Experiences of the ‘Nearest Relative’ provisions in the compulsory detention of people under the Mental Health Act: rapid systematic review

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Abstract

Background

Service users detained for assessment and/or treatment under the Mental Health Act 1983 are allocated a ‘Nearest Relative’. The Nearest Relative has access to confidential information about the service user, and can make decisions about their care and treatment. Tensions exist regarding the identification, displacement and powers of the Nearest Relative.

Objectives

To examine the experiences of service users, carers and relevant professionals of the Nearest Relative provisions of the Mental Health Act 1983, and the equivalent Named Person provisions in Scotland. Five research objectives were defined, understanding the experiences of and issues associated with i) identification of the Nearest Relative, ii) displacement of the Nearest Relative, iii) confidentiality and information sharing iv) access to support from carers and v) making decisions about treatment or care.

Data sources

Seven bibliographic databases: MEDLINE (via Ovid), MEDLINE In-Process & Other Non-Indexed Citations (via Ovid), PsycINFO (via Ovid), Social Policy and Practice (via Ovid), HMIC (via Ovid), CINAHL (via EBSCO) and ASSIA (via ProQuest). Citation searching, author contact and grey literature searches were conducted.

Review methods

A rapid systematic review was conducted in six weeks. Evidence published after 1998 was sought from the UK, pertaining to the experiences of those involved in compulsory detention under the Mental Health Act 1983 (or UK variants), including service users, carers, family members, Nearest Relatives, Named Persons, mental health professionals, policy makers and lawyers. Study selection, data extraction and critical appraisal were completed independently by two reviewers. We sought data about experiences obtained through qualitative means or surveys. Included studies containing several paragraphs of participant quotes and/or author interpretations were entered into a framework synthesis; the rest were summarised.
descriptively. The framework synthesis was based upon the five research objectives and refined using the findings of key studies from England and Scotland and inductive thematic analysis.

**Findings**

Twenty studies were included with 12 prioritised for framework synthesis. Four themes emerged i) issues regarding the identification of the Nearest Relative/Named Person, ii) confidentiality and information sharing, iii) enabling use of the Nearest Relative/Named Person role and iv) importance of maintaining relationships. The involvement of service users in choosing their representative and the role of services in supporting the Nearest Relative/Named Person was identified as important.

**Limitations**

There is little recent evidence to inform this important and complex discussion. The review was rigorously conducted despite the short timescale; however a more in-depth, iterative thematic analysis of all the included studies may have provided additional insights into the mechanisms underpinning the issues.

**Conclusions**

The Nearest Relative provisions of the Mental Health Act 1983 are complex and of significant importance to individuals detained under the Act and their carers. This rapid review provides specific examples of issues that individuals may experience. More research is needed to aid understanding of this complex topic.

**Future work**

Primary research specifically focussed on the perceived and actual use and impact of the Nearest Relative provisions in England and Scotland.

**Study registration**

Registered: PROSPERO CRD42018088237

**Funding**

NIHR HS&DR programme: Project number 16/47/22
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<th>Description</th>
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<tbody>
<tr>
<td>AMHP</td>
<td>Approved Mental Health Worker</td>
</tr>
<tr>
<td>ASW</td>
<td>Approved Social Worker</td>
</tr>
<tr>
<td>BME</td>
<td>Black and Minority Ethnic</td>
</tr>
<tr>
<td>CTO</td>
<td>Community Treatment Order</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health</td>
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<tr>
<td>DHSC</td>
<td>Department of Health and Social Care</td>
</tr>
<tr>
<td>MeSH</td>
<td>Medical Subject Heading</td>
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<tr>
<td>MHA</td>
<td>Mental Health Act (England and Wales)</td>
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<td>MHA 1984</td>
<td>Mental Health Act (Scotland)</td>
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<tr>
<td>MHA 2007</td>
<td>Mental Health Act (England and Wales)</td>
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<tr>
<td>MHCT 2003</td>
<td>Mental Health Care and Treatment Act Scotland</td>
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<tr>
<td>MHO</td>
<td>Mental Health Officer</td>
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<tr>
<td>NP</td>
<td>Named Person</td>
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<tr>
<td>NR</td>
<td>Nearest Relative</td>
</tr>
<tr>
<td>PRISMA</td>
<td>Preferred Reporting Items for Systematic reviews and Meta-Analyses</td>
</tr>
<tr>
<td>SCT</td>
<td>Supervised Community Treatment</td>
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Glossary

Approved Mental Health Professional
Approved Mental Health Professionals are responsible for the assessment and hospital admission of people who have been detained under the Mental Health Act 1983. Approved Mental Health Professionals were introduced in the 2007 amendment to the Mental Health Act 1983 and replace the role of Approved Social Workers. They include social workers, nurses, occupational therapists and psychologists.

Community Treatment Order
Community Treatment Orders allow people who have been detained under the Mental Health Act 1983 to be discharged from hospital on the condition of meeting certain requirements. If the requirements are not met then a person can be involuntarily re-admitted to hospital.

Forensic Detention
Detention of an individual under the MHA by any of the forensic services e.g. police or a court of law.

Mental Health Act (MHA) 1983
The Mental Health Act 1983 is a UK Act of Parliament which applies in England and Wales and gives approved mental health professionals the power to detain people who have a mental health disorder in hospital. The MHA 1983 was amended in 2007.

Mental Health (Scotland) Act 1984
The Mental Health (Scotland) Act 1984 replaced the Mental Health (Scotland) 1960 Act and is primarily concerned with the detention of people with mental health disorders. It is comparable to the Mental Health Act 1983 for England and Wales.

Mental Health (Care and Treatment) (Scotland) Act 2003
The Mental Health (Care and Treatment) (Scotland) Act 2003 replaced the Mental Health (Scotland) 1984 Act. As per the 1984 Mental Health Act it is primarily concerned with the detention of people with mental health disorders.
Mental Health Officer
Mental Health Officers are responsible for the assessment and hospital admission of people who have been sectioned under the Mental Health Act 1984 (Scotland). The role is broadly similar to the role of approved mental health professionals in England and Wales.

Mental Health Tribunal
A Mental Health Tribunal is a legal proceeding which people who are sectioned under the Mental Health Act 1983 can apply for in order to be discharged. A Mental Health Tribunal involves a panel of experts including a judge, a psychiatrist and a lay person with specialist knowledge of the Mental Health Act, and usually takes place in a hospital.

Named Person
The Named Person is an individual who is chosen by a person who is detained under the Mental Health Act 1984 (Scotland) to represent their interests. The Named Person role is similar to the Nearest Relative role in England and Wales, under the Mental Health Act 1983.

Nearest Relative
The Nearest Relative is a family member allocated to represent the interests of a person who is, or may be, detained under the Mental Health Act 1983. The Nearest Relative is a safeguard to protect the rights of a service user, with particular importance when the service user lacks mental capacity.

Reflexivity
This refers to the reflections of an author conducting qualitative research on how their knowledge, views and experiences may influence the research process.

Restricted service users
Service users who are admitted involuntarily hospital under the criminal pathway of the Mental Health Act 1983 and who are subject to a ‘restriction order’ are known as a ‘restricted service users’. Amongst other things, approval of leave, transfer and discharge needs to be granted by the Ministry of Justice for these individuals.
**Sectioned**
A person who is detained under the Mental Health Act 1983 under section 2 or 3 is sometimes described as ‘sectioned’.

**Supervised Community Treatment**
Supervised Community Treatment takes place under a Community Treatment Order, which allows people who have been detained under the Mental Health Act 1983 to be discharged into the community.
Plain English Summary

If people with severe mental health problems are assessed or treated against their will, the Mental Health Act 1983 states that a relative or carer should be appointed as the ‘Nearest Relative’. This means that they will receive important information and be involved in decisions about the person who is unwell. The Nearest Relative is an important but controversial role, with some perceived flaws in the way they are selected, the powers they have and the sensitive information they receive. We were asked to undertake a review of evidence to try to understand the experiences of people involved with the Nearest Relative provisions of the Mental Health Act 1983.

