Zavirsek, 2009). The ASW was similarly affected by the advent of new roles such as case management, lay advocacy and community psychiatric nursing.

In spite of burgeoning developments affecting the nearest relative and its importance to families, carers and service users, the literature and evidence base surrounding the role at and near the start of the study, was meagre. Whilst small scale studies suggested that the powers were very occasionally used (Cantley and O'Donovan, 1987; Carter, 1999; Rapaport, 2000), one identified the nearest relative as an 'Overlooked Stakeholder' (Gregor, 1999, title page). Given the general absence of information about how the role was being used and stakeholder views about its value and functions, the case for research was compelling.

CONCEPTUAL MAP

The nearest relative research is about a legally enhanced designation that interacts with the roles of professionals (especially social work) carers and service users. Thus the study's conceptual framework is based on theories and their 'nearest relative' methodologies, introduced and also portrayed in *Illustration 2* below, concerning **role** and **social interaction**. As an example of *ethnographic* research it focuses on the scientific description of ethnicity and cultures of mankind. *Ethnomethodology* is a theoretical model closely related to social interactionism and aims to make sense of things and events that occur in the course of social interaction.

The main overarching concepts relevant to this study are **social interactionism** and **social role valorisation ('SRV')**. **Structural functionalism** is also significant because of its contribution to role theory and its relationship with social interactionism. The legal designation of nearest relative was conceived during the era of modernism and beliefs in standard theories of evolution and reason. However, it has mostly existed in the period of post-modernism and influences of *relativism*, fragmentation and chaos (Cheal, 1991). Functionalism is aligned with modernism whilst interactionism, although not post-modern, allows for more relativity than structural functionalism.

Talcott Parsons' (1902 – 1979) theories of social structure argued that all societies must have systems to make them work (Parsons, 1951). Micro-processes, such as family interaction, must be conceived in relation to the macro structure. The family was conceived as performing necessary and universal functions and producing functioning people. Merton's structural functionalism introduces the notions of family dysfunction (Merton, 1957) and role deviancy where, in capitalist society, the legitimate road to success was blocked (*ibid*, 1968). Both theories, although critiqued, in particular by feminists for their negative perception of role difference, continue to influence macro-sociology. However, more specifically, they devalue the caring role because the carer (often also the nearest relative) is looking after and is associated with, a deviant family member whose condition is seen as

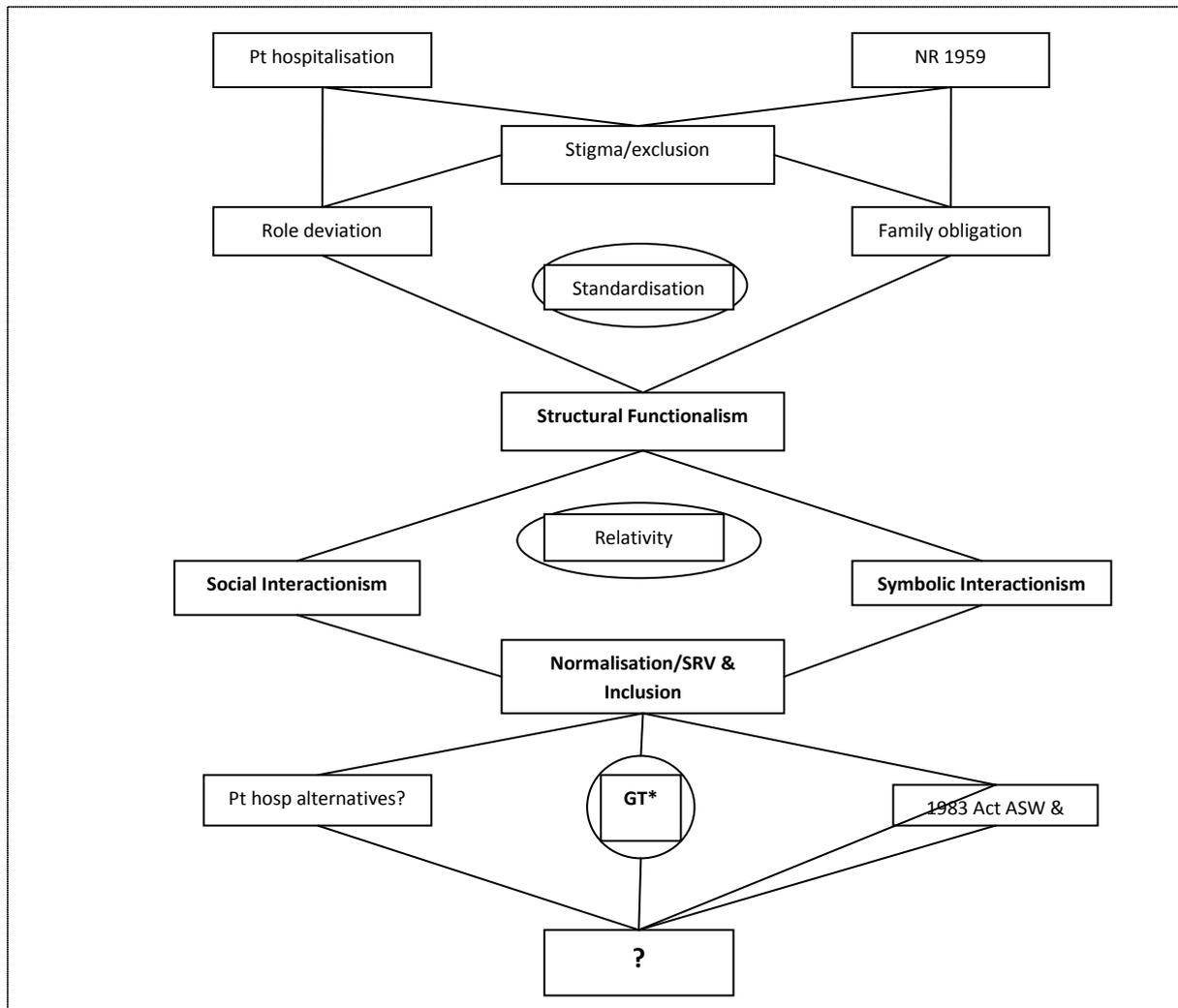
a response to failing to achieve social norms through the usual means ('courtesy stigma' Birenbaum, 1992; 265).

Interactionist theories hold more promise for the carer role because they suggest that in the course of necessary human interaction people come to appreciate one another. **Symbolic interactionism** evolved out of functionalism, social psychology and anthropology. It is part of the conceptual base of **Grounded Theory** methodology, a methodology frequently used in interactionist research to examine subjective and inter-subjective experiences, and **normalisation** and '**SRV**' theories. **Symbolic interactionism** asserts that people live in a symbolic environment as well as a physical one and that they act in response to symbols in addition to physical stimuli (Jacob, 1987). Symbols are represented in the language and actions of others. Any research that focuses on people's perceptions of their worlds or realities must seek to understand what they and those with whom they interact, think and feel.

Normalisation (Nirje, 1969) and its later '**SRV**' version promulgated by Wolfensberger (1983), developed in response to labelling theories which developed out of concepts of role deviancy. Normalisation and SRV principles hold that professionals should strive to prevent individuals from being cast in negative roles which cause them to live up to the expectations associated with such roles. Professionals are exhorted to *overcompensate* to minimise the devaluing effects of stigma and to establish social identities for people that are culturally valued and not just tolerated. Normalisation and SRV are extensively associated with the de-institutionalisation of people with mental health problems and learning disability. Whilst the theories have been criticised for failures to address issues relating to class, ethnicity and gender (Ramon, 1991) and to break the hold that advantaged groups have on defining what is and what is not valued (Brown and Smith, 1992), their role enhancing potential is arguably visible in the nearest relative functions. Although evidence suggests that carers often feel marginalised (Rapaport, 2005), nearest relatives are in theory at least, unusually empowered carers. Their rights *overcompensate* for an otherwise disadvantaged position to help improve self-image, the images others have of them and raise their level of functioning and as such, strongly suggest SRV influence.

A reciprocal dynamic lies at the heart of nearest relative and ASW interaction and role holders should feel able to approach the ASW for advice and guidance regarding use of their functions. Ramon (1991; 10) posits that 'SRV can become a meaningful process only if it is reciprocal'. This suggests that the seeds of a theory to explain reciprocal role enhancement, which was to become the integrating core category underpinning the positive potential of the nearest relative, had been identified some time before the research began. However, the connection between SRV and the value of the overcompensated position of the nearest relative and relationship with the ASW had not at this stage been made. Yet reciprocal role enhancement, or in SRV-speak, Reciprocal Role Valorisation (RRV), has the potential to enable the nearest relative and the ASW to work together to seek normative options most suited to the patient's lifestyle and to enhance his or her recovery. Given the potential of the nearest relative, it is curious that the powers are apparently so seldom used or extolled. This puzzle and what the role signifies to carers, service users and ASWs was what the nearest relative research set out to discover.

Illustration 1 – overview of conceptual map



*Grounded Theory

Grounded Theory is described below under **Methods for Data Analysis**. The development of the coding frame and steps leading up to the identification of an overarching theory to validate the nearest relative role are explained, with illustrations, under **Conducting the analysis** also below.

THE RESEARCH

This section provides an overview of the contemporary element of the research, the *research design*, the basic plan of the study and logic underpinning the chosen methodology, and methods used for data generation, collection and analysis. The practical aspects of the research namely collecting data and the conducting the analysis are more comprehensively covered on the basis that social workers may recognise, with reference to this particular study, that they use research-type skills in some of their everyday work. This includes, in respect of data collection, arranging and carrying out interviews and an accredited and systematic way of analysing data.

The research questions

The research questions were pitched to reflect the historical and political contexts of the nearest relative and to explore the views of the main stakeholders, carers, service users and ASWs about its current and future potential, specifically:

Historical element:

- 1) What are the historical origins of the nearest relative functions and how was the role conceived?

Contemporary element:

- 2) What are the current conceptual and ethical issues surrounding the role and its operation?
- 3) What do relatives and service users know and understand of the powers and what impact does the role have on their lives?
- 4) How are the rights and powers assigned to the nearest relative currently being exercised and what helps and hinders their practical implantation?
- 5) What are the actions, interactions and relationships between the main stakeholder parties?
- 6) Are the rights and powers appropriate in view of community care developments and social change and are there any recommendations for reform?

Philosophy and Methodology

At a very general level, the main choice of research *paradigm* rests between the *ontological* positions of *positivism* and *anti-positivism* and their opposing claims about the basis of existence. Each paradigm follows distinctive philosophies, methodologies and methods. It is sufficient here to state that in its practical application, the experimental method of **positivism** is based on the notion of the controlled static *variable*, theory testing and a *deductive* approach and is typically aligned with quantitative methodologies. By way of contrast, **anti-positivism** recognises the importance of subjective experiences and the different realities of the human mind. It is based on *hermeneutics*, which involves the study of meanings, interpretation and understanding of human behaviour, and relativism defined by Hammersley (1992) as treating truth in relation to a cultural framework or what people within a particular framework hold to be true. One of the responses to positivism in social science research is **interpretative** research. This aims to find the meanings which influence people's lives and to build or develop theory. Data analysis is guided by an *inductive* approach.

The main factors to be taken into account when choosing the most suitable paradigm were:

- The nearest relative was an under-researched topic and its literature base was meagre;
- The issues under investigation involved feelings, experiences and attitudes of individuals located in three distinctive stakeholder groups *viz.* service user/patient; carer; social worker (ASW);

- The focus on stakeholder interaction when the MHA pertained;
- The likelihood that carers and service users would need to be informed about the nearest relative role and helped to participate in focused discussion;
- The sensitive nature of the enquiry, given that it touched on human relationships at the critical and stressful time of assessment for compulsion and/or hospital admission.

The above factors determined that the nearest relative study was clearly suited to interpretative and qualitative research. There was no theory to prove or disprove. Quantitative methods, essentially statistical and survey-based, would have discouraged stakeholder participation, especially given the likely low knowledge-base of carers and service users about the nearest relative, and thwarted objectives to explore the meanings stakeholders attributed to the role and how these influenced their actions. Qualitative studies have a few downsides. They are small and labour intensive. Because of their size their results cannot be widely generalised. However, they are recognised as providing in-depth information and are also frequently used to complement large scale surveys, for example, to investigate an outcome which is beyond the limits of quantitative approaches and requires further exploration.

Factors to be considered in choice of methods: reliability and validity

Reliability, the accuracy and consistency of the methods used and *validity*, the trustworthiness of the data analysis, are of central tenets of scientific rigour, which Lincoln and Guba (1985) assert must be clearly demonstrated. A conceptual framework promulgated by Yin (1994) and used in this study, identifies four overarching logical tests to evaluate a research design. These are:

Construct validity: establishing the correct methods for the concepts being studied;

External validity: establishing the domain to which the study's findings can be generalised;

Internal validity: establishing certain causal conditions whereby certain conditions are shown to lead to other conditions;

Reliability: demonstrating that the research methods such as data collection can be repeated with similar results.