We performed a thorough, systematic search for any studies or reports about people’s experiences of the Nearest Relative. There were not many sources of evidence, but there was enough for us to develop an understanding of the sorts of issues that might be encountered when people are detained under the Mental Health Act and a Nearest Relative is allocated.

One key finding was that it would be better for service users to be actively involved in choosing their Nearest Relative. However, this choice can have a significant impact on family and carer relationships. Professionals involved in the treatment of people with mental illness are in a position to be able to help service users and the Nearest Relative deal with the pressure and responsibilities they will face in this situation. The law was seen as being very complex and hard to understand by most people.

There was little recent evidence to inform this important and complex discussion, however the findings of this rapid review provide specific examples of issues that many individuals may experience. More research is needed in the area if we are to better understand the complex issues involved.

Word count: 300 words
Scientific summary

Background

Under the Mental Health Act 1983 (MHA), individuals with severe mental health difficulties may be detained involuntarily for assessment and/or treatment if they are considered at risk of harming themselves or other people. When a person is admitted to hospital for a period of assessment and/or treatment involuntarily, the MHA states that they are eligible to receive support from an assigned ‘Nearest Relative’ (NR). The NR is a statutory role within these process of care and decision-making. The NR has several rights and responsibilities, including the power to apply for the detention or discharge of the service user, and to receive confidential and potentially sensitive information about their care.

The NR is an important role; however issues over the identification, displacement and powers of the NR have been raised. Under the MHA, the NR is identified from a hierarchical list by an Approved Mental Health Practitioner (AMHP). The AMHP goes through the list, which begins with a partner of over six months (including civil partners), through children, parents, siblings, grandparents, grandchildren, uncles or aunts and nephews or nieces, until a person over 18 and a resident in the UK is identified. The nature of the personal relationship of that individual to the service user is not considered, leading to the potential for ‘unsuitable’ individuals to be appointed (e.g. living far away, poor relationship with service user, unfamiliar with the service user’s needs and wishes regarding their treatment). Given that the NR is privy to sensitive information about the service user, is eligible to make decisions about care, and is the lead point of contact with mental health professionals, significant disruption to the support the service user receives may occur if an inappropriate person is appointed in this role. Because of the potential disruption to care and resulting distress to the service user which may result, the opportunity for service users to apply to ‘displace’ (i.e. change) the person who is assigned NR is possible. This happens through application to the County Courts and was incorporated into the 2007 amendments to the MHA.

There is an alternative to the NR role currently in use within the UK. In Scotland, the Mental Health (Care & Treatment) Act (Scotland) 2003 (MHCT) introduced the ‘Named Person’ (NP) role as an alternative provision to the NR. The NP can be nominated by the service user, and
relatively easily displaced via a written declaration. However, the NP has fewer rights and powers than the NR.

In 2017, the government outlined their intention to commission an independent review of the MHA. To inform the independent review of the MHA, this systematic review was commissioned by the Department of Health and Social Care in January 2018 to explore how the legislation is being used in practise and examine its impact on service users, families and carers.

Objectives
The aim of this systematic review was to summarise and synthesise experiences of the NR provisions of the MHA from the perspectives of service users, family members, carers and relevant professionals. More specifically, it aimed to gather research evidence to answer the following question:

*What are the experiences of services users, family members, carers and relevant professionals of the use of the ‘Nearest Relative’ provisions in the compulsory detention and ongoing care of people under the Mental Health Act (1983)?*

This included the following five objectives:

From the perspective of service users, family members, carers and relevant professionals:

- Explore experiences relating to the identification of the NR in the care of an individual who has been compulsorily detained under the MHA,
- Explore the experiences of requesting displacement of the assigned NR, including the process of going through a tribunal and issues associated with this, such as influences on ongoing care,
- Explore issues relating to service user confidentiality and information sharing, relating to all aspects of compulsory detention,
- Explore issues relating to decisions about care during detention and after discharge, including discharge to a Community Treatment Order (CTO),

- Explore issues relating to service users having access to support from individuals who they want to be involved with or informed about their care.

**Methods**

This was a rapid systematic review, conducted in six weeks. We searched seven bibliographic databases: MEDLINE (via Ovid), MEDLINE In-Process & Other Non-Indexed Citations (via Ovid), PsycINFO (via Ovid), Social Policy and Practice (via Ovid), HMIC (via Ovid), CINAHL (via EBSCO) and ASSIA (via ProQuest). Citation searching of included sources, relevant reviews and websites was also conducted, which in addition to author contact enabled the identification of relevant grey literature.

We searched for qualitative research and survey evidence from the UK, published after 1998 and pertaining to the experiences of those involved in compulsory detention under the MHA (or UK variants, including the MHCT). Studies relating to the experiences of the NR provision for individuals detained under the criminal pathway were not included in this review. We considered the perspectives of service users, carers, family members, NR/NP, mental health professionals, policy makers and legal professionals.

Study selection, data extraction and critical appraisal were completed independently by two reviewers, with disagreements resolved by discussion or referral to a third reviewer. Due to time restrictions, data were extracted, critically appraised and entered into a framework synthesis only from the studies which included the greatest quantity of qualitative data. This was a pragmatic step that considered both the quality and quantity of relevant evidence available in each record, such that those containing several paragraphs of relevant data or more were prioritised. The key characteristics of non-prioritised studies were data extracted, described and tabulated. Critical appraisal was not used to exclude any sources of evidence.

Given the time available, a pragmatic decision was made to perform a framework synthesis, which involved four stages. First, relevant data extracted from prioritised studies was entered into a framework which had been developed based upon the five research objectives. In the
second stage of synthesis, the studies which contributed the most data across all five research objectives were then searched for themes pertaining to each research objective. The studies contributing the most relevant data were then explored for relevant themes, which were then used to refine the framework. Finally, the content of each of the preliminary themes was examined and subthemes developed using an inductive, iterative approach. The relationships between these themes were then described.

Findings
In total 35 papers and reports met our inclusion criteria, reporting on 20 studies. Of these, twelve studies were prioritised for inclusion in the framework synthesis, although the majority of evidence was supplied by seven studies. The prioritised studies included two PhD theses and four reports for government. The rest were peer-reviewed journal articles. Only one study was conducted in Northern Ireland, while three Scottish studies reported on experiences of the NP provisions of the MHCT. The evidence from England was spread across eight studies, although only half were published since the 2007 amendments to the MHA. Sample sizes ranged from 21 to 115 interview participants. All top tier studies utilised interview techniques to collect data, with some using supplementary questionnaires with open responses (n=3), observation of group discussions (n=2) and workshops or group exercises (n=3).

Four themes emerged from the framework synthesis: Issues regarding the identification of the NR/NP; Confidentiality and information sharing; Enabling use of the NR/NP role, and; Importance of maintaining relationships. The first two of these themes were more descriptive, mapping onto our research objectives, while the final two themes were more interpretative.

The first theme, Issues regarding the identification of the NR/NP explored how the hierarchical nature of the NR provision in England can leave service users vulnerable to abuse and biased care; how the NR provision in England is not always representative of the home and family circumstances of service users and their carers, which may mean that the NR role may be assigned to someone who is not involved with the care of the service user. Experiences of both the NR provision in England and the NP in Scotland indicate that the current legislation does not fully support the needs of individuals who do not have and/or do not wish to have an identified NR/NP.
Experience of the NP provision in Scotland suggests that it may be beneficial to be able to allocate a friend or carer of the service user’s choice. Although legislative amendments in Scotland now allow people to opt for no NP, we found no evidence which focused on the relative merits and drawbacks of this approach.