With above principles in mind, Grounded Theory and the Case Study approach, both widely used in social science research (Moriarty, 2011) were selected for the purposes of data analysis and focus group interviews for data collection. As an important consideration, Mason (1996) suggests that by combining *cross-sectional analysis* (the application of a consistent indexing/coding system across a whole data set) and *non-cross-sectional analysis* (examination of discrete elements/units/cases of the data set) confidence in research validity is strengthened. In addition, in respect of bolstering reliability, a well established armoury of processes exists in qualitative research. Social workers will be familiar with techniques such as audio recording, clear documentation of events and pre-testing interview schedules, as notable examples used in the nearest relative study.

Methods for Data Analysis

Grounded Theory

Grounded Theory is both a theory and a method. It was developed by Glaser and Strauss (1967) and inspired by phenomenological philosophy which seeks to explain the essence of intersubjective human experiences (Tesch, 1990). The methodology subscribes to the principles of social interaction and is closely related to the phenomenological approaches of ethnomethodology and symbolic interactionism. Its focus is to allow a particular phenomenon to speak for (represent) itself and is an example of the theory comes last approach i.e. theory building as opposed to theory testing. It is typically used in research studying personal experiences and how these are interpreted by the people involved and human interactions and interrelationships.

Emergent strands

Since its introduction, there have been a number of theoretical and methodological debates and developments regarding grounded theory, particularly in the aftermath an acrimonious rift between Glaser and Strauss (Moriarty, 2011). Mills *et al*, (2006) identify three strands: 'traditional', 'evolved', where this study is most closely located, and 'constructivist'. Glaser's traditional stance posits that researchers should enter the field of inquiry with as few predetermined thoughts as possible to ensure data are uncontaminated by pre-existing hypotheses and biases, and truly representative of a 'real' reality (Glaser, 1978). Conversely, Strauss and Corbin (1994) of the evolved school are aligned with the relativist position which denies the existence of an objective reality in favour of multiple individual realities, embedded in and influenced by historical and situational contexts. Thus data derived from texts (used in the historical element), notes from observations and observational studies and transcripts of group or one to one interviews are utilised. Whilst the existence of bias is acknowledged, the importance of maintaining objectivity and a distanced expert position from the participants and data is emphasised. Charmaz, a student of Glaser and Strauss, described as the leading proponent of constructivist grounded theory (Mills *et al*, 2006), reaffirms the relativist approach (Moriarty, 2011). The underlying assumption here is that the interaction between the researcher and participants produces the data. Thus the researcher is part of the research endeavour rather than a distanced objective observer. He or she provides a co-construction of meaning which may be enhanced by entertaining use of a literary writing style to illustrate participants' experiences (Charmaz, 2001).

In a nutshell, the main difference between the traditional and later evolved and constructivist schools is the appropriateness or otherwise of incorporating context and between the constructivist approach and its predecessors, the position of the researcher in the research process. However, the story does not end here and will doubtless continue to run. For further reading please refer to Mason (1996), Mills *et al*, 2006) and Moriarty (2011).

Characteristics and process

Grounded theory is an example of cross-sectional analysis, described above. Essentially, the method involves the development of a hierarchy of codes or categories identified in the text or transcripts, usually with the assistance of specially designed software (typically N-VIVO). The coding process

should be seen as a series of little steps leading up to the discovery of an overarching and integrating core theory. Each step is informed by increasing levels of *theoretical sampling* and the *theoretical sensitivity* of the researcher to drive and guide the thinking analysis. These require the use of *inductive* and also *deductive* processes (more typically associated with *quantitative* approaches!) to generate and test hypotheses (in practical terms, especially in the early stages, often hunches based on the researcher's observations) derived from the data. Like all approaches, Grounded Theory has its critics. In its defence, the constant examination and re-examination of the data which connects the data collection, analysis and theory development are credited with enhancing scientific rigour (Strauss and Corbin, 1990). As its name suggests, the discovered core theory which finally emerges is intrinsically grounded in the data.

The main coding 'steps', are as follows:

Open sampling and *open coding* usually take place during the early stages of the analysis. This stage involves the process of identifying and selecting sections (large or small) of text for examining, comparing, conceptualising and categorising the data. The open codes are grouped and linked to conceptual categories for further analysis. For example, you might identify sections of text which demonstrate 1) 'happiness', 'sadness' or 'fear', 2) 'mothering', 'fathering' and 3) 'chip on the shoulder', 'harshness'. These you would be likely to group correspondingly under 1) 'FEELINGS', 2) 'ROLES' (or maybe 'Relationships' or 'Parenting' depending on the focus of the study) and 3) 'ATTITUDES' (all common themes in social research). Much research stops at this level of 'thematic analysis'.

Axial coding builds on the previous process and is where interrogation of the data intensifies. It involves reassembling data after open coding has occurred to make new connections and insights between the categories, using a 'coding paradigm'. This involves asking questions of the data under examination (as a practical example – about 'feelings'):

- What is the context and set of properties/characteristics?
- What are the action and interaction strategies?
- What are the variations and exceptions to the rule?
- What appear to be the causal conditions?
- What are the consequences?

Here and throughout, hypotheses arising from deductive processes are used to question the links between categories supported by the data and inductive processes employed to verify hypotheses by comparing incident with incident. Any differences to emerge are further explored to decide whether or not they disprove a theory or add variation and deepen understanding.

Discriminate sampling, as its name suggests, involves data sampling and coding development at increasing levels of discrimination, as these follow the flow of what appears to be the main emerging story line. This process builds as the analysis progresses.

Theoretical saturation of each coding category occurs when data has been exhaustively interrogated and nothing new is emerging from any of the categories, all the coding paradigm questions (above) are accounted for and the relationships between the categories are well established and validated.

Selective coding involves the identification of the core category and systematically relating it to the other categories and validating their relationships. The core category or discovered core theory integrates the whole coding hierarchy.

This represents the main flow. *Table 1* below provides a supporting overview. However, in reality, coding is a messy business, especially as theoretical sampling and deductive and inductive processes occur throughout. Furthermore, the coding hierarchy is likely to undergo many changes before the defining core category becomes apparent.

Table 1 *Overview of Grounded Theory processes*

| <i>Stage of analysis</i> | <i>Analytic processes and coding stages</i> | | | | <i>Explanation of terms</i> | |
|--------------------------|---|---|---|---|-------------------------------------|---|
| Early | T H E O R E T I C A L | D E D U C T I V E | I N D U C T I V E | T H E O R E T I C A L | Open sampling | Sampling phenomena relevant to the research |
| | | | | | Open coding | Breaking down, examining, comparing, conceptualising and categorising the data |
| Mid to late mid | S E N S I T I V I T Y | I N K I N G | T H I S | S A M P L I N G | Relational and variational sampling | Verifying statements against the data. Comparing the categories for similarities and differences Seeking explanations for differences |
| | | | | | Axial coding | Making new connections between categories by using a coding paradigm |
| Final | S E N S I T I V I T Y | I N K I N G | T H I S | S A M P L I N G | Discriminate sampling | Purposively choosing codes to enhance the main story line |
| | | | | | Integrating categories | Grouping and linking the conceptual categories at an abstract level |
| | | | | | Theoretical saturation | Filling the gaps in knowledge |
| | | | | | Selective coding | Identification of the core category and validating its relationship to the other categories |

From Rapaport (2002) (See Glossary for an explanation of terms)

It is important to note that one advantage of theoretical saturation is that it is possible to do research with a very small population sample as the process yields so much data – a real case of making a lot out of a little!

The Case Study

A Case Study is an example of non-cross sectional analysis. It entails the management of data to facilitate comparisons between the particular and holistic elements of the research. Yin (1994) defines a Case Study as an empirical enquiry which:

- Investigates a contemporary topic in its real-life context where the boundaries between the topic and context are not clearly evident;
- Manages studies where there are likely to be many variables of interest;
- Relies of multiple sources of evidence;
- Benefits from prior theoretical propositions to guide the data collection and data analysis.

It is defined as an empirical inquiry which investigates a single topic/case in its real-life context. A Multiple Case Study contains more than one case. As a further variation, both may contain *embedded units* which are distinct units of analysis embedded in a single or multiple Case Study. Typical units of analysis are population groups, projects and business or professional teams, as just some examples. Case Studies are a form of enquiry which are useful for a range of research purposes such as policy, political science and public administration and management research and community psychology, sociological, organisational and management studies.

The Multiple Case Study was adopted because its non-cross-sectional application facilitated the holistic analysis of data arising from each of the individual stakeholder groups and thus also comparative analysis between these and any other emergent sub-groups. In respect of the nearest relative research, carers, service users and ASWs were treated as distinct cases. Embedded sub-groups, made up of participants from any of the main stakeholder groups who shared common features, were anticipated. These might appear from within the main groups, or across stakeholders such as 'hybrid' service user/carers and ASW/carers or ASW/service users and so forth.

Yin (1994) contends that Case Studies enable answers to the 'when', 'how' and 'why' questions 'when the investigator has little control over events, and when the focus is on a contemporary phenomenon with some real-life context'. The nearest relative fits these criteria admirably. The Case Study has the additional advantage of flexibly accommodating many methods to obtain data such as archival material, group and individual interviews and participant observations. The Case Study uses pattern-matching, explanation-building, causal link and interpretative approaches in the analytic process and thus enhances many of the strategies used by Grounded Theory.

A major criticism that Case Studies provide little basis for scientific generalisation derives from positivism. Yin (1994) observes that scientific facts are usually based on a multiple set of experiments which have reproduced the same phenomenon under different conditions, rather than a single experiment. He suggests that the same approach can be used in Multiple Case Studies provided appropriate attention is paid to the theoretical starting point. He further observes that Case Studies, like experiments, are generalisable to theoretical propositions and not to populations and universes. The goal of the approach is to build theories, as with Grounded Theory.

Yin (1994) identifies problems in combining the Case Study and Grounded Theory because the former requires some theory development or clear purpose before data collection, whereas the latter does not. However, the theoretical starting point of a Case Study need not be at the level of grand theory. The problem would only have applied if the nearest relative had not had a preliminary focus, which was far from the case.

Methods for data generation

The main choices open to qualitative researchers to generate data are 1) interviews 2) observation and 3) analysis of texts and documents. The latter was used to inform the historical background of the nearest relative role. The study did not lend itself to the techniques of observation where the researcher immerses him or herself in a research setting and systematically observes phenomena such as actions, interactions and events. In terms of nearest relative activity, much of the action occurs in the privacy of people's homes at a traumatic time for the patient and his or her family. Further, many of the reactions to the role are likely to be outwardly unobservable as much of the activity takes place after the event in the minds and memories of those involved.

In respect of interviews, described by Burgess (1984; 102) as 'conversations with a purpose' there are further choices. An interview may be conducted on a one to one basis or involve groups of people. It may be conducted informally without an obvious format, guided by themes or issues identified by the researcher or designed on the basis that either the interviewees or the interaction provide the main data sources. The latter are associated with the school of interactionism. Interactionists tend to reject standardise interviews in favour of open-ended interviews (Silverman, 2001).

Focus group choice

Available literature (Carter, 1999; Gregor, 1999) provided conflicting evidence of what carers and relatives were likely to know about the nearest relative powers. It was also considered that users would very probably know very little about the role and thus might be reluctant to participate in the research. A method that would actively encourage participation and interaction and allow for information-giving was required. These factors suggested that both topic-centred and open-ended approaches were necessary.

The focus group interview supported by a topic guide and other tools were selected for the purposes of data generation. Krueger (1996; 6) defines a focus group as a 'carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive nonthreatening environment'. Focus groups were selected because they do not discriminate against people who have problems reading or writing and can encourage participation where people are reluctant to be interviewed on their own or who feel they have nothing to say (Kitzinger, 1995). The method has the added advantages of being flexible to accommodate additional tools and to encourage interaction (Kitzinger, 1995) and compatibility with Grounded Theory (Kitzinger, 1994) and Case Study methodologies. It was favoured above the individual interview as being a more economical way of collecting data. From an important ethical standpoint, the safety in numbers element was also conceived as a reassuring, participant-friendly measure.

Whilst recommendations vary, a focus group interview usually comprises between three and twelve people (Thomas *et al*, 1995). Participants are usually selected for their similar backgrounds and values relevant to the research topic. Homogeneity is favoured because discussion of sensitive topics is facilitated if participants view one another to share the same perspective (Knodel *et al*, 1984). Opinion is divided as to whether group members should be strangers or well acquainted. Thomas *et al* (1995) contend stranger groups encourage honesty and spontaneity and avoid the problems of group dynamics. Kitzinger (1994; 105) advocates selective use of pre-existing groups because these provide 'one of the social contexts within which ideas are formed and decisions made'. She suggests that problems of group censorship may be overcome by the complementary use of questionnaires.

The supporting methods used to strengthen the reliability of the focus group approach were:

- Semi-structured topic guide with user friendly questions relevant to the main enquiry devised in consultation with a project manager of a mental health charity (all stakeholder groups);
- Pre-test vignette – essentially a brief scenario of an assessment under the Mental Health Act with potential for nearest relative involvement to test carer and service user knowledge at the start of the interview;
- Verbal explanation of nearest relative powers and duties to carer and service user groups;
- 'Narrative' vignettes – stories to stimulate discussion following the verbal explanation above (carer and service user groups);
- Pairs exercises asking participants to consider 1) what they liked and disliked about the role and 2) what they would like to see changed, to focus thinking about the value of the nearest relative and generate ideas for group debate (all stakeholder groups);
- Group feedback following the pairs exercises recorded on a flip chart (all stakeholder groups);
- Card exercise at the conclusion of the interview asking participants what they had and had not got out of the interview (all stakeholder groups);
- Nearest relative information guide at the end of the first interview only (carer and service user groups);
- Double carer and service user interviews, the second being to test recall of nearest relative information and find out if the powers had been used in any way.

All the vignettes were adjusted to accommodate carer and service user perspectives, to simulate real-life contexts and to encourage participants to tell their own stories.

Conducting the research

Ethical matters

It is a basic principle that research should not harm its participants. When the nearest relative study began NHS ethics' committees did not encompass wider social issues and social services departments did not have such committees or governance bodies. In lieu of such approval the research was conducted following negotiations with senior managers and group co-ordinators responsible for the selected groups. On reflection, I am not at all sure if ethics' committees, had they existed, would have allowed the nearest relative research, given the controversy surrounding the role. I could well imagine very strong objections on grounds that informing relatives and service users of the functions would cause unrealistic expectations and harm to patients. I may just have squeezed into a window of opportunity in the nick of time!

The interview procedures were selected to be sensitive to stakeholder circumstances. Explanations about the powers were provided. Interviews were taped with participants' agreement. Participants were assured of confidentiality and encouraged to respect each others' privacy. Each group was allocated an alphabetic letter and each member a name starting with that letter to protect anonymity of groups and individuals. Participants were advised they could stop or leave the interview if the research resurrected painful memories. The discretionary nature of the powers was emphasised to avoid possible false hopes and fears. Debriefing for all carers and service users about any problem arising from the research was also built into the programme.

Setting up the stakeholder groups

Kitzinger (1995) stresses the importance of imaginative population sampling to address the key variables of the research. Given the researcher's limited resources a decision was taken to focus on mainstream areas. Groups, although of great interest, such as young carers, carers of people with dementia and private patients, were therefore excluded. The quest to encompass a wide range of minority ethnic groups was also abandoned. However, in view of the inherent richness of social groups (Ramon and Tallis, 1997) a range of variables from mainstream groups was anticipated: this proved to be the case, significantly in respect of age, gender, ethnicity, sectioning experience and nearest relative living and family relationships. Stakeholder groups from inner-city, urban and more rural areas were targeted. An Afro-Caribbean project facilitated access to a black carer and service user group. It was considered to be highly likely that the carer and service user groups would contain a sizeable proportion of people who had experienced the sectioning process and this proved to be correct. However, it was also anticipated that the nearest relative would be of interest to people even if they were under the impression, mistaken or otherwise, that no such experience had occurred. Enlisting the interest of stakeholder group coordinators or managers proved to be the magic ingredient in engaging groups. Where this failed the request was either rejected or too few participants appeared on the day. There was no lure of a prize or inducement, such as often occurs in funded studies. It was down to my persuasive powers to convey the importance of the research.

Conducting the interviews

In the event, five carer (A-E), four service user (F-I) and four ASW (J-M) groups were interviewed. As a stark reminder of the challenges of the ASW role, one inner-city ASW group had to withdraw because a colleague had been tragically killed by a patient living in the community. Most groups comprised between five to eight members. Carer and service user interviews involved two sessions. ASWs attended a single interview. The second interview caused apprehension amongst a few service users as they realised that they would be asked about what they could recall of the nearest relative information. Care was taken to explain that problems in recall would be an important finding to inform future policy. Highlighting intentions to use the research in this way was an important part of enthusing interest. In the event, only two service users dropped out of an interview and one may have had an appointment. Nobody objected to the presence of the tape recorder.

The interview schedule flowed as already identified in the bullet points describing the supporting methods above. Carer and service user interviews, in particular, followed a set format. They were initially presented with very short pre-test vignettes depicting mental health scenarios relating to admission and discharge, as two examples:

Carer group: So, what could you do if you were worried about your son/daughter's behaviour – not sleeping/eating properly, signs of agitated behaviour and hearing voices. You, as an NR wanted your relative to be assessed for/admitted to hospital?

Service user group: Mr and Mrs Grey were worried about their 16 year-old daughter who was behaving very oddly, talking to herself and locking herself into her room for hours on end. What could they do if they felt she needed hospital?

After the vignettes, the rights and powers of the nearest relative were explained followed by post-test vignettes to assess understanding of the information. Participants were then asked to work in pairs to decide what they liked and disliked about the powers and to note this information on pre-prepared cards. Group discussion, assisted by a topic guide, followed the pairs' exercise and views were recorded on a flip chart. At the end of the first session, carers and service users were provided with written information describing the nearest relative role.

At the start of the second session, the pre-tests used the first time round were revisited to test recall. A summary of the previous sessions' outcomes was provided orally and on a flipchart. More involved 'narrative' vignettes were then introduced and discussed to explore views and the robustness of information recalled. Following this, participants worked in pairs to decide what they would keep or change. Group discussion followed and viewpoints were once again recorded on a flipchart. Before leaving, participants were asked to state (anonymously) on cards what they had 'got out of' and 'not got out of' the two sessions.

In respect of the single ASW groups, participants were initially asked to identify nearest relative concerns. These were recorded on a flipchart. As a next step, the ASWs were asked to flesh out problem areas which were used to stimulate debate about the related issues, actions and frustrations. ASWs then worked in pairs to define aspects of the role they would like to keep and change. This information was then discussed in the main group and recorded on a flip chart. As predicted, ASWs provided copious vignettes of their own. At the conclusion of the session, ASWs were also asked to state on cards what they had and had not got out of the event.

Table 10 Summary of interviewing methods

| Session 1 Carers and Users | Session 2 Carers and Users | ASW (one session only) |
|-------------------------------|---|-----------------------------------|
| Explanation of the research | Brief summary of research | Explanation of research |
| Pre-test vignettes | Pre-test vignettes | Each ASW identifies concerns |
| Nearest Relative information | Summary of session 1 outcomes | State issues/actions/frustrations |
| Post-test vignettes | Summary of Nearest Relative | Group discussion |
| Work in pairs; likes/dislikes | Narrative vignettes | Spontaneous vignettes* |
| Group discussion/flipchart | Work in pairs; keep/change | |
| Nearest Relative guide | Group discussion/flipchart | |
| Demographics questionnaire** | Evaluation; one thing got out/one thing not got out | |
| | Summary of outcomes sent to group leader for verification | |

*Anticipated **Also completed by ASW groups

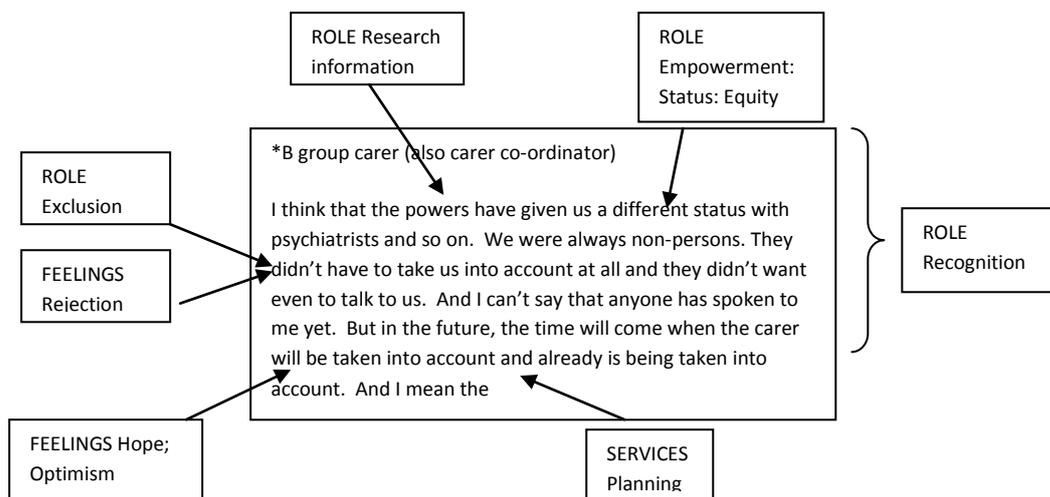
Comments from all groups indicated that apart from one or two people, most participants enjoyed the process and participating in focused discussion. Any criticisms related to the nature of the nearest relative role and its demands. As general points, carers said they valued the information, service users felt their views were taken seriously and ASWs appreciated the opportunity to discuss an important practice issue.

Conducting the analysis

The researcher transcribed the tapes within a few days of the interview. Brief notes were taken at the conclusion of each session. The flipchart and pairs' exercises' records proved to be extremely useful as the tape failed on two occasions and recording was at times compromised by external noise. Transcripts were read and reread countless times. The analysis was assisted by an accredited software programme, an antecedent of N-Vivo. This provides an economical way of storing data, essential given that particular sections of text may illustrate multiple themes and a considerable amount of repetition will almost inevitably occur during the coding process. It is quite legitimate to do some manual coding and this is recommended where the researcher is new to the experience (Webb, 1999). This I did in the early stages as I needed to see the whole picture in one go. Bedroom cupboard doors were covered with post-its which were moved around until I was satisfied I had the beginnings of a coding frame. In respect of both manual and computer coding and with case study (non-cross sectional) and comparative analysis in mind, I was careful to keep the stakeholder groups separate. Thus three identical coding frames were created. When coding text, the anonymised identities of the participants were also retained so that features common to any embedded sub groups, such as anticipated 'hybrid' carer/service users and unexpected finds, of which lone carers were just one example, could be easily spotted. In addition to the coding frame, a set of tables based on the research questions and emergent core themes was devised to help with the comparative analysis of the main stakeholder and embedded sub groups. These were eventually worked up as overheads for presentation purposes.

It is usual to start the coding frame with the research questions, allocating each an individual code. Demographic information may also be stored in this way. Data indicating themes relating to the actions, interactions and underpinning motivations of the stakeholders were analysed using the Grounded Theory method as described above in **Methods of Data Analysis**. As a result of the literature research and trawl of historic documents, themes such as families requiring access to hospital treatment for their relative and a means of protection against the abusive use of institutional care, safeguards for patient welfare and aftercare and beliefs in family obligation were identified. These themes helped to provide a beginning focus for the contemporary study and neatly dovetailed with the emerging story line as the analysis progressed. An illustration of the early categorisation of data from one of the carer group transcripts is shown in **Illustration 2** below. This also demonstrates how multiple themes can occur in a small piece of text.

Illustration 2 – Early stage of coding



Summaries of interview themes were checked with carer and service user participants during the second session to validate the data for analysis. Dissemination of the second interview findings provided a further means of verification. Early drafts of the research findings were sent to selected participants for comment.

During the mid phase of coding development outlined above, the emerging themes were scrutinised for similarities, differences and frequencies. The coding paradigm was used to examine the conceptual categories for their relational and variational dimensions. The example at **Illustration 3** demonstrates that carers like the service users, were barely able to recall the nearest relative information provided in a variety of formats during the first interview. The main factors to be

considered (listed under *Properties*) were stakeholder detachment from the actual action, the complexity of the nearest relative information and the psychosocial interface when the functions could be applied. However, the participants who recalled the most (of a very little), were those for whom the information was timely and relevant (listed under *Specific dimensions of bare recall*). For example, one carer had challenged a ward nurse about the future care of her son: ‘I know my rights’ and observed the impact of her statement on the nurse whose response suggested she knew something about the nearest relative powers. She had felt empowered and recognised (listed under *Consequences (Intended)*). This contrasted with the efforts of another with similar positive indicators who had been rebuffed by a professional who appeared to be ignorant of the role, which reinforced his underlying negative feelings (listed under *Consequences (Unintended)*).