The second theme, *Confidentiality and information sharing* explored the value of confidentiality to both service users and carers, alongside the sometimes conflicting need for professionals and carers to share information with each other about the service user and their care. There were examples of professionals working flexibly with carers to ensure the carers had access to the support they need, whilst respecting the service user’s right to privacy. Several instances regarding the need for professionals to consider the wider family context of the service user when sharing information were highlighted. Service users also valued the opportunity to exercise their right to withhold certain information from their NR or carer.

Carers indicated they would like to improve the processes which would enable them to discuss information about a service user with professionals. They highlighted that whilst they wanted to be able to provide information, they did not always want the patient to know about these conversations, through fear of damaging their relationship.

The theme, *Enabling use of the NR/NP role* explored ways in which all stakeholders can be supported to make full use of the NR provisions of the MHA. The research evidence suggests that the role of the NR or NP is complex and may be poorly understood by service users, carers and professionals alike. It shows how the NR provision supports carers and service users to have their say during an involuntary admission, the type of information that carers, NRs and professionals need so that they can effectively support the service user, and the support that professionals can provide to help carers and service users to make use of the information they are given. Being recognised as the NR or NP also enabled carers to offer support to the service user, through their improved awareness of their rights under the provisions and the recognition of these by professionals.

The theme, *Importance of maintaining relationships* was considered to underpin the other three themes, and explored relationships between service users and carers; service users and
professionals; and carers and professionals. The quality of these relationships may influence the balance between protecting the service user’s confidentiality and information sharing as discussed within Theme 2, and also empower service users and carers and thus act as a protective factor against abuse of the service user and carer burn-out.

The experience of being compulsorily detained places strain on these relationships. There was evidence of experience of a heavy responsibility on carers or the NR/NP; especially when the primary carer is also the NR. Disagreements over treatment decisions, carers feeling ignored, and conflicts with mental health professionals are some of the ways in which relationships can be placed under significant strain. However, there were positive reflections on instances where professionals worked closely with carers to optimise the care service users received.

**Strengths and limitations**

The findings of this review are primarily limited by the lack of available, up-to-date, evidence from rigorously conducted studies. In particular, the included studies were from quite specific localities and health services, so they may not be strongly representative of the broader population experiencing or providing care to individuals compulsorily detained under the MHA in 2018. While similar experiences were seen across studies, the entire synthesis was based upon only twelve studies. Lack of clarity in the reporting of rigour in the collection and analysis of data further limits conclusions. Evidence relating to experiences of the NR provisions since the MHA was amended in 2007 was particularly lacking. At best, findings may be considered indicative of issues with the legislation in England and Scotland that may be experienced by service users and carers.

The review was rigorously conducted in line with published guidelines, despite the short timescale; however a more in-depth, iterative thematic analysis of all the included studies may have elicited more information about the mechanisms underpinning the issues around the NR provisions.

**Conclusions**

This rapid review synthesised qualitative evidence regarding the experiences of various stakeholders involved in the involuntary detention of individuals for assessment or treatment

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of mental health problems. This included those with experience of the NR provisions of the MHA (in England) and the NP provisions of the MHCT in Scotland. We identified a number of common experiences across our twelve included studies. Given the modest number of study participants involved, and how and when they were sampled, the findings should be considered as plausible examples or indicators of experiences of the MHA and related professional practise, rather than a current or totally representative picture of all views and/or practice across the UK.

The synthesis highlighted the importance of the NR role, and the responsibility associated with it, indicating the importance of the right person being identified for the role. Scottish service users valued the ability to nominate their NP, and to easily displace them if needed. However, there was a risk that this power could be exercised too freely, potentially damaging relationships with carers and/or friends. Understanding and communication of the rights, powers and responsibilities of the NR or NP by professionals was considered poor by some service users and carers. It was also suggested that professionals are well placed to improve care by improving their communication with service users and carers, and offering carers emotional and informational support.

The main implications of this review are that the topic of the NR provisions of the MHA is complex, of significant importance to individuals detained under the Act and their carers, and has not been not studied in great detail to date. In order to better understand the NR provisions of the MHA and their influence on individuals involved in their application, more high quality primary research must be undertaken that is specifically focussed on the perceived and actual use and impact of the NR provisions. There is a need for investigation to take place across all relevant population groups. In particular, we recommend:

- Examination of experiences of the NR/NP in light of the most recent legislative changes throughout the UK
- Further research is warranted in all areas of the UK. Northern Ireland and Wales were particularly under-represented. The three studies from Scotland should be supplemented by non-government reports. In England, most of the useful evidence
arose from a very small number of studies, and none of these had been conducted since key legislative amendments were made in 2007.

- There has been a lack of consideration of the experiences of those who are not married or in a civil partnership

- The views of mental health professionals and mental health advocates were not well represented

- We uncovered a dearth of evidence relating to the specific experiences of the NR/NP provisions from the perspective of ethnic minorities

- Qualitative methods may be the most appropriate means of eliciting data about experiences of the NR/NP provisions of the MHA. However, reporting of methodological considerations should be improved

**Study registration**

This study is registered as PROSPERO CRD42018088237

**Funding**

This report was commissioned by the Department of Health and Social Care via the NIHR HS&DR programme as a review project within NIHR HS&DR programme project number 16/47/22.

Word count: 2576 words
1 Background

This report is concerned with the ‘Nearest Relative’ provisions of the Mental Health Act 1983. The work was commissioned by the NIHR’s HS&DR programme. The following sections provide a brief overview of the key features of the Mental Health Act 1983 and the Nearest Relative provisions contained within it, or as amended since 1983. Perceived problems regarding the use of the Nearest Relative provisions are briefly discussed, and the relevant legislative changes which apply to Scotland and Northern Ireland are also described. Finally, justification for the methodological approach, and the aims and objectives of the review are set out.

1.1 The Nearest Relative provisions of the Mental Health Act 1983

The Mental Health Act 1983

The Mental Health Act 1983 (MHA) is a piece of United Kingdom legislation which governs the assessment, care, treatment and related matters pertaining to individuals with a ‘diagnosed mental health disorder’ who are detained in hospital via civil or criminal pathways. The MHA outlines the process by which individuals may be detained and treated, their rights to appeal, and the rights of those receiving aftercare. The MHA also outlines the rights of family and carers of the person being detained. The MHA fully applies to England and Wales, and partly applies in Scotland and Northern Ireland.

‘Sectioning’ under the Mental Health Act 1983: Civil Pathway

Section 2 of the MHA states that a person may be involuntarily admitted to hospital for a period of assessment no longer than 28 days if they are suffering from a mental disorder “of a nature or degree which warrants the detention of the service user in a hospital” and it is in the interests of the health or safety of the service user or for the protection of the public.

A person can be involuntarily admitted to hospital under Section 3 of the MHA for treatment for a period of up to six months initially if they are deemed to be suffering from a ‘mental disorder’ requiring treatment in hospital, and it is necessary for the safety of the service user or anyone else that treatment is given under detention.
The MHA has a series of safeguards to ensure that the powers to detain individuals in hospital involuntarily for a period of assessment and/or treatment are used appropriately. Before an individual can be detained under sections 2 or 3 of the MHA, two medical practitioners should independently assess the service user. The two practitioners should discuss the results of their assessments together, before reporting to an Approved Mental Health Professional (AMHP), who then decides whether to apply to a hospital to detain the service user. An emergency detention can be sought under sections 4 or 5 of the MHA where seeking an assessment by a second medical professional may “involve undesirable delay”. A section 4 can be converted to a section 2 or 3 if a second assessment, by a different medical professional, is conducted within 72 hours.