Illustrations 3 & 4 – Mid to late stages of coding

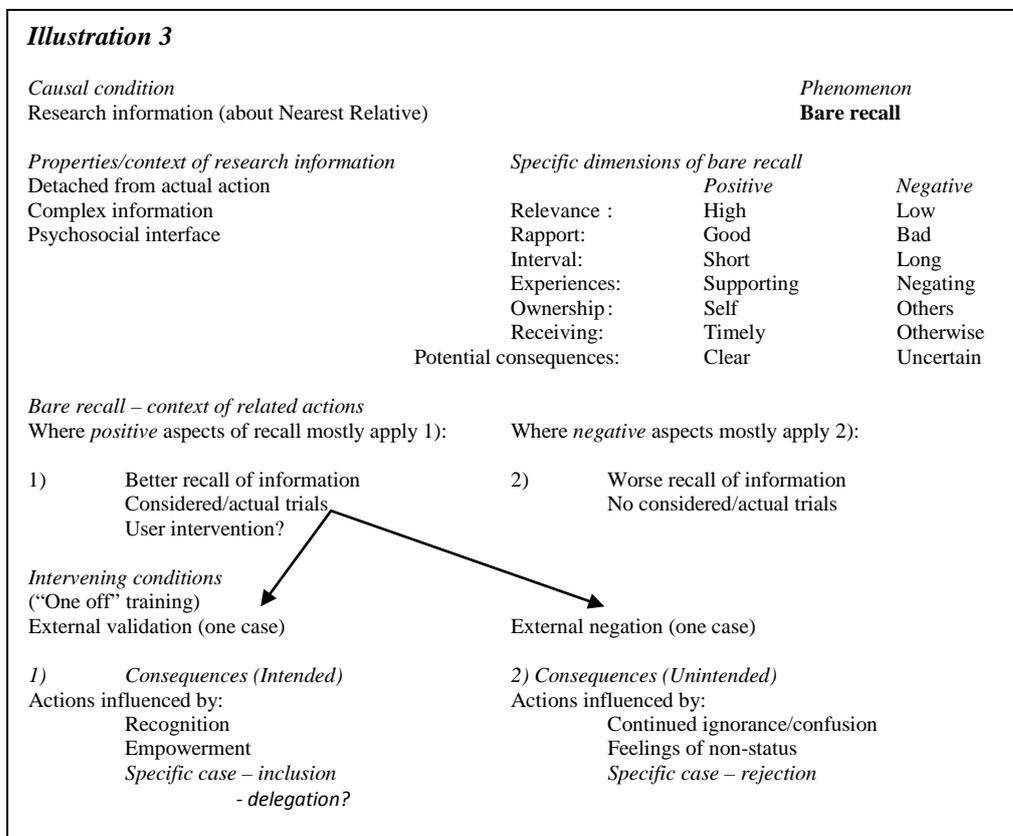


Illustration 4

| | | |
|---|-------------------------------------|-----------------------------------|
| <i>Causal condition</i> | | <i>Phenomenon</i> |
| Wise use (of Nearest Relative (NR) role) | | Validation |
| <i>Properties/context of wise use:</i> | | <i>Specific dimensions:</i> |
| Statutory functions | | Conviction High |
| Psychosocial interface | | Sympathy High |
| Extenuating circumstances | | Support Timely |
| | | Response High/extensive |
| | | Assertion High |
| | | Reciprocation Evident |
| | | Duration Focused |
| | Potential consequences | Positive |
| <i>Context of validation and related actions</i> | | |
| Where conviction is high and the NR's actions and motives are officially recognised (by ASW) then the NR can be supported to: | | |
| <i>Strategies:</i> | <i>Intervening conditions</i> | <i>(Intended) consequences</i> |
| Seek assessment | NR empowerment | Actions influenced by: |
| Object to treatment | ASW empowerment | NR/ASW reciprocity |
| Prevent discharge | Reciprocal Role Valorisation | Recognition of NR/ASW |
| Seek a carer's assessment | Robust least restriction | Working safeguards |
| | Positive images | NR and ASW inclusion:- |
| | Positive feelings | <i>Specifically:</i> |
| | | <i>Hospital diversion</i> |
| | | <i>Galvanising team support</i> |
| | | <i>Robust decision-making</i> |
| | | <i>Involving NR in decisions</i> |
| | | <i>Debriefing NR after crisis</i> |
| Exceptional – ASW student with extra time | | |

Illustration 4 above illustrates the properties and dimensions of situations where participants who had declared nearest relative experiences, had felt **validated** and had used their safeguarding functions, possibly unwittingly, to advocate for or against hospital admission in the patient's best interests. The main factors and context to be considered (listed under *Properties*) were wise use of the statutory functions, the psychosocial interface and extenuating circumstances. The *specific dimensions* of **Validation** existed were for example, conviction and sympathy from others was high, support timely and reciprocation between the carer and professional was evident. Where these positive dimensions pertained and carers' motives were recognised by the ASW as well intentioned, carers were able to use their powers *strategically* to seek assessment, object to treatment, prevent an untimely discharge and seek a carer's assessment for themselves. At such times, the nearest relative and carer were found to be empowering each other by working reciprocally for the patient's benefit. Some of the *specific intended consequences* were a number of hospital diversions, robust decision-making regarding the need for detention or otherwise and appropriate nearest relative inclusion in decisions about the patient's care plans.

'Frequencies' were treated cautiously, as the incidence of repeated words or phrases could lead to misleading conclusions. As just one example, in respect of the universally acknowledged safeguard potential of the nearest relative, service users were particularly vociferous about the danger of the

role landing in the wrong hands because of the inflexibility of the legal hierarchy. However, whilst carers and ASWs were not so preoccupied with this issue, the quality rather than quantity of their information suggested that they were no less concerned.

Identifying the core category

The lens through which the data were analysed was influenced by the researcher's reflexivity, carer policy and role theory. Fook (2001) regards subjectivity as an asset rather than a problem, capable of enhancing research and forming a creative part of the research process. Riessman (1994) posits that an explanation of the researcher's stance helps readers to evaluate the knowledge outcomes. The researcher's interpretative practices were almost inevitably influenced by her reflections on her ASW and also carer experiences. The concept of 'carer recognition', over the years a central theme of carer literature and government policy, emerged as highly relevant to the nearest relative. One carer commented that as nearest relatives they were 'recognised people' and another that better recognition for the carer meant better recognition for the patient. There were also examples where lack of recognition had led to negative consequences, its absence highlighting its importance.

Equity, Empowerment and Role Validation (see *Illustration 4* above) appeared as likely integrative and core categories of the research during the stage of axial coding. Examples of the safeguarding potential of the role having been exercised to advocate for or against hospital compulsory admission in the patient's best interests, emerged from nearest relative and ASW stories. Here the conceivably *overcompensating* powers enabled the nearest relative to fulfil the role's advocacy functions and engage and activate ASW duties to counterbalance medical power. This role enhancing reciprocation, discovered at the stage of selective coding, moved Social Role Valorisation a stage further to Reciprocal Role Valorisation ('RRV'). RRV was found to occur:

where the nearest relative and ASW supported each other to achieve mutually respected and identified goals to help the patient, that were also recognised by the professionals and significant others involved. Where the nearest relative and ASW were not working together effectively, or at all, the opposite occurred.

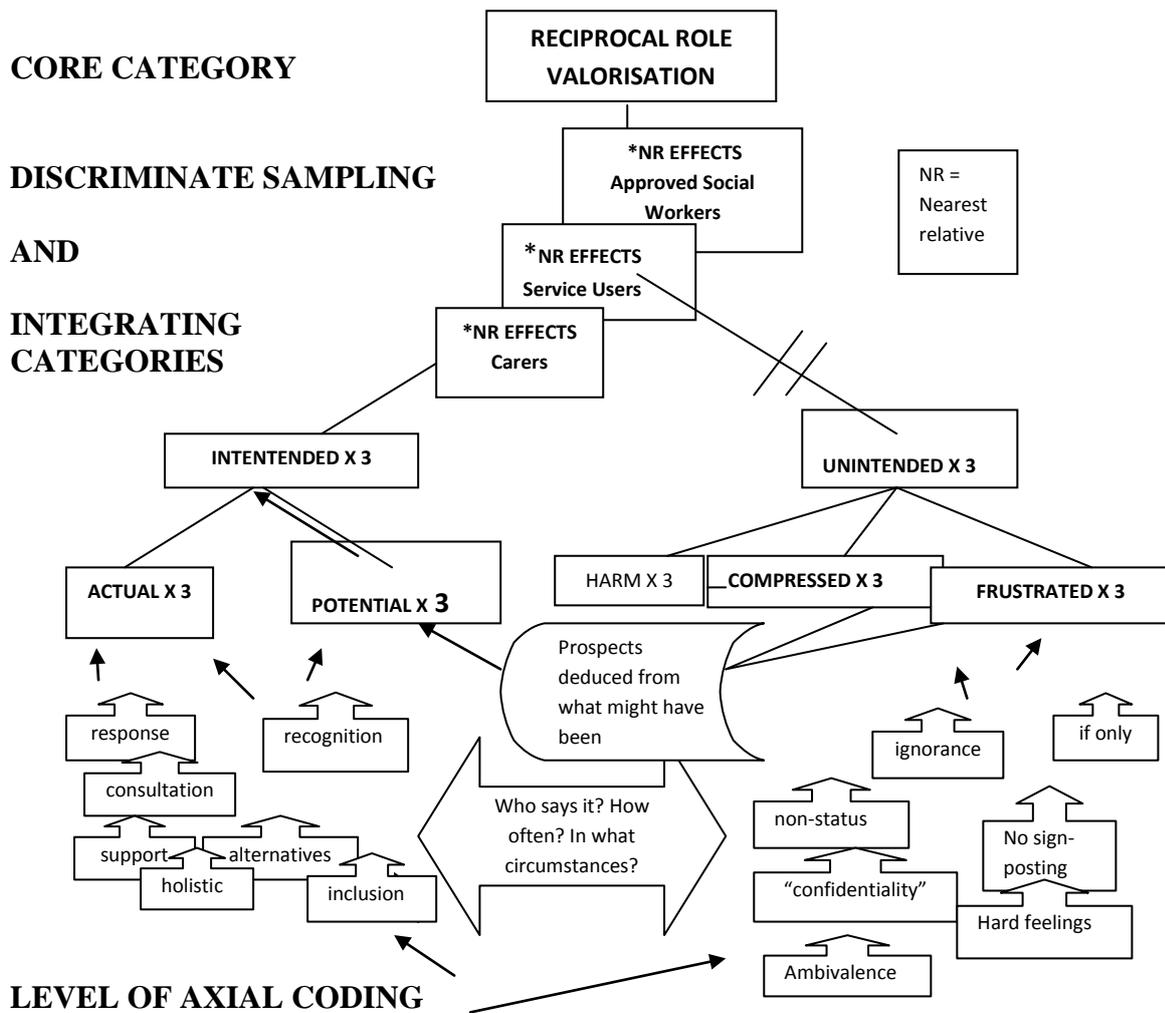
As a practical example of RRV, a few relatives had objected to the patient's hospital admission, thus exercising their rights in respect of Section 3. In those instances, the ASW had recognised that the powers were being used wisely and had therefore striven, also in conjunction with medical and nursing colleagues, to find alternative solutions to hospital admission which were appreciated by everyone concerned. Conversely, if nearest relatives had not been aware of their role, or properly supported to use it, they were unable to help the patient either by seeking admission or preventing it (the 'if only' scenarios depicted in the negative domain of *Illustration 5* below). The discovery of RRV was strengthened by deducing positives from negative examples and vice versa. By interpreting the data in this way, the core category emerged within the dynamics of nearest relative and ASW interaction. An impressionistic overview of the final stages leading to the core category is depicted in

Illustration 5 below. The reference to 'x3' relates to the synthesis of coding in respect of carer, service user and ASW data.

Illustration 5 - Final stage of coding

Positive domain

Negative domain



Testing the categories for patterning and frequency confirmed that the nearest relative usually operated in the negative domain. Its virtues were less well exercised. There were no findings that could not be sufficiently explained by the analysis. The negative and positive dimensions revealed by Grounded Theory and the Case Study analyses were all accommodated by the core theory.

Back to the logical tests to evaluate the research design

The research applied accredited interpretative methods to a relatively unexplored area of live law. In respect of the research methods described above, Yin's (1994) overarching logical tests were addressed by:

Construct validity: Grounded Theory and the Case Study proved to be highly suitable methods for data analysis and focus groups assisted by additional tools as an appropriate method of data collection.

External validity: the study identifies the types of groups to which the research findings can be generalised.

Internal validity: this was facilitated by the techniques integral to Grounded Theory and the Multiple Case Design and examination of the findings across a range of research tools;

Reliability: this was demonstrated by the successful re-application of methods to different groups. The research used additional techniques to check accuracy of data and interpretation. The researcher's professional and personal experiences provided an important source of verification and dynamic interpretation.

FINDINGS: BACK TO THE RESEARCH QUESTIONS

This section provides an overview of the main findings to emerge from the study's methods and research questions (also summarised in Rapaport, 2003; 2004). The historical aspects are more briefly discussed as the contemporary element of the study has been the main focus throughout. The main stakeholder cases of relatives and carers, service users and ASWs were found to contain several embedded sub-groups, some of which are identified below. Some will appear under questions 2 – 6.