A service user sectioned under sections 2 or 3 of the MHA has the right to appeal against the decision via a Mental Health Tribunal. The decision to detain a service user also has to be reviewed regularly, although the time-frame for this varies according which section has been used to detain the service user in hospital.

**The Nearest Relative provision**

The Nearest Relative (NR) provision of the MHA was intended as another safeguard to protect the rights of a service user who is being involuntary detained. The NR is an individual assigned to the service user who has several rights and responsibilities relating to the care the service user receives. The NR:

- can make a direct application to a hospital for the detention of the service user.
- can object to the detention of the service user under section 3 and, if this occurs, the service user cannot be compulsorily admitted.
- receives confidential information about the detained person.
- can request that the service user be discharged from sections 2, 3 and a section 7 guardianship order.

Whilst a NR can also request the discharge of a service user from a Community Treatment Order (CTO), they are unable to object to the initial imposition of the CTO or the recall of a...
service user to hospital should they not meet the criteria set by a CTO.¹ For ‘unrestricted’ service users admitted via the criminal pathway on section 37, their NR can apply to the Tribunal to request a discharge from their section.¹

**Identification of the Nearest Relative**

Section 26 of the MHA defines and differentiates ‘relatives’ and ‘Nearest Relatives’. ‘Relative’ means anyone in the following hierarchical list:

- Husband, wife or civil partner
- Son or daughter
- Father or mother
- Brother or sister
- Grandparent
- Grandchild
- Uncle or aunt
- Niece or nephew

Under the MHA, the AMHP will proceed through this list from top to bottom until an eligible NR, who meets the criteria required to take up the position, has been identified. To be considered eligible for the NR role a person must be over 18 years of age, living in the UK if this is the service user’s country of residence and, in the case of partnerships, in a relationship with the service user of longer than six months.¹ Ex-partners who have permanently separated from the service user cannot be considered for the role. In circumstances where two individuals are eligible to fulfil the role (e.g. two siblings), the eldest and/or whole-blood relatives are selected.

**Displacement and delegation of the NR role**

The NR may be ‘displaced’ (i.e. a different person appointed to the role) through application by an AMHP to the County Court. Possible reasons for displacement include when the NR cannot take up their duties due to illness, objects to an admission for treatment (or guardianship
application) without good reason, has not considered the service user’s welfare or protection of the public in their application to discharge the service user or is considered unsuitable to act for any other reason.¹ Displacement of the NR is the only way to detain a service user under section 3 of the MHA if their NR has objected to the detention.

The NR can choose to nominate someone else if they do not wish to take up the responsibilities associated with the role, and may delegate responsibilities to the next eligible NR.²

1.2 Legislative amendments influencing the Nearest Relative provisions

The NR role emerged in the Mental Health Act 1959 and was largely unchanged in the 1983 Act.³ However, since 1983 elements of the MHA 1983 Act have been amended, or influenced by the development of other legislation and codes of practise, which has influenced how the NR provisions are implemented. The key legislative changes are summarised in chronological order below.

The Mental Health (Northern Ireland) Order, 1986

This legislation is broadly similar to the Mental Health Act 1983. It specifies that compulsory admission will normally be on the basis of a recommendation by a general practitioner and application by an Approved Social Worker (ASW).⁴ The role of the NR is similar to that detailed by the MHA.

Human Rights Act 1998

The Human Rights Act 1998 outlines the rights and freedoms that everyone in the UK is entitled to.⁵ These rights are set out in a series of twelve articles, each of which detail a different right. Such rights include: the right to life, the right to privacy, freedom from torture and inhumane or degrading treatment and a right to a fair trial.⁵ The Act means that people in Britain can seek justice in court if they feel their rights have been violated and that public bodies such as hospitals, courts and the police must respect people’s rights.⁶ The Human Rights Act was implemented in the UK in October 2000.

The implementation of the Human Rights Act provides a context for issues relating to information sharing and confidentiality in particular, given that the assigned NR is entitled to
receive confidential information about the service user. Because all health legislation post 1998 must be compliant with the Human Rights Act, we believe that it is of central importance for interpreting and implementing the MHA.

**National Service Framework for Mental Health 1999**

The National Service Framework for mental health section 6 outlines the support that carers of individuals with mental ill health should expect. This includes a yearly assessment of their needs and an implementation of a care plan based upon this. The framework also advises that carers are provided with information regarding the mental health needs of the person they care for, including an explanation of the person’s care plan.

**Mental Capacity Act 2005**

The MCA is intended to protect individuals aged 16 or above who do not have the capacity to make certain decisions for themselves. The MCA is intended to support professionals to assess the capacity of an individual regarding a specific choice and, if capacity is lacking, make a decision that is in the best interests for that person.

**The Mental Health (Care and Treatment) Act (Scotland) 2003**

The Mental Health (Care and Treatment) Act (Scotland) 2003 (or MHCT, 2003) introduced key changes to the processes involved in the detention of people with ‘mental disorders’ in Scotland. The change of greatest relevance to the present review was the introduction of the ‘Named Person’ (NP) role, in place of NR provision. The Millan Committee was established to review the MHA 1984 (Scotland), which included NR provision as set out in the MHA 1983. The NP was recommended in response to a number of concerns over the suitability of the NR, namely that the appointed NR may not be appropriate for reasons of practicality, lack of genuine interest in the service user, and the potential for abuse of powers.

Under the MHCT, the powers of the NP are reduced, the service user has choice over who is appointed and can revoke the NP in writing. If the service user does not nominate a NP, an individual can be appointed by default, turning first to the primary carer, and then to the NR hierarchy set out in the MHA 1983 (with the addition of civil partners as set out in the MHA 2007). Key differences in the NR and NP are shown in Table 1.
The Mental Health Act 2007

The MHA 1983 was revised in 2007, leading to a number of significant changes to the Act. These include changes to professional roles, such as introducing the Approved Mental Health Professional (AMHP) to replace Approved Social Workers (ASW); the introduction of CTOs to replace supervised discharge; certain definitions; interaction with the Mental Capacity Act 2005 and the structure of mental health tribunals. Of direct relevance to the NR provisions were the following amendments:

- When identifying NR, those in civil partnerships were considered as being equal status to people who were married
- Service users were given the power to displace the NR on grounds of unsuitability. Application should be made to a County Court.

Information Sharing and Mental Health: Guidance to Support Information Sharing by Mental Health Services 2009

This Department of Health publication discusses the rights of service users to know about the information which is held about them by public bodies and the right of carers and other members of the public to receive enough information to enable them to support the service user and protect themselves. The document also acknowledges the role carers may play in providing information to services. It recommends criteria which should be fulfilled when sharing information regarding a service user between different parties.

Mental Health (Wales) Measure 2010 and associated Code of Practice to Parts 2 and 3

The Mental Health (Wales) Measure (MHWM) 2010 details the support people living with a mental health problem should receive in both primary and secondary care. With regard to the NR role, the MHWM 2010 aims to ensure that people receiving secondary mental health services in England all have a Care and Treatment Plan (CTP). The associated Code of Conduct for parts 2 and 3 of the MHWM 2010 stipulates that the service user should be involved as much as possible with the assessment to inform their CTP, with their carers and ‘significant others’ should be involved where appropriate.
NHS Five Year Forward View 2014

This policy document outlines government proposals regarding new models of care within the NHS. Of particular relevance to the NR role, this document outlines a commitment to improve the support carers of individuals with long-term conditions receive. The document outlines the goal to improve access to information regarding the service user’s condition, history and care, not only for the service user themselves, but also any other individuals the patient wishes to share this information with.