- Carers and service users with experience of the sectioning process;
- Carers and service users without experience of the sectioning process;
- 'Hybrid' service users with carer related experiences;
- Widowed carers from the county groups coping alone;
- Carer group co-ordinators, both voluntary and paid.

The main stakeholder and sub-groups, within and spanning the three 'cases', provided the basic structure for comparative analysis. The combination of grounded theory and case study approach worked well. In particular, the integral analytical processes of Grounded Theory, such as the coding paradigm, enhanced the comparative facility of the Case Study by winking out the subtleties which distinguished each of the sub-groups. As just one example, using the category of FEELINGS identified across the dataset, lone carers more than other carers viewed the nearest relative powers to be an

imposition on carers and potentially burdensome. Although anticipated, hybrid ASW service users did not emerge as a distinct sub-group as no personal experiences were volunteered. These ASWs were firmly located in their professional role. Their reticence to sharing such sensitive information to their close colleagues was also understood.

1) *What are the historical origins of the nearest relative functions and how was the role conceived?*

The trawl of historic documents suggest that the nearest relative foundations are deeply embedded in the interplay between the legal, policy and social developments that took place in Britain during the nineteenth and first half of the twentieth centuries. The current role was crafted out of lunacy legislation by the Percy Committee, developed by Standing Committee E and introduced under the Mental Health Act 1959. It has undergone changes as a result of two legal reforms and unlike Scotland, in England and Wales has narrowly survived. Its main purpose is to act as a lay patient safeguard to facilitate hospital admission where appropriate and guard against abusive use of institutional care. Its development is deeply intertwined with the social work role which over time has now assumed almost total responsibility for making the application for compulsory hospital admission.

The hierarchy is based on principles of 'kindred and affinity'. In spite of extensive searches, the precise source of the hierarchy was never found. It is of course very similar to the hierarchy relating to the laws of inheritance, that used by the Poor Laws where relatives were pursued to pay for a family member's care and also the Tables of Kindred and Affinity, Book of Common Prayer, Church of England. David Hewitt (2007), who refers to my PhD, opts for the latter. In a personal communication he has since explained that this is because the Poor Law provisions and those relating to statutory inheritance may both be based on the Book of Common Prayer. However, of utmost importance, it is clearly apparent that prior to the most recent legal reform, stakeholder consultation regarding the identification of the nearest relative and its functions was meagre.

2) *What are the current conceptual and ethical issues surrounding the role and its operation?*

All three stakeholder groups recognised the potential safeguarding functions of the nearest relative. In this respect, patients without relatives were deprived of someone to stick up for them. However, the role was considered to have many drawbacks. A major concern, heightened by the deficiencies of the displacement sanctions, was the lottery of the identification process and potential for abusive use of the powers and infringement of patient civil liberties. Doubts about carer impartiality were endorsed. Carer bias could exaggerate or underplay the need for admission. Service users who had poor or variable relationships with their families were worried that they could not choose their nearest relatives. ASWs were the most vocal about the harmful and disempowering effects of contact and consultation with a nearest relative where past abuse was suspected.

Leonard [county group ASW] '... It's something so anti-therapeutic to be giving the power to the historical abuser, power of information, power to determine whether the patient receives treatment, it's such a contentious issue when it arises. Particularly if one's feeling that there is a link between that experience in childhood and the illness they throw out really. So to bring back the historical abuser into this therapeutic arrangement seems crazy. And the law doesn't provide a remedy for that'. (Rapaport, 2002; 262).

Surprise about the absence of patient choice or voice regarding the identity of the nearest relative was expressed across all stakeholder groups: the role contravened the current ethos of patient autonomy:

Hannah [service user – inner city black and ethnic minority group]: “I think it’s all quite old fashioned isn’t it, the way it’s all designed? ... this seems to be geared for, you know, nice families as it were (LAUGHING) you know, 2.1 families where the mother comes round and comes into hospital and says ‘how are you son?’” (Rapaport, 2002; 251).

Both principles of nonmalificence and beneficence were seriously compromised because not only could the identification process result in an inappropriate relative having charge of the functions, but it could also exclude the very best. Stakeholders across all groups but more particularly those representing ethnic minorities, were concerned that the hierarchy was out of step with social change and multi-cultural society. As a consequence, the most closely involved relative might be automatically excluded or discriminated against. The misfit could also lead to confusion and possibly argument about the true identity of the nearest relative.

Irene [service user – inner city black and ethnic minority group] “The live-in relative comes, well I think some of these things need changes ... the male and female partnerships of over six months ... I mean what is a half-sister, half-brother? Because, sometimes in our family, my Mum’s got six kids. All of them are my mother’s kids and as far as I’m concerned they’re all my brothers and sisters. One may have a different father”. (Rapaport, 2002; 253).

Edward [carer – county group] “ ... you can imagine the legal argy-bargy that could occur ... I think for myself we’ve really assumed we’re the nearest relative but we don’t know. Having read this we think, are we?” (Rapaport, 2002; 252).

The research suggested that the positive safeguard potential of the role was seriously compromised. The law does not require local authorities to produce written information about the nearest relative powers and ASW duties. The findings revealed that carers are generally uninformed about their powers. The ethical dilemma faced by ASWs when attempting to provide complex legal information to the nearest relative at the time of crisis was a major concern.

Lionel [ASW – county group] ‘... I mean a lot of people who in theory would be exercising are quite isolated, they’re quite ill-informed, some are going to be very frightened and some are going to be stressed. And then to expect them to use this complicated power wisely and with any kind of enthusiasm is a load of nonsense I think, in those circumstances, which is why the powers are very rarely used. And it’s one of those things I think people would rather not know about very often when they have a close relative who’s very ill. They don’t want to know. (Rapaport, 2002; 263).

Several carers and a few ‘hybrid’ service users who had also acted as carers, considered that they had lost golden opportunities to insist on a Mental Health Act assessment (S13(4)). As a result, in their view, tragedies that might have been avoided had occurred. Furthermore, the implicit right of the nearest relative to be involved in decision-making contained within the powers was not understood by the carer stakeholders or, according to their accounts, by many hospital staff. The carers complained they were not receiving information on vital matters such as the side effects of medication. Furthermore, some felt prevented from sharing sensitive carer information to medical staff because they feared it would be indiscriminately disclosed to the patient. This strange block in

communication occurred in spite of the prevailing *safe, sound and supportive* (DH, 1998) government policy, advice of psycho-education programmes and the potentially empowered position of the nearest relative.

3) *What do relatives and service users know and understand of the powers and what impact does the role have on their lives?*

The pre-test questions revealed that carer and service user knowledge about the nearest relative and also ASW functions was either very meagre or totally absent, irrespective of experience or otherwise of the sectioning process. The most knowledgeable carers were from two of the stakeholder groups, led by an experienced and trained carer co-ordinator. They knew that they could contact the social worker direct if concerned about a close relative, although were not aware of the wider ramifications of S 13(4). A sizeable proportion of carers and service users thought that the psychiatrist and a few the community nurse, made the application for hospital admission, rather than the ASW.

Amelia [carer – county group] ‘Joan, I have had nothing to do with social workers. For all the years that I was co-ordinator of the NSF [now Rethink] group I was never referred to a social worker. I knew nothing of this. It was always the community nurse’. (Rapaport, 2002; 236).

Greta [service user – county group – sectioned several times] ‘... The Approved Social Worker. I didn’t know there was such a thing. I knew the social worker but not Approved Social Workers who, as I understand now are people who specialise in psychiatric problems’. (Rapaport, 2002; 236).

Although their starting base was very low, after the nearest relative explanation, the discussions in carer and service user groups showed that these participants had quickly grasped the dynamics of the role. However, carer attempts to use nearest relative knowledge between the two interviews were small and generally uneventful because their understanding was not sufficiently robust to support full implementation of the role. Carers were slightly better than the service users at recalling the nearest relative information between the interviews. However, in spite of explanations given in a variety of formats, with implications for the need for widely available publicity about the role, recall was generally poor.

The impact of the powers on the carer and service user participants was generally negative because of the low knowledge base. In some cases carers had used the powers apparently unwittingly. A black inner-city carer was, at the time of the research, recovering from the devastating effects of having been pressurised to sign her son into hospital. Another county-based carer had felt like a gaoler for refusing to discharge her son’s section. ‘Not objecting’ to a treatment section was, in the eyes of some, tantamount to signing a person into hospital. ASWs provided more graphic accounts of the powers being used for the relative’s gain and patient’s loss, such as to obtain custody of children. In one instance it was thought that a high status nearest relative was using his powers to object to his frail and elderly aunt’s treatment to hasten her death and gain inheritance. Service users also felt betrayed by their relatives’ actions to have them hospitalised, although some also admitted that when unwell they felt unsafe at home. The effects of such scenarios on relationships could be long term.

However, there were a few examples of positive effects the powers, mostly provided by the ASWs who had consciously used their complementary functions to good effect. These included hospital diversions, carer involvement in treatment plans and the outcome of a judiciously implemented carer's assessment which avoided a precipitous hospital discharge. The empowering impacts of these scenarios will be revisited under Question 5 below.

4) *How are the rights and powers assigned to the nearest relative currently being exercised and what helps and hinders their practical implementation?*

As already stated, evidence of conscious nearest relative action was very small. Several carers had apparently unwittingly invoked their powers with varying success. In a few such cases, carers had received ASW help to avoid or procure hospital detention. However, ASW stakeholders provided several examples of assertive nearest relative influence to obstruct or seek the patient's detention. The majority resulted in displacement applications. These nearest relatives were clearly aware of their rights and powers, although the source their support was rarely identified. Personal attributes clearly played a part. One determined relative had repeatedly re-delegated her role to a series of relatives to dodge displacement: legal advice and support was clearly being provided from somewhere.

Martin [inner-city ASW group] 'I had a case we were talking about it last time, where the nearest relative, definitely this person needed to be displaced as nearest relative, [we] went ahead with, you know, filing an affidavit with the court. A court date was set and then what the nearest relative did was appeal through her solicitor to the court for more time, to respond to my affidavit. And once she'd done that she got the original nearest relative to whom, who had signed over the power of nearest relative to her, she got the original nearest relative to sign over to her brother, so she was out of the legal loop. So the whole thing dragged on. We had to amend the affidavit and include him. He continued to object, although he was really doing it by proxy for her. She was still pulling strings. And what happened in the end, we never went to court. The thing dragged on and on, and on and on. The court set a date a long way, in fact it still hasn't arrived yet. It doesn't matter anymore because what happened was the consultant got so worn down that the section was rescinded. So we had to withdraw the court application. And the patient disappeared into the ether, taken by her sister. ... (Rapaport, 2002; 268)

In another instance, a high status relative had connived with senior management against the ASW to challenge the displacement application. The ASW had bravely persisted. This nearest relative finally avoided displacement by going abroad!

Katharine [county group ASW] '... And her nearest relative opposed the situation. I think he was a Professor of Ethics or something ... and had all sorts of views about people being allowed to die if they were choosing to do so ... I was absolutely adamant that I thought this woman was making a decision whilst she was influenced by a very significant degree of depression. ... And I didn't get much support from Social Services' staff. Because I felt that certain people in Social Services were more concerned about appeasing him than actually following the law which in a sense I believed was protecting the client. And in fact, at the very last minute it didn't come to court, although it was all booked up and the brother took himself off abroad somewhere so he was out of the country ...

Kenneth So it's not only social agencies but the articulate, how articulate the nearest relative is as well and how to operate the system'. (Rapaport, 2002; 269)

The importance of the critical power to seek an early social assessment (S13(4)) which had held so much promise for the ASW role was generally lost. Most carers approached the patient's GP, although a few said they would have preferred the ASW option if they had known their rights as they found the ASW to be more sympathetic. However, an ASW highlighted problems that could arise because of rigid interpretation of what amounted to a request under S13(4) with implications not only for further diminution of the power and also ASW potential.

John [county group ASW] '... but certainly I've come across instances in other authorities of calls that have come through and ASWs saying "well thank goodness they didn't mention Section 13(4) of the Mental Health Act" which obviously a nearest relative wouldn't know about. So it's just to ensure they we're receptive to those requests and understand the framework of the Act'. (Rapaport, 2002; 264).

Whilst ignorance of carers and healthcare staff was a limiting factor, carers were also deterred from seeking help because of feelings of guilt, fears of adverse repercussions on their relationship with the patient and bad experiences of mental health services. They were also concerned that if they challenged professional opinion they would risk upsetting the patient's care team on whom they might later need to rely. Service users and ASWs also recognised some carers might be deterred because of dependence on the patient for company or other needs. There was more general recognition across groups that carers in daily contact might fail to recognise the signs of creeping mental illness. Absence of community alternatives was also identified as another barrier to seeking help at the early stages of a crisis. Delaying tactics inevitably increased the risk of compulsory admission.

5) What are the actions, interactions and relationships between the main stakeholder parties?

This question refers to the pre-crisis, crisis and post crisis stages of mental health breakdown. These largely correspond with the 1) pre-assessment, 2) assessment and admission and 3) discharge and after care sequences of the Mental Health Act. Carers described the dread of waiting for the crisis and in some cases experiences of unresponsive services which had culminated in near tragedies. For service users, the pre-crisis was dominated by fears of losing self-control. However, discussions from a carer and service group led by a 'hybrid' service user/carers suggest that the phenomenon referenced in professional terms as 'denial' might also be understood as the patient desperately clinging to self-perceptions of sanity:

George (county group service user/carers and group coordinator): '... You seem to hang on to the idea that once you've been ill that you'll never be ill again. So any movement towards actually admitting you're ill again is a problem. ... (Rapaport, 2002; 258)

Betty (county group carer): 'And you can't get any help really before you've got a problem. You've got to wait until there is a crisis. OTHERS AGREE ... and it's only later on that fortunately that whereas he was logical at the time then they took him in, later on he became disturbed. At the time of the crisis he was perfectly logical with everybody. OTHERS AGREE But they do, they fool them all, which they do. They are the sane person when they are in a crisis. OTHERS AGREE

Beatrice: 'Nobody would know anything was wrong'. (Rapaport, 2002; 259)

Although return to patient-hood was unwanted, service users also acknowledged that they needed help during the pre-crisis stage. Some had successfully sought help from families whilst others had avoided such contact. A few had left the family home because of disagreement or of their own volition. Two had barricaded themselves in leading to forced entry by the Police and ASW and subsequent compulsory admission.

Whilst carer and service user accounts of ASW presence during the pre-crisis stage were generally missing, the ASW took centre stage at the point of coordinating the assessment and admission. The role involved juggling practical, psychosocial tasks and information gathering under great pressure. ASWs acknowledged that they dealt with tremendous emotional distress from relatives, friends and patients during the assessment process. Their concerns about a relative's distress and doubts about the appropriateness of the powers could influence information giving practice. Doctors were sometimes inconsiderate about the ASW's duties to the nearest relative. Last minute requests for assessments took no account of problems of identifying and locating the appropriate person and health designed databases did not record nearest relative details. Inner city ASWs appeared to be working under tremendous pressure. As a result of these and other problems, the nearest relative was often not identified.

However, in spite of many practical ethical and practical problems surrounding the nearest relative, ASW and also some carer and service user accounts identified examples of relatives and ASWs working together for the patient's benefit. These include:

- *Unwitting use of power to request an assessment (S13(4))*: where the patient was on the ASW's caseload and also working with the family. In some such cases the nearest relative would give the ASW early warning of a possible deterioration in the patient's condition;
- *Successful hospital diversion*: nearest relatives working with the ASW and team to encourage the patient to resume taking the medication to avoid hospital admission;
- *Patient and nearest relative who had lost contact with each other, reunited*: as a result the nearest relative said s/he would care for the patient and hospital admission was avoided;
- *Objection to S3*: the patient's mother objected to S3 because her daughter had nearly died as a result of anti-psychotic medication. Her objection was understandable and reasonable and grounds for displacement did not apply. The nearest relative's objection enabled the ASW to obtain a consultation for the mother with her daughter's consultant. The mother was reassured about the change of medication and withdrew her objection;
- *Discharge from S2 to the community and objection to S3*: the nearest relative objected to S3 for treatment. He persuaded the care team that his wife's breakdown was due to having lost a baby several years previously. An intensive community care package was instigated as a result:

Kenneth (county group ASW): ' ... it depends on the circumstances because you deal with a lot of emotion there and then. I mean funnily enough I had one recently where a nearest relative objected and so I supported him against the doctors and luckily with a lot of consultation we managed to work through an alternative plan of action which was quite involved in terms of this person because she was in hospital, she was on a Section 2,

it was going to be made up to Section 3, and we managed to get a care package together with a consultant in the area, reviewed it after a week and did another domiciliary visit and it worked. It did work. ...

Katharine: I think what's very interesting about that one is that Kenneth did a lot of massive amount of work in actually was an alternative to hospital ... because she didn't remain on section as intended. And in a way that was primarily because the husband, the nearest relative was objecting ... '. (Rapaport, 2002; 271; Rapaport, 2004;389).

As extended by the carer's assessment, a nearest relative was helped by an ASW to attain her 'encoded' right (Twigg, 1994; 295) to necessary information to enable her to continue to look after her family member. A timely carer's assessment highlighted the real needs of the carer to such an extent that the patient saw 'the dynamics' (Larry, county group ASW) of his circumstances and withdrew his appeal against detention. A precipitous discharge was thereby avoided. In line with good practice, an ASW had experienced the gratifying effects of contacting nearest relatives the day after a Mental Health Act assessment. These nearest relatives had clearly appreciated the time to off-load their distress. This luxury was now denied her because of the pressures of the job:

Maria (black inner city ASW): 'I haven't had a lot of problems with the nearest relative but the thing I would like to do is give them more time sometimes. Because I've actually, the sections that I've done have been first time sections and they're quite young people. And sometimes it's the first time the nearest relative has gone through having contact with the mental health services. And I think they need more time to talk over what's been happening to them ... what came in very useful when I was on ASW training, that we could go back and speak to relative, but, that actually met quite a few people's needs. But now I'm back at work, I really don't have time to go back and actually speak to people about, you know, about what's going on for them really. Even though I've left my number and said you can, you can call me, but oh, they do call but not to spend hours to speak to, because you know, you just don't have the time really ... some kind of tender loving care for them as well'. (Rapaport, 2002; 280).

In each of the above cases the nearest relatives were empowered to clarify their stance regarding the need or otherwise for the patient's hospital admission. The nearest relative's position further empowered ASW negotiations with the care team and doctors. Whilst these reciprocal enhancements worked for the patient's benefit, they simultaneously cast a positive image on both nearest relative and ASW roles. The above examples represent the positive intentions underpinning the changes to the nearest relative under the Mental Health Act 1983 and the rationale for the discovery of *Reciprocal Role Valorisation ('RRV')* as described.

Post-discharge, carers and service users provided positive examples where family relationships were mended and re-established but also some negative scenarios of furthering alienation. Carers spoke about their apprehension waiting for the next crisis. ASWs found difficulty in re-establishing relationships with the patient's nearest relative where displacement had occurred. Their main contact with service users and carers appeared to be in relation to preparing reports for appeals against detention and attending care planning meetings.

6) Are the rights and powers appropriate in view of community care developments and social change and are there any recommendations for reform?

The main body of concern expressed by all stakeholder groups focused on the weaknesses of the identification process. There was much debate about the degree of patient autonomy to choose

their nearest relative. Carers generally favoured patients having a say in the decision, whereas most service users and ASWs preferred full patient choice. However, notably and with reference to the embedded sub-groups, carer-experienced service users and ASWs opted for patient voice. Reservations related to concerns about the patient's volition and capacity to choose and, given the limits of the small nuclear family, possible problems regarding the availability of suitable willing candidates. A service user and a carer touch on some of these concerns:

Georgina (county group service user): 'It seems jolly unfair that you might have one relative that is prepared to take responsibility who's not necessarily your closest but the nearest relative that is closest won't take responsibility ... the situation that I was in last year after the death of my father. If I'd been with my mother, because my mother cannot cope with me when I am ill, I would have been in hospital for the duration of my illness. Whereas living with my partner, my partner refused for me to be admitted into hospital even though it was suggested, and insisted on caring for me at home and being involved in my drug therapy. And I recovered a lot quicker in that environment'. (Rapaport, 2002; 250).

Beth (county group carer): I think in a normal situation if it happens to be mother or father or whatnot I think it should stay. I don't think the patient themselves should have the right to change it because that's personal and they should know that authority rests where it rests and it's not negotiable. But supposing the nearest relative were alcoholic or really had proved himself assaulting the patient ... maybe there could be some loophole'. (Rapaport, 2002; 251)

All groups favoured safeguards of a lesser or greater degree to be an important part of any new identification process. The advance statement made by the patient when well was supported by three carer, three ASW and two service user groups. Three carer and two ASW groups proposed the introduction of a panel or professional advocate to ratify patient choice. There was some discussion, principally from carer and service user groups favouring befrienders, advocates or guardians as appropriate candidates. Service users promoted peer advocacy, although one member strongly disagreed, preferring a representative unaffected by mental illness. One service user wanted legal advocacy on a par with the criminal justice system. The dual advocacy and carer strands of the nearest relative were apparent in all discussions.

In terms of suitability to act, all stakeholder groups considered that the person appointed should be easily identified, accessible, reliable and committed to asserting the patient's best interests. Patient confidence in the person was universally held to be paramount. Carers and service users in particular wanted the person to be informed and supported to carry the functions and command the respect of the care team. There was some conflict regarding the greater desirability of intimate patient knowledge, possibly tainted by vested interest, versus the impartial perspectives of an accredited outsider, so apparent in the debates preceding the 1959 and 1983 Acts.

In spite of the nearest relative's obvious low profile, the research revealed a few cases of successful nearest relative intervention. The inner city service user and ASW groups apart, most viewed that Section 13(4) should be recommended for retention. This power was possibly of reduced relevance in the inner cities where several service users were at variance with or distanced from their relatives. The inner city ASWs said that they assessed high numbers of people who were estranged from their families.

The powers to object to treatment and apply for discharge were valued by most groups as providing potential for carer consultation and patient protection. Carers admitted that they were unlikely to implement their powers against detention, save as a 'last resort' because they feared exclusion by the care team. The power of the nearest relative to apply for the patient's admission was universally considered to be the most questionable because of the potential for its abusive use but also likely risk of harm to a close relationship.

The carer's assessment was valued by most service users who perceived better prospects of care for themselves from better supported families. Carers had reservations about its real worth: services were patient-focused and did not recognise their wide-ranging needs. Most ASWs supported the carer's assessment with greater conviction than the nearest relative powers. An example of a very constructive use of the assessment was provided by one of the ASW county groups:

Larry (county group ASW): 'There's one case recently where I had to address it for a mental health appeal, a managers' appeal and it concentrated very, it concentrated on it a lot, because the managers actually discharged the person on one occasion and ten days later the nearest relative requested an assessment. And the person was admitted to hospital and again appealed. So I had to do a fairly extensive report for the managers' meeting. And I, you know, taking into account the real needs of the carer, to such an extent that the person actually saw it himself, he withdrew his appeal. When they saw that, what was the dynamics that were going on and the needs of the carer. ... they sort of came back that they realised themselves, you know, they were getting a little bit more insight ...'. (Rapaport, 2002; 280).

COMMENTS AND CONCLUSION

Given the seriousness of mental illness, the complexity of mental health treatments and still mysteries surrounding its aetiology, readers will doubtless have many more thoughts and reservations than have been highlighted, about the wisdom of locating such august powers in a lay role, especially where vested interests may feature. However, the study suggests that the development of the nearest relative and reciprocal ASW functions under the 1983 reforms were influenced by principles of empowerment and role theory, specifically normalisation and social role valorisation which were then in the intellectual ether of mental health and sociological circles. It is disappointing therefore that the positive potential of these roles has been ignored to the extent that the findings suggest both struggle for recognition. The failure of S13(4) and the intended early social assessment, which had held so much promise for the social work role, is particularly dispiriting. The apparent continuing diminution of social work in adult social care is especially disconcerting, given that the term 'social work' is now a protected title in law and mandatory professional registration has also been introduced. This suggests that external supports, though important, have limits. More than ever before, social workers need to demonstrate their relevance and position in relation to other professionals and to provide evidence as to how their interventions work.

As already stated, the focus of this contribution is to try to reverse current trends and to encourage social workers to undertake research. The discussion points arising out of the contemporary element of the study are therefore considered under the headings of 1) theoretical and methodological contributions and 2) imperatives for social work policy and evidence-based practice.

Academic matters

Role theory

The findings reveal that the nearest relative is a neglected area of mental health law and many psychosocial, systemic and political factors have frustrated its potential. The role's negative image cast by its neglected position has reflected badly on the ASW. However, in the course of seeking a binding core theory, I discovered within the meanings underpinning the stakeholders' views regarding the nearest relative, the potential for the role to enhance not only its own position but also that of the ASW. The study provides multiple examples of its potential value. The term Reciprocal Role Valorisation (RRV) is advanced as an original contribution to sociological knowledge to explain the potential of mutual role enhancement:

where the nearest relative and ASW supported each other to achieve mutually respected and identified goals to help the patient, that were also recognised by the professionals and significant others involved. Where the nearest relative and ASW were not working together effectively, or at all, the opposite occurred.

Reciprocal Role Valorisation 'RRV' is the main contribution of the nearest relative study.