MHA Code of Practice 2015

The Code of Practice provides guidelines for professionals on their roles and responsibilities under the MHA. Revisions to the Code were made in 2015, in light of changes in law and policy since it was first published, and aims to improve protection of the rights of service users, families and carers. It also outlines how to determine when the MHA should be used instead of the Mental Capacity Act (MCA) and vice versa.
Table 1. Key differences between the Nearest Relative and Named Person roles

<table>
<thead>
<tr>
<th></th>
<th>Nearest Relative (MHA 1983, 2007)¹,¹³</th>
<th>Named Person (MHCT 2003)¹⁰</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Region</strong></td>
<td>England and Wales</td>
<td>Scotland</td>
</tr>
<tr>
<td><strong>Appointment</strong></td>
<td>By default, according to hierarchy of ‘nearness’ of relatives set out in MHA 1983</td>
<td>Nominated by service user. In absence of nomination, defaults to primary carer, then defaults according to the hierarchy of ‘nearness’ of relatives set out in MHA 1983</td>
</tr>
<tr>
<td><strong>Displacement</strong></td>
<td>Via application to County Court</td>
<td>Can be revoked in writing by service user. Can be challenged by mental health professional if deemed inappropriate.</td>
</tr>
<tr>
<td><strong>Option to decline</strong></td>
<td>Powers can be delegated by NR to another eligible relative</td>
<td>Can be declined by NP</td>
</tr>
<tr>
<td><strong>Rights to information</strong></td>
<td>‘Can be’ consulted before a decision is made about compulsory detention for assessment or treatment</td>
<td>To be consulted when a short term detention or compulsory treatment order is under consideration</td>
</tr>
<tr>
<td></td>
<td>‘Can be’ consulted when a CTO is being considered</td>
<td>To be informed of any orders that have been made and any subsequent changes</td>
</tr>
<tr>
<td></td>
<td>To be told the reasons for detention</td>
<td>To receive a copy of a compulsory treatment application</td>
</tr>
<tr>
<td></td>
<td>To be informed about decisions relating to treatment</td>
<td>To attend and provide evidence at tribunals</td>
</tr>
<tr>
<td><strong>To be informed if the service user is placed on a CTO, or placed under guardianship</strong></td>
<td><strong>To be informed of cross-border transfers and hospital transfers (the latter only when the service user challenges the transfer)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>To be informed when a section, CTO or guardianship order is renewed or changed</strong></td>
<td><strong>To be informed when a service user is discharged from detention or from a CTO</strong></td>
<td></td>
</tr>
<tr>
<td>A detained service user may request that information is withheld from the NR</td>
<td><strong>Discretionary powers</strong></td>
<td></td>
</tr>
<tr>
<td><strong>To request an assessment of the service user for compulsory detention</strong></td>
<td><strong>To request an assessment of need for mental health care or community care services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>To apply to detain the service user in hospital for assessment or treatment</strong></td>
<td><strong>To appeal to the sheriff principal and thereafter to the Court of Session</strong></td>
<td></td>
</tr>
<tr>
<td><strong>To request reception of the service user into guardianship</strong></td>
<td><strong>To apply to a Mental Health Tribunal to appeal against the service user’s detention</strong></td>
<td></td>
</tr>
<tr>
<td><strong>To seek to have the service user discharged from an assessment s2) or treatment order (s3)</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1.3 Issues regarding the Nearest Relative provisions

Despite amendments to the MHA (2007) and the introduction of a revised Code of Practice (2015) to give guidance in applying the MHA, there are still concerns about the use of NR provisions. The Care Quality Commission has raised concerns that detained service users are not given enough say in their care. Others have highlighted how the system for involving partners, carer and family members in the care service users receive under the NR provision of the MHA is inflexible, and does not always represent either the wishes of the service user or the person identified as their NR. This is despite the amendments to the MHA in 2007, which recognised same-sex relationships within the NR hierarchy and enabled detained service users to displace people they felt were inappropriate to act for them within the NR role.

In 2017, the government commissioned an independent review of the MHA, to focus on how the legislation is being used in practise and examine its impact on service users, families and carers.

1.4 Overall aims and objectives of the systematic review

The aim of this systematic review is to summarise and synthesise experiences of the NR provisions of the MHA from the perspectives of service users, family members, carers and relevant professionals. More specifically, it aims to gather research evidence to answer the following question:

What are the experiences of services users, family members, carers and relevant professionals of the use of the ‘Nearest Relative’ provisions in the compulsory detention and ongoing care of people under the Mental Health Act (1983)?

This is to include the following objectives:

From the perspective of service users, family members, carers and relevant professionals:
• Explore experiences relating to the identification of the NR in the care of an individual who has been compulsorily detained under the MHA

• Explore the experiences of requesting displacement of the assigned NR, including the process of going through a tribunal and issues associated with this, such as influences on ongoing care

• Explore issues relating to service user confidentiality and information sharing, relating to all aspects of compulsory detention

• Explore issues relating to decisions about care during detention and after discharge, including discharge to a CTO

• Explore issues relating to service users having access to support from individuals who they want to be involved with or informed about their care.
2 Methods

We conducted this systematic review in six weeks. The methods used to identify and select evidence followed the best practice approach recommended by the University of York’s Centre for Reviews and Dissemination. Reporting of the methods and results was consistent with PRISMA reporting guidelines and ENTREQ checklist guidelines. A protocol was registered on the PROSPERO database (PROSPERO CRD42018088237).

2.1 Search strategy

Background scoping searches were performed to help develop a bibliographic database search strategy for the identification of evidence. This consisted predominantly of basic key word searching in Google and Google Scholar. Wherever possible we ensured that relevant papers that were identified in the background scoping process would be retrieved by our bibliographic database searches by deriving search terms from the titles and abstracts.

An information specialist (SB) developed the bibliographic database search in consultation with the review team. The search strategy made use of both controlled indexing (e.g. MeSH in MEDLINE) and free-text (i.e. title and abstract) searching. A qualitative study search filter was used with adaptations to limit the results to qualitative studies. We also included search terms for ‘questionnaires’ and ‘surveys’ in order to compliment the limited qualitative evidence that our background scoping indicated would be available to us. The search results were limited to English language publications in view of the UK focus of our review, and to publications from 1998 onwards in view of the central importance of the Human Rights Act 1998 for interpreting and implementing the MHA. The final search strategy was translated for use in seven bibliographic databases, selected based on their relevance to the topic area: MEDLINE (via Ovid), MEDLINE In-Process & Other Non-Indexed Citations (via Ovid), PsycINFO (via Ovid), Social Policy and Practice (via Ovid), HMIC (via Ovid), CINAHL (via EBSCO) and ASSIA (via ProQuest). The bibliographic database search strategies are reproduced in Appendix 1.1.

Forward citation chasing (identifying papers that cite our included studies) was conducted using Web of Science, Scopus and Google Scholar. Backwards citation chasing (inspecting the
reference lists of included studies) was performed manually by reviewers. The reference lists of previously conducted systematic reviews on topics related to the NR provision of the MHA were also inspected.

The websites of several relevant organisations which were identified through our background scoping were searched using basic keyword searching, as permitted by the search interfaces of the websites. The website search strategies and list of websites searched are reproduced in Appendix 1.2. Finally, authors of relevant studies were contacted to enquire about unpublished or unobtainable studies.

2.2 Inclusion and exclusion criteria
The following inclusion criteria and exclusion criteria, according to the PICo categories (Population, phenomenon of Interest and Context) were applied to the studies identified through the search strategy:

Population:
People detained under Section 2 or 3 of the MHA, their family and carers and the individuals involved with their care who work within the remit of the MHA.

More specifically, this may include:

- Current service users
- Former service users
- Service users’ family members and carers
- Health and social care professionals
- Approved Mental Health Professionals (Community nurses, psychologists, occupational therapists, social workers)
- Advocates
- Police

Include if:
• A service user who has experience of being compulsorily detained under sections 2 or 3 of the MHA
• Carers, relatives, related professionals (listed above)

Exclude if:

• Individuals who have agreed to a voluntary admission and carers, relatives and relevant professionals involved in their care
• Individuals with mental health difficulties not leading to compulsory detention under the MHA

Phenomenon of Interest
Experiences of, or attitudes towards, the application of the Nearest Relative provisions of the MHA. This includes any experiences in relation to the involvement of relatives, carers or professionals in the care of or decisions about a compulsorily detained person.

Include if:

• Data about experiences obtained through qualitative means (e.g. interview, focus group)
• Data about experiences obtained through survey or questionnaire

Context
Use of the NR provisions of the MHA (1983) within the United Kingdom only.

Include if:

• Detention took place under the jurisdiction of England, Wales, Scotland or Northern Ireland
• Data from any time since the publication of the Human Rights Act 1998

Exclude if:

• Detention was not under the jurisdiction of England, Wales, Scotland or Northern Ireland
• Detention of an individual undertaken by forensic services

**Study Design**

**Include if:**

Data from studies using stand-alone qualitative studies and from mixed methods studies using several different methods.

**Exclude if:**

• Blogs, social media posts

• Commentaries, opinion pieces and editorials

• Case studies

• Conference abstracts

• Case law

**2.3 Study selection**

Searches were performed and all results were downloaded into Endnote (Endnote X8, Thomson Reuters, New York, USA) for removal of duplicate records. A pilot screening exercise was performed on a sample (n=100) of bibliographic database search results in order to calibrate inclusion/exclusion judgments for all reviewers (MN, LS, SB), and refine the clarity of inclusion criteria. Decisions were discussed in a face-to-face meeting to ensure consistent application of criteria. Where necessary, inclusion and exclusion criteria were revised to reflect reviewer interpretation and judgement.

The revised inclusion and exclusion criteria were then applied to the title and abstract of each identified citation independently by two reviewers (MN, LS). Disagreements were resolved through discussion, with unresolved disagreements resulting in inclusion for full text screening. Sources excluded on the basis of relating to forensic detention were labelled upon exclusion.
The full text of each source taken forward from title and abstract screening was assessed independently for inclusion by two reviewers. Disagreements were settled by discussion with a third reviewer when necessary.

References were managed in Endnote software. Reasons for exclusion were recorded at full text screening and documented in a PRISMA flowchart.22

2.4 Data extraction

A data extraction form was developed using Microsoft Excel, piloted by MN, LS and SB and refined accordingly. Summary data were extracted for each study included after full text screening (both ‘tiers’ of studies) by one reviewer (MN, LS or SB) and checked by a second reviewer (SB, LS or MN). Extracted data included first author, date of source, title of source, focus/aim of source, sample size, sample demographics, stakeholder groups represented, data collection technique (e.g. survey, interviews, focus group), type of analysis performed, themes or ideas presented relevant to research question.

2.5 Critical appraisal strategy

Critical appraisal was performed on studies prioritised for synthesis only (‘top tier’). Critical appraisal was performed by one reviewer during data extraction using the Wallace Checklist26 (LS, MN) and checked by a second reviewer (MN, LS). Disagreements were discussed and resolved, referring to a third reviewer where necessary. Critical appraisal did not influence eligibility for inclusion or synthesis, but was intended to provide context to findings.

2.6 Methods of data synthesis

Due to the time restrictions imposed on the review process, after full text screening decisions had been completed, a purposive sampling approach was applied to prioritise the best available evidence for inclusion. This was a pragmatic step that considered both the quality and quantity of relevant evidence available in each record. All included studies were rated by two reviewers (MN, LS) based on the volume of relevant primary data collected. Studies that contained at least half a page of qualitative data directly relating to the research objectives, were prioritised into the ‘top tier’ of included studies, ready for inclusion in the framework synthesis. Data from surveys and questionnaires was not prioritised as there were no free text responses to open

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questions presented. Disagreements on the classification of studies were resolved with discussion. Studies which did not meet this rating were retained in the ‘second tier’ of studies. Key details (country, aim of paper, data collection methods and sample characteristics) of studies sorted into the second tier were described and tabulated.

We made a pragmatic decision to use a framework synthesis approach, because a thematic analysis utilising an inductive, interpretative approach would not have been possible within the limited period of time available to complete this review. Framework syntheses have been recognised for their utility in making sense of qualitative evidence within the short time-frame associated with rapid reviews of health research.\textsuperscript{27}

Typically, the initial framework used within a framework synthesis would be selected from an existing theory or model relevant to the field or constructed by drawing upon a thorough understanding of relevant background literature and related theory (for example, see Dixon-Woods et al.\textsuperscript{28}). However, our background scoping and preliminary searches did not identify any accessible theory or framework which was relevant to all of our research objectives. Hence, the process used for the framework synthesis differed from that stated in our protocol. The synthesis process used in this review was as follows:

**Extraction of data relevant to research question(s):**

Participant quotes illustrating the views of service users, carers and Nearest Relatives and the author interpretations of these views, (known as first and second order-construct data respectively\textsuperscript{29}) were extracted from the results section of each top tier article. The information was placed within a framework based upon our five research objectives, by one reviewer (LS, MN) and checked by a second reviewer (MN, LS) using Microsoft Excel. This information was used to identify which papers which contributed towards a range of different research objectives and represented a variety of participant perspectives.

**Identification of initial themes**

This process was carried out independently by two reviewers (LS, MN), with each identifying eight top tier papers from three studies with the most data relevant to multiple research objectives, accounting for a range of participant perspectives. One of these studies was
conducted in England, and two in Scotland. One reviewer (LS) selected the themes presented in each article which were most relevant to the research objectives. A second reviewer (MN) checked the selection of themes (see Appendix 2), which were then used to revise the Stage 1 framework. Studies in the second tier of includes did not influence the identification or development of themes.

**Final framework revisions using thematic analysis**

The content of each of the themes generated through Stage 2 of the synthesis was then re-examined. Within each broad theme, first and second order data which appeared to be discussing similar or related concepts were grouped together. This formed the beginnings of descriptive subthemes. The data contained under these subthemes was moved, both within and across existing sub themes to reflect changes in their content. Preliminary subthemes were divided, merged and content changed in an inductive, iterative process, in order to capture current or relevant ideas within the included studies that were not represented by the initial framework. As this process evolved and additional interpretation occurred, the names of subheadings and their placement under certain themes were changed in order to reflect the data within them. Towards the end of the process, some theme names were also changed in order to better represent the content of the framework and the reviewer’s understanding of the data.

The synthesis was conducted by one reviewer (LS) within Microsoft Excel. The names of emerging subthemes and themes were checked with other members of the review team (MN, SB, JTC, RA), whose feedback was incorporated into the developing themes and subthemes to ensure their names accurately reflected their content.

**Relationship between the themes**

A figure representing the relationship between the themes identified through the framework synthesis of the top tier papers was then developed through discussion (LS, SB, MN, RA, JTC). The data synthesis process is summarised below in Figure 1.
End user involvement
One carer with experience of the Nearest Relative provisions provided feedback on the themes and subthemes identified by the synthesis and commented on the write up of the results within this report.

Figure 1: Framework synthesis process for prioritised studies

Reflexive statement
The methods utilised within this review were reflective of the expertise and experience within the review team. The team consisted of three systematic reviewers (JTC, MN, LS), an information specialist (SB) and a health economist (RA) with prior experience of conducting systematic reviews for the National Institute of Health Research. This prior experience meant the team aimed to maintain a rigorous methodology throughout the review, despite the limited
timeframe available. This is reflected in the decision to retain searching across multiple databases, double screening of references at both title/abstract and full text, searches within the grey literature and citation chasing. The team’s prior experience of managing large numbers of retrieved studies within a set time frame meant that we were quickly able to identify a method to prioritise the studies for inclusion in the main synthesis.