RRV is conceptually based on the principles of Social Role Valorisation (SRV). It is here described through the examination of the specific functions of the nearest relative from the perspectives of the three stakeholder groups most directly associated with the role. As the nearest relative functions are exclusive to mental health services, they provide unique opportunities to pursue in a tangible way, the interactions of carers, service users and social workers in respect of decisions regarding formal and informal care arrangements. For the first time, as a result of this study, an overarching theory to validate the nearest relative role has been identified.

As already explained, ASW duties to involve the nearest relative resulted in three or four diversions from hospital. Individual examples of ASWs helping nearest relatives to attain their 'encoded' right to information (Twigg, 1994; 295), procure a carer's assessment and debrief after a hospital admission, confirm the positive potential of the nearest relative. In each of these cases the nearest relatives were empowered either to avoid hospitalisation or clarify their position regarding the admission. The stance of these relatives empowered ASW negotiations with the care team and doctors. These reciprocal enhancements cast a positive image on nearest relative and ASW roles.

Support for the nearest relative's perspective was essential to the enhancement process. The nearest relative whose daughter had reacted badly to medication was entirely reasonable in her objection and therefore immune from displacement. Her stance had enabled the ASW to procure a special consultation for her with her daughter's psychiatrist. Kenneth had managed to exert pressure on the patient's doctor and care team to compel them to provide a fitting community support package where a visibly very caring husband had refused to agree to his wife's further detention. A review had demonstrated the care package's success. Maria had debriefed relatives in the wake of Mental Health Act assessments and had felt rewarded and valued by relatives who had clearly appreciated a home visit and personal attention. A notable sense of triumph surrounded accounts of

these rare successes. However, in line with the prevailing culture (Ramon, 2000), these were apparently neither celebrated nor promoted for future learning.

However, it was disappointing that, in spite of their legal role, most of the participant carers and relatives felt no more empowered than the study's service users to deal with the psychiatric system. The role-enhancing potential of 'SRV' had passed them by. The research carers did not feel recognised, empowered or respected and their actions were not influenced by any sense of authority. The all important power to request an assessment (S13(4)) was obliterated by ASW and care team practices favouring the GP assessment. Nearest relative information was not generally available to relatives in a pre-crisis period and healthcare staff seemed to be unaware of its relevance. Thus, as suggested by a few accounts, some golden opportunities for an early social assessment of the patient's circumstances and timely carer support were probably missed. Service users were also concerned that their carers were unaware of the role as they considered carer recognition empowered their own position. The ASW image was also tarnished by problems associated with the designation and healthcare staff did not appear to understand the importance of their duties to nearest relatives under the law. The concept of 'compressed power' was used to describe frustrated potential of the nearest relative and SRV and RRV.

Methods and methodology

The nearest relative study provided an original contribution to research methodology on several levels. Significantly, at the start of the proceedings, there were no interpretative or qualitative models available on which to base ideas to progress the study, as most Mental Health Act research of the period was of a quantitative nature. Furthermore, the views of the three main stakeholders regarding the role had not previously been investigated.

The combination of Grounded Theory and Case Study methodologies was adventurous during the period of research (1995 – 2002), given the reservations then held about the theoretical starting point discussed under ***The Case Study*** above. However, the view was taken that these were a matter of semantics rather than real substance. Significantly, the use of repeat focus group interviews to investigate the role was entirely original.

Data generation: predictably service user groups were the hardest to attract (McIver, 1992), whilst carers were the easiest with ASWs falling mid-way. Minority ethnic groups were the most difficult to involve. However, once engaged, participants appeared to enjoy the process. Some service users were apprehensive about the second interview, as they thought they were being tested about their powers of recall. They were reassured when it was explained that the role was being tested and not they themselves. The double interview combined with the pre- and post-test vignettes, revealed carer and service user difficulties in recalling the nearest relative powers but their ability to debate the issues if directly provided with the information. The written nearest relative information guide handed out at the end of the first interview to the service users and carers, was the least effective tool. It was scarcely read or referenced. I have no explanation for this and can only conjecture that it may have resurrected painful experiences.

Research frameworks: the themes and categories which emerged from the historical analysis (explained in Rapaport, 2002) provided a beginning focus for the contemporary research. The Case

Study successfully accommodated the helped to integrate the historical and contemporary elements and facilitated the comparative analysis. Grounded Theory provided the necessary framework to explore stakeholder views about the topic and to develop theory. The Multiple Case Study enabled comparisons to be made between the stakeholder cases and individual groups contained within the main cases. Embedded groups with distinguishing variables, such as lone carers and participants with a combination of carer, service user and/or professional experiences were identified.

Research design: the use of the focus group method inevitably meant that the study did not investigate the nearest relative by way of single incidents (such as a Mental Health Act assessment). Economies of time and human resources were constraining factors, but other reasons, not least likely ethical constraints and the danger that concentration on a single Mental Health Act scenario might detract from the *wider* role, were additional concerns. Stakeholder positions were amply demonstrated through the interviewing methods. The narrative vignettes brought the nearest relative to life, stimulated discussion relating to personal experiences and enabled carers and service users to evaluate the benefits and burdens of the role. The mix of narrative and naturally occurring vignettes enabled participants to consider the role in relation to multiple, rather than single case scenarios.

Sampling methods: the rationale for allowing carers and service users who declared no experience of the statutory process was justified. It transpired during the course of the interviews that a few of the 'non-experienced' participants were probably otherwise and in any case, the information was still relevant and worthy of consideration by all in case of future eventualities.

Reliability and validity: the methods were appropriate for the topic under investigation and met the logical tests devised by Yin (1994). Triangulation and the comparisons of the three main stakeholders strengthened the internal validity provided by Grounded Theory and the Multiple Case Design. Repetition of the focus group interviews demonstrated that the study could be repeated on similar groups.

The main limitations of the study relate to its size and scope. The population sample was small, confined to London and adjacent counties and did not investigate a range of ethnic minority groups. The majority of carers were providing care for relatives suffering from schizophrenia and other conditions were under-represented. Virtually all the service users had been discharged from hospital and for them the immediate relevance of the powers was therefore diminished for the time being. The voices of isolated relatives and service users not linked to groups were also missing. There were very few ASW participants with personal nearest relative and service user experience. Finally, the research did not include any private patients who may have different experiences, especially if their nearest relatives were paying for their hospital care under section.

Contribution: the nearest relative study added to a small body of research regarding the nearest relative (Cantley and O'Donovan, 1987; Carter, 1999; Gregor, 1999). The general success of the research design in achieving the main objectives suggests its value as a useful model for future investigations of live law. Significantly, with prospects for future research in mind, the mix of legal and psychosocial codes which emerged from the analysis supports the assertion that knowledge and attitudes are highly influential in the use of the Act (Eastman *et al* 2000).

Social Work Imperatives

Policy and Practice

ASWs highlighted multiple problems with the fixed nearest relative hierarchy and inadequacies of the displacement process, which could result in the worst person being identified and the best excluded. The inflexibility of the identification process presented a major issue for ethical practice. In the wrong hands, the principles of beneficence and non-maleficence were deeply compromised. The Mental Health Act Commission had already reported on concerns and drafted appropriate recommendations for change (MHAC, 1991) which had been ignored. It was several years later following the stance of the European Court of Human Rights, before the government agreed to make necessary changes to the nearest relative. Government failings to act on the MHAC's advice arguably resulted in unnecessary legal costs and the prolonged reform of the Mental Health Act, and, most important of all, ongoing misery for some patients. Yet ASWs were more directly involved than any other profession with nearest relative issues. It was in their gift to highlight the risks and ethical problems that they faced, to provide case examples and to collect the compelling evidence for change. Could delays, patient misery and much public expense been avoided if, fuelled with their first hand experience, they had stepped up the pressure? In so doing, would they have raised their profile not only in the eyes of carers, service users, other professionals and decision-makers but also themselves?

In similar vein, if the powers had been publicised and S13(4) implemented, would the early social assessment have come to fruition as had been intended and would social alternatives to hospital have been developed? On a sobering note, there may indeed have been some lost potential here as a six-year study published after the completion of the PhD, found that discharges by the nearest relative against psychiatric opinion were not associated with poor clinical outcome (Shaw et al, 2003). It is of course impossible to know for certain whether greater ASW visibility surrounding the nearest relative powers would have enhanced the social work role. However, lost opportunities for innovation and research cannot be denied either. In addition, if ASWs had been more active in this area, contrary to what actually transpired, would they have been officially represented on the Expert Committee appointed by the government (DH, 1999) to advise on the reform of the Mental Health Act 1983? Furthermore, would the applicant role have remained with social work and not, as later transpired, also opened up to nurses and other non-medical professionals, with the new title of Approved Mental Health Professional (AMHP)?

Social Workers as Researchers

By its nature, social work is deeply embedded in law, politics and social values. This suggests that social workers are arguably well placed to investigate the likely factors, such as attitudes and knowledge base which influence the use of legislation, including the Mental Health Act (Eastman *et al*, 2000) and more generally, govern human actions or behaviour. Grounded theory has developed a highly sophisticated system for analysis of such data which may at first blush seem formidable. However, many if not most social workers during their work, if not also during their training, have experiences of mulling over a client's behaviour and asking themselves: what lies behind this? When does it occur? Is it constant or are there times of change? What are the consequences flowing from the pattern or patterns of these behaviours? These types of questions which concern the dynamics

that influence people's thinking and associated behaviours, are very much in line with the coding paradigm of the mid-stages of grounded theory analysis. As the case study incorporates some similar techniques, albeit to compare and contrast individual and group situations, it should arguably be equally accessible to social worker researchers. Interviewing, putting people at their ease, making observations and recording are of course core social work skills, which can readily be adapted for research purposes. Whilst the list of methods used in the focus groups may also seem long and formidable, aren't training days run on similar lines?

The point is that the methods used in the nearest relative study were very closely related to every day bread and butter social work. Furthermore, apart from one, possibly two, service users, participants stated (anonymously and in writing) that they had enjoyed the interview process. ASWs relished debating a role which sometimes helped and sometimes hindered their practice. Carers were interested to know their rights and like the service users, enjoyed the debate. The explanation about the role to those who professed no prior nearest relative knowledge, perhaps unsurprisingly, provoked much fun. The interviews were punctuated with considerable laughter, in a context of serious thought and reflection.

It has been impossible to provide a full account of the study and its findings here but it is hoped there is sufficient to stimulate thought about the need for more research, carried out by social workers, into issues of concern to the profession. As recent developments have shown, social work cannot rely on external supports to enhance its status. However, it is to be hoped that the new College of Social Work will promote a culture of research within the profession. There is much work to be done, not just to fill epistemological voids but also to raise the social work profile and assert its rightful position in a myriad of multi-professional contexts.

On a finishing note, research to investigate how the roles of the English AMHP under the amendments of the 2007 Act and Scottish Mental Health Officer under the Mental Health (Care and Treatment) (Scotland) Act 2003) compare and contrast, would seem to be burning social work issue of today. This would be most appropriately undertaken by a social worker or group of social workers. Is anyone out there willing to take up the challenge?

EPILOGUE

The Expert Committee (DH, 1999) appointed by government to advise on Mental Health Act reform contained representatives from the medical, legal, nursing and social work professions. Although credited with expertise in the community care field, the social work representative had no direct ASW experience. In view of the huge responsibilities of the ASW in respect of decisions about hospital detention, this omission was indeed astonishing and highlights the necessity for the social work profession to assert itself.

In respect of the nearest relative, the Committee recommended its abolition and replacement by the new roles of the nominated person, appointed by the patient, and carer (see Hewitt, 2007 for more detailed information). These would have rights to be involved in the patient's care plans, although the latter at the patient's discretion. The Committee's recommendations, though generally

welcomed by mental health organisations, were largely rejected by the government. However, significantly the AMHP, nominated person and carer proposals were accepted, although the nominated person was not brought into law. As a representative of the British Association of Social Workers (BASW) Mental Health Special Interest Group on the Mental Health Alliance, a coalition of mental health organisations convened to monitor the legislative reform, I wrote the first draft of the carer policy paper based on the findings of my thesis. I will never know whether it was because of or in spite of my research information, also by this time published in two journals (Rapaport, 2003; 2004), that the government decided to retain the nearest relative, albeit with the long overdue changes to the displacement criteria, in the third and final Mental Health Bill. However this departure may be viewed, the main point here is that it was because of my research I was able to contribute accredited information.