The focus of the review was novel for most members of the team. This meant the background reading and identification of search terms was informed by objective appraisal of existing literature; albeit restrained by the time available. The team knew of some relevant policy due to previous projects and the experience of one reviewer (LS) of working alongside individuals detained under the MHA and working in accordance with the MCA. This reviewer utilised their prior experience and knowledge gained through their training as a Clinical Psychologist and of conducting qualitative synthesis within this review. Their experience provided a lens through which the information included in this review was selected, placed within themes and interpreted. This was balanced by the checking of extracted data by a second reviewer and incorporation of views from other members of the team and a carer with experience of the MHA. The limited time frame necessitated the use of a framework methodology and a more descriptive analysis; which also limited the potential bias during the synthesis process.
3 Results

3.1 Study selection

The PRISMA diagram in Figure 2 summarises the study selection process. Bibliographic database searches identified 2439 records and supplementary search methods identified 126 records. Following the removal of duplicates there were a total of 1851 unique records which were screened against our inclusion and exclusion criteria. The full texts of 173 papers were sought for further consideration. Of these, 159 full texts were successfully retrieved (92 per cent). Following full text screening, 124 papers were excluded for the reasons specified in Figure 2. Just over half of excluded papers (n = 62) were excluded due to not reporting relevant data. Other common reasons for exclusion included non-UK study (n = 22) and no primary study data (n = 21). A smaller number of papers were not about compulsory detention (n = 12), were not about the MHA or a relevant section of the MHA (n = 1 and 3, respectively) and there was one conference abstract for which no follow up journal article could be identified. Thirty eight papers identified at the title and abstract screening stage focused on involuntary hospital admissions through the criminal pathway of the MHA. The citations of these records are listed in Appendix 4. These were not full text screened and are not included in any further analysis.

In total 35 papers were identified that met our inclusion criteria3, 19, 30-62; 22 papers via searching bibliographic databases and 13 papers via supplementary search methods.

As described in section 2.2, papers which met our inclusion criteria were categorised according to the volume of relevant primary data presented. Papers with several paragraphs of data or more were prioritised into the ‘top tier’ of included studies for synthesis; and studies which did not meet this rating were retained in the ‘second tier’ of studies for narrative description.
Figure 2. PRISMA flowchart
3.2 Description of included studies

Included sources – prioritised studies

Of the 20 studies that met criteria for inclusion in the review, there were 12 studies, reported across 22 papers, which contained enough relevant and usable data for inclusion in the framework synthesis.3, 30-32, 35-37, 39, 44, 45, 47, 48, 50-59 Table 2 contains a summary of the foci, sample characteristics and qualitative data collection and analytic methods employed in these studies.

Amongst the ‘top tier’ studies, there were two PhD theses30, 31 and four reports.32, 48, 55, 59 The three studies from Scotland31, 32, 55 consisted solely of government reports and subsequent publications in peer-reviewed journals, all focusing on the implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003, with specific regard to the ‘Named Persons’ provisions. One study37 was conducted in Northern Ireland and focused on the views of various stakeholders on advocacy services available after compulsory detention. The remaining eight studies conducted in England could broadly be grouped as focusing on experiences of CTOs,56, 59 interactions with various mental health professionals48, 57 or perceptions of the MHA 1983 and the Nearest Relative provisions and implications for care.30, 44, 45, 47

All of the ‘top tier’ studies collected data using interviews. Other data collection methods that were used included administering questionnaires with space for open responses,30, 37, 48 observation of group discussion,44, 48 and workshop events or group exercises.30, 47, 48 There was a mixture of national and local sampling approaches, resulting in sample sizes ranging from 21 carers44 to 998 survey respondents.48 Interviews were conducted with samples ranging from 2144 to 11555 individuals from a range of perspectives. Analysis was described as “Thematic analysis” (eight studies),31, 35-37, 45, 47, 48, 56-59, grounded theory (two studies)32, 44 or framework analysis(two studies)3, 30, 50-55.
Table 2. Description of studies included in framework synthesis

<table>
<thead>
<tr>
<th>First author, date</th>
<th>Country</th>
<th>Publication type</th>
<th>Study focus</th>
<th>Qualitative data collection method (date of data collection)</th>
<th>Participants providing qualitative data</th>
<th>Study context and sampling</th>
<th>Type of qualitative data analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berzins, 2009a³¹; 2009b³⁶, 2010³⁵</td>
<td>Scotland</td>
<td>D, JP, JP</td>
<td>Perceptions of Named Person provisions</td>
<td>Semi-structured telephone (carers) and face to face interviews (data collected 2005-2007)</td>
<td>Total n=46: service users (n=20); carers (n=10) (as potential named persons, n=3 already named persons, n=4 considering, n=3 not considering); MHOs (n=7)</td>
<td>MHOs from local authorities, service users</td>
<td>Thematic analysis</td>
</tr>
<tr>
<td>First author, date</td>
<td>Country</td>
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</tr>
<tr>
<td>Campbell, 200837</td>
<td>Northern Ireland</td>
<td>JP</td>
<td>Nature of legal advocacy services available after compulsory admission</td>
<td>Focus group interviews and questionnaires (date of collection NR)</td>
<td>Total n=44 respondents from five mental health service user groups: carer group; lawyers; Mental Health Review Tribunal member; Questionnaires posted to solicitors and hospital administrators in Northern Ireland. Focus</td>
<td>Direct contact/newsletter</td>
<td>Thematic analysis</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td>Dawson, 2009(^{32})</td>
<td>Scotland</td>
<td>R</td>
<td>Perceptions of Named Person provisions</td>
<td>Face to face interviews, telephone interviews and focus groups (data)</td>
<td>Professional advocacy service managers; hospital administrators</td>
<td>Four local authority areas and their associated health board across Scotland.</td>
<td>Framework analysis</td>
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<td>Total n=44: service users (n=2); Named Persons (n=4); tribunal members (n=13); MHOs (n=14); nurse (n=1); legal reps</td>
<td>group recruitment NR</td>
<td>Contact with voluntary</td>
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<td>First author, date</td>
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<td>Henderson, 2002&lt;sup&gt;44&lt;/sup&gt;</td>
<td>England</td>
<td>JP</td>
<td>Service users’ experiences of mental health care after compulsory admission</td>
<td>Semi-structured interviews and observation of group discussions</td>
<td>Total n=21: carers (n=11); service users (n=10)</td>
<td>Participants had to be or have been in a relationship where one partner has a</td>
<td>Phenomenological framework analysis</td>
</tr>
</tbody>
</table>

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<th>Type of qualitative data analysis</th>
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<td></td>
<td></td>
<td></td>
<td>Diagnosis of bipolar disorder</td>
<td>(data collected 2001)</td>
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<td>First author, date</td>
<td>Country</td>
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<td>Qualitative data collection method (date of data collection)</td>
<td>Participants providing qualitative data</td>
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<tr>
<td>Jankovic, 2011⁴⁵</td>
<td>England</td>
<td>JP</td>
<td>Experiences of family caregivers of relatives involuntarily admitted to psychiatric hospital</td>
<td>In-depth, semi-structured interviews (date of collection NR)</td>
<td>Total n=31 family caregivers</td>
<td>Contact by letter or telephone. Service users recruited in larger national multi-centre study on Outcomes of Involuntary Hospital Admission in England</td>
<td>Thematic analysis</td>
</tr>
<tr>
<td>First author, date</td>
<td>Country</td>
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<td></td>
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<td>provided informed written consent to approach their family caregivers</td>
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<table>
<thead>
<tr>
<th>Marriott, 2001</th>
<th>England</th>
<th>JP</th>
<th>Opinions about the MHA 1983 from those subjected to, or affected by it</th>
<th>Focus group, telephone interviews, consensus meeting or written responses</th>
<th>Total n=85* in three groups. Group One (n=40) of which: mental health nurses (n=9); approved social workers (n=10); general psychiatrists (n=4); Mental Health Act administrators (n=5); service users (n=5); their carers (n=7). Group Two (n=19), of which: hospital managers</th>
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<tr>
<td></td>
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<td></td>
<td>Focus group, telephone interviews, consensus meeting or written responses</td>
<td>Total n=85* in three groups. Group One (n=40) of which: mental health nurses (n=9); approved social workers (n=10); general psychiatrists (n=4); Mental Health Act administrators (n=5); service users (n=5); their carers (n=7). Group Two (n=19), of which: hospital managers</td>
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<td></td>
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<td>Initial nominations made by national experts or representative organisations. Contacted by telephone or in writing</td>
<td>Thematic analysis</td>
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</table>
(n=2); solicitors
(n=2); general practitioners
(n=3); policy makers (n=4);
police surgeons
(n=2); police liaison officers
(n=3); specialist psychiatrists (one from each of learning disability, forensic and child and adolescent services) (n=3)).

Group Three (n=26), consisting of people leading
organisations representing groups 1 and 2: these included a number of national organisations representing users and carers and professional groups affected by or using the Act
<table>
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<tr>
<th>First author, date</th>
<th>Country</th>
<th>Publication type</th>
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<th>Participants providing qualitative data</th>
<th>Study context and sampling</th>
<th>Type of qualitative data analysis</th>
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<tbody>
<tr>
<td>Pinfold, 2004⁴⁸</td>
<td>England</td>
<td>R</td>
<td>Identify examples of good practice, or issues with information sharing between mental health practitioners and carers</td>
<td>Telephone interviews, face to face group discussions, multi-disciplinary workshop events, open ended survey questions (date of</td>
<td>Survey (n=998) of which: service users (n=168), professionals (n=212), carers (n=496), carer support workers (n=93), young carers (n=29). Interviewed (n=34) of which: service users (n=5);</td>
<td>National advertising. Convenience, purposive and snowball sampling</td>
<td>Thematic analysis of interview data and content analysis of open responses</td>
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<td>NR</td>
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<td>collection professionals working in mental health and ageing (n=5); professionals working in adult mental health services (n=9); carers for people with severe mental illness (n=7); carers supporting people</td>
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<tr>
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<tr>
<td><strong>Rapaport, 1999</strong>; 2002; 2003; 2004; 2012</td>
<td>England</td>
<td>JANP, D, JP</td>
<td>Investigate conceptual and ethical issues and carers’ and service users’ perspectives of Nearest</td>
<td>Focus group interviews, role information, vignettes and group exercises, questionnaires (data)</td>
<td>Total n=79: carers (n=34); service users (n=19); ASWs (n=26)</td>
<td>Recruited through local groups. Invited by letter, followed up by telephone and visit. All had to have experience of Nearest</td>
<td>Comparative content analysis of historical data. Grounded theory and Multiple Case Design analysis of contemporary data</td>
</tr>
<tr>
<td>First author, date</td>
<td>Country</td>
<td>Publication type</td>
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<tr>
<td>Ridley 2009&lt;sup&gt;55&lt;/sup&gt;; 2010&lt;sup&gt;54&lt;/sup&gt;; 2013&lt;sup&gt;53&lt;/sup&gt;</td>
<td>Scotland</td>
<td>R, JP</td>
<td>Experiences and views of the early implementation of the MHCT Act</td>
<td>Focus group and telephone interviews (data collected 2007-2009)</td>
<td>Total n=115: service users (n=49); carers (n=33); professionals (n=38 of which n=15 representatives of organisations and n=23 individual)</td>
<td>Purposive sampling from four health board areas in Scotland, chosen to reflect rural, urban and mixed geographical areas (Dumfries)</td>
<td>Grounded theory</td>
</tr>
<tr>
<td>First author, date</td>
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<td></td>
<td>practitioners (General Practitioners, Psychiatrists, Community Psychiatric Nurses, psychologists, MHOs, lawyers, and advocacy workers)</td>
<td>and Galloway, Fife, Greater Glasgow &amp; Clyde) and the State Hospital</td>
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<td>Rugkasa, 2017&lt;sup&gt;56&lt;/sup&gt;; Canvin, 2014&lt;sup&gt;39&lt;/sup&gt;</td>
<td>England</td>
<td>JP</td>
<td>Experiences of carers and involvement of family in CTOs</td>
<td>Interviews (data collected 2012)</td>
<td>Total n=24 family carers</td>
<td>Family carers of service users with experience of CTOs</td>
<td>Thematic analysis</td>
</tr>
<tr>
<td>Smith, 2015&lt;sup&gt;57&lt;/sup&gt;</td>
<td>England</td>
<td>JP</td>
<td>Nearest Relative’s experiences of mental health crises, identify improvements that could be</td>
<td>Telephone interviews (data collected 2014)</td>
<td>Total n=32 Nearest Relatives</td>
<td>Nearest Relatives in contact with ASWs in the south of England</td>
<td>Inductive thematic analysis</td>
</tr>
<tr>
<td>First author, date</td>
<td>Country</td>
<td>Publication type</td>
<td>Study focus</td>
<td>Qualitative data collection method (date of data collection)</td>
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<td>Stroud, 2014&lt;sup&gt;59&lt;/sup&gt;; 2015&lt;sup&gt;58&lt;/sup&gt;</td>
<td>England</td>
<td>R, JP</td>
<td>Service user and practitioner experiences of</td>
<td>In-depth semi-structured interviews (data)</td>
<td>Total n=72: service users (n=21); Nearest Relatives (n=7); care coordinators</td>
<td>Consulted CTO records from Sussex Partnership NHS Trust,</td>
<td>Thematic analysis</td>
</tr>
<tr>
<td>First author, date</td>
<td>Country</td>
<td>Publication type</td>
<td>Study focus</td>
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<td></td>
<td>the use of CTOs</td>
<td>collected 2011-2012)</td>
<td>(n=16); Responsible Clinicians (n=10); AMHPs (n=9); service providers (n=9)</td>
<td>approached by letter of invitation</td>
<td></td>
</tr>
</tbody>
</table>

*Participant details taken from methods section, results section lists n=82 respondents but does not provide breakdown of stakeholder groups.

AMHPs=Approved Mental Health Practitioners; ASW=Approved Social Worker; D=Dissertation/thesis; JP=Journal Article Peer-reviewed; JANP=Journal Article Not Peer-reviewed; R=Report; CTO=Community Treatment order; MHA 1983=Mental Health Act 1983; MHCT Act=Mental Health (Care and Treatment) (Scotland) Act 2003; MHO=Mental Health Officers; NR=Not Reported;
Included sources – ‘second tier’ studies

Ten papers, reporting eight studies, met the inclusion criteria for the review but did not contain enough relevant data for synthesis.\textsuperscript{19, 33, 38, 40-43, 46, 49, 60} Table 3 contains a summary of the aims, sample characteristics and methods for these ten papers. Abstracts are provided in Appendix 3.

There were eight peer-reviewed journal articles reporting six primary studies\textsuperscript{33, 38, 40, 42, 43, 46, 49, 60} and two survey-based reports.\textsuperscript{19, 41} Eight papers reported research conducted in England and/or Wales,\textsuperscript{19, 33, 40-43, 49, 60} and two reported research conducted in Northern Ireland.\textsuperscript{38, 46} The papers by Campbell et al.\textsuperscript{38} and Manktelow et al.\textsuperscript{46} were based on survey data collected in 1998-1999, in the context of The Mental Health (Northern Ireland) Order (1986). Of the studies conducted in England and Wales, only the study by DeMaynard et al.\textsuperscript{40} may have been conducted prior to the 2007 amendments to the Mental Health Act 1983, although the date of data collection