So what happened to my career? By the time I had completed my PhD I had left my social services post. I was subsequently invited to work on a research project about carers and confidentiality jointly managed by Rethink and the Institute of Psychiatry at King's College London (KCL). A year later I joined the Social Care Workforce Research Unit also at KCL where I worked on several projects including those investigating topics such as advocacy, Mental Capacity Act issues and safeguarding. My PhD led to several additional publications (Rapaport 2005a; 2005b; Rapaport and Manthorpe, 2009) and others arising out of my Unit's work programme. I also helped to co-ordinate the Social Work History Network which was and is supported by my Unit. I eventually became a research fellow of which I am extremely proud. However, although grateful for all these post-PhD opportunities, my main disappointment is that I was unable to return to social work as a 'Dr' social worker. Whilst I am able to use my PhD knowledge as a lay or specialist member of the Mental Health Review Tribunal, I should have liked to have had the chance to implement my research findings to enhance the quality of my social work practice. However, if I have succeeded in stimulating interest amongst social workers to pursue a PhD, I hope others will be able to put their findings to good use in this way.

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Information Guide to the Terms Used in the Nearest Relative Research

Research and sociological and psychological terms are in italics

| <i>TERM USED</i> | <i>EXPLANATION OF TERMS: SUMMARIES</i> |
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| Advocate | A person who helps an individual who uses services or a carer to make their needs known |
| <i>Analytic induction (AI)</i> | <i>Equivalent of statistical testing of qualitative associations to see if they are greater than might be expected at random [random error]. Using AI, the researcher examines a case, and, where appropriate, redefines the phenomenon and reformulates the hypothesis until a universal relationship is shown (Silverman, 2001;304)</i> |
| <i>Anti-positivism</i> | <i>Recognises metaphysical facts</i> |
| Approved Social Worker (ASW) | Social Worker appointed to undertake assessments under the Mental Health Act 1983. |
| Care Programme Approach (CPA) | System to assess, provide, plan and review the health and community care needs of a patient/user of services |
| Carer | Provides care on an informal basis, not under contract or for a voluntary organisation. Also defined under the Carers (Services and Recognition) Act 1995 below |
| Carers (Services and Recognition) Act 1995 | Establishes a carer's right to an assessment of own needs. Carer must provide regular and substantial care |
| Carer support worker | Person employed by a statutory or voluntary body to support carers and carer projects |
| <i>Case study</i> | <i>An empirical inquiry that investigates a topic in its real-life context</i> |
| <i>Categories</i> | <i>Classification of concepts</i> |
| <i>Concepts</i> | <i>Clearly specified ideas deriving from a particular model (Silverman, 2001;304)</i> |

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| Community Mental Health Team (CMHT) | Provides local mental health services. Staffed by the multi-disciplinary team (see below). Managed by the local NHS Trust |
| Community Psychiatric Nurse (CPN) | State Registered Mental Health nurse who works in the community; usually member of CMHT (above) |
| <i>Confounded (also intervening) variable</i> | <i>A variable with hidden influences of unknown size on the results (see also “controlled” “dependent” “independent” variables below)</i> |
| <i>Controlled variable (see also “variable” below)</i> | <i>A variable controlled by exclusion, holding it constant (ensuring consistency) or “randomisation” (see below)</i> |
| <i>Conversation analysis</i> | <i>Based on an attempts to describe people’s methods for producing orderly talk-interaction (Silverman, 2001;304)</i> |
| <i>Deductive processes (in Grounded Theory. See also “Inductive processes” below)</i> | <i>Creating ideas and hypotheses about possible causal relationships between concepts or set of properties (contexts) and their dimensions</i> |
| <i>Dependent variable</i> | <i>The variable hypothesised to alter as a consequence of manipulation (see also “independent variable” and “variable” below)</i> |
| Detained (also compulsorily detained/sectioned/formal) patient | Patient detained in hospital under a Section of the Mental Health Act 1983 following statutory assessment |
| <i>Discourse analysis</i> | <i>The study of rhetorical and argumentative organisation of talk and texts (Silverman, 2001;305)</i> |
| <i>Emancipatory (also Inclusive or Participatory) research</i> | <i>Research in which people with learning disabilities are involved as more than just research subjects or respondents</i> |
| <i>Embedded units</i> | <i>Distinct units of analysis embedded within a single or multiple case study</i> |
| <i>Empirical research</i> | <i>Based on observation or experiment</i> |

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| <i>Epistemology</i> | <i>Body of knowledge with special regard to its methods and validation</i> |
| <i>Ethnography</i> | <i>Refers to highly descriptive writing about particular groups of people (Silverman, 2001;305)</i> |
| <i>Ethnomethodology</i> | <i>Seeks to describe methods people use in going about their social lives. Ethnomethodology is not a methodology but a theoretical model (Silverman, 2001;305)</i> |
| <i>Feminism</i> | <i>Concerns discrimination against women in societies organised around male dominance</i> |
| <i>Focus group</i> | <i>A special type of group defined by purpose, size, composition and procedures. Facilitates carefully planned discussion</i> |
| <i>Grounded Theory</i> | <i>A systematic method of analysing complex social phenomena and building theory.</i> |
| Group co-ordinator (carers) | A person who co-ordinates a local carer group on a voluntary basis |
| Guardianship under the Mental Health Act 1983 (see below) | Requires a patient to receive community care and attend for treatment. A guardian is appointed |
| <i>Hermeneutics</i> | <i>Concerns interpretation</i> |
| Human Rights Act 1998 | Incorporates the European Convention on Human Rights into UK domestic legislation |
| <i>Hypothesis</i> | <i>Testable propositions (Silverman, 2001;305)</i> |
| <i>Hypothetico-deductive method</i> | <i>Theoretical propositions are generated in advance of the research process and modified through the process of falsification by the empirical research</i> |
| <i>Ideographic</i> | <i>Descriptive</i> |
| <i>Independent (also experimental) variable</i> | <i>The variable that is manipulated in an experiment (see also “variable” below)</i> |

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| <i>Inductive processes (in Grounded Theory. See also "Deductive processes" above)</i> | <i>Checking and verifying concepts and relationships created by deductive thinking</i> |
| <i>Interpretative (also non-positivistic) paradigm (model)</i> | <i>Research governed by the exploration of meanings and the reasons for intentional actions in relation to contexts, concepts and practices</i> |
| Mental Health Act (MHA) 1983 | The main Mental Health Act covering treatment, detention and rights (now amended by the Mental Health Act 2007) |
| Mental Health Act Commission (MHAC) | Special Health Authority to review the operation of the MHA, visit detained patients and investigate certain complaints; abolished in 2009 when its duties were transferred to the Care Quality Commission. |
| <i>Metaphysics</i> | <i>Theoretical philosophy</i> |
| <i>Methodology</i> | <i>Refers to choices made about cases to study, methods of data gathering, forms of data analysis etc., in planning and carrying out a research study (Silverman, 2001;306)</i> |
| <i>Methods</i> | <i>Specific research techniques. These include quantitative techniques like statistical correlations, as well as techniques like observation, interviewing and audio recording (Silverman, 2001;306)</i> |
| <i>Monism</i> | <i>Theory of unity of scientific method – holds that methods for acquiring knowledge are essentially the same for all experience</i> |
| Multi-disciplinary team | Team comprising many professionals, e.g. psychiatrist, community nurse, occupational therapist |
| <i>Multiple-case design</i> | <i>A case-study containing more than one case (see case study above)</i> |
| <i>Naturalism</i> | <i>Model of research that seeks minimise presuppositions in order to witness subjects' worlds in their own terms (Silverman, 2001;306)</i> |
| Nearest Relative | Identified under Section 26 of the MHA 1983. Has legal rights concerning the patient's detention and discharge. Often also the carer |

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| New long-stay patients | Patients/users in contact with current mental health services who have chronic mental health problems |
| NHS Trust | Body designated by the Government with executive responsibilities to provide local health services |
| <i>Nomothetic</i> | <i>State scientific laws of behaviour and generalisation about reproducible and predictive phenomena</i> |
| <i>Nominalism</i> | <i>Regards universals and general ideas as mere names</i> |
| Old long-stay patients | Resident patients of the former asylums who suffered from chronic mental health problems |
| <i>Paradigms (Models)</i> | <i>Provide an overall framework for how reality is perceived. They describe reality and the basic elements it contains (ontology) and the nature and the status of knowledge (epistemology) (Silverman, 2001;306)</i> |
| Participant | An individual relative, user or ASW who voluntarily participated in the research focus groups |
| Patient | Refers to service users who are 1) subject to compulsion under the MHA 1983, 2) liable to be detained, 3) informal (voluntary) inpatients |
| <i>Phenomenalism</i> | <i>Holds that separation of essence from phenomena should be eliminated</i> |
| <i>Phenomenology/phenomenological research</i> | <i>Seeks to illuminate intersubjective human experiences by describing the essence of the subjective experience (Tesch, 1990;51)</i> |
| <i>Positivism</i> | <i>Recognises only non-metaphysical facts and observable phenomena – rejects metaphysics and theism. Social facts exist independently of both participants and researchers. Positivists aim to generate data that are valid and reliable, independently of the research setting (Silverman, 2001;306)</i> |

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| <i>Positivist paradigm (model)</i> | <i>Research governed by predetermined hypotheses testing for associations between "independent" or experimental variables and "dependent" variables (for both terms see above)</i> |
| <i>Post-modernism</i> | <i>A contemporary approach that questions or seeks to deconstruct both accepted concepts (e.g. the "subject" and "field") and scientific method. It is both an analytical model and way of describing contemporary society as a pastiche of insecure and changing elements (Silverman, 2001;306)</i> |
| <i>Post-structuralism</i> | <i>Holds that all theory, sociological or otherwise, contains subjective elements. Theory is a way of seeing as well as a description of something. Perspectives include both structural and interpretist poles</i> |
| <i>Probability sampling</i> | <i>A representative sample where every member of the population has a statistically equal chance of being selected. Usually achieved by randomisation (see below)</i> |
| <i>Ontology</i> | <i>Branch of metaphysics that concerns the nature of being</i> |
| <i>Randomisation/random sampling/randomness</i> | <i>Technique to distribute hidden influences (confounding or confounded variables) across trials according to a predetermined method. Aims to eliminate bias</i> |
| <i>Realism</i> | <i>Regards things in their true nature independently of subjective conceptions and interpretations</i> |
| <i>Realist</i> | <i>Regards abstract concepts as having an objective existence</i> |
| <i>Relative</i> | <i>Defined under Section 26 of the Mental Health Act 1983. For the research purposes also includes other blood relatives.</i> |
| <i>Relativism</i> | <i>Regards knowledge, truth, morality etc. as relative and not absolute</i> |
| <i>Reliability</i> | <i>The degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different occasions (Silverman, 2001;306)</i> |
| <i>Respondent validation</i> | <i>Involves taking research findings back to the subjects being studied. Where findings are verified, it is argued, that this increases confidence in validation (Silverman, 2001;306)</i> |

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| Responsible Medical Officer (RMO) | Consultant Psychiatrist responsible for the patient's treatment: under the 2007 amendments to the Mental Health Act 1983, now Responsible Clinician (RC). |
| Restriction Orders (Sections 41; 47/49) | Relate to criminal proceedings. Secretary of State has special powers regarding the patient's detention, discharge and movements: nearest relative powers to not apply. |
| Sectioning | Process to detain a person in hospital under a Section of the MHA 1983 (see "statutory assessment" below) |
| Service user | See "user" below |
| Stakeholder groups (in relation to the nearest relative research) | Main groups with major interests or concerns regarding the nearest relative role, viz. Carers, Users and ASWs |
| Statutory agency | Authority with legal duty to provide services |
| Statutory Assessment (under MHA 1983) | Two doctors (one in an emergency) and an ASW (or nearest relative) decide whether a person with mental health problems requires admission to hospital against their wishes |
| Supervised Discharge Section 25A-J MHA 1983 | Required a patient to receive community supervision and to attend for treatment. A supervisor was appointed e.g. a community nurse or social worker. This section has now been abolished and replaced by Supervised Community Treatment and the Community Treatment Order ('CTO') under the 2007 amendments to the Mental Health Act 1983. |
| <i>Symbolic interactionism</i> | <i>Seeks to understand the ways in which individuals' images of themselves are shaped by their interactions with others</i> |
| <i>Theoretical sampling</i> | <i>Non-probability sampling. Development of theory influences the sampling of data collection</i> |
| <i>Theoretical saturation</i> | <i>Testing hypotheses until all the knowledge gaps are complete and relationships between categories are established and validated</i> |
| <i>Theories</i> | <i>Sets of concepts that define and explain some phenomenon (Silverman, 2001;307)</i> |

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| <i>Triangulation</i> | <i>Involves comparing different kinds of data (e.g. quantitative and qualitative) and different methods (e.g. observation and interviews) to see if they corroborate one another (Silverman, 2001;307)</i> |
| Service user | The preferred term for people who receive psychiatric services but not currently under the MHA 1983 or in hospital |
| <i>Validity</i> | <i>Extent to which an account accurately represents the social phenomena to which it refers (Hammersely, 1990;57*, in Silverman, 2001;307)</i> |
| <i>Variable</i> | <i>Used in an experimental context, anything that is free to vary.</i> |
| Voluntary agency | Operates under a management committee, trustees or directors to provide services |

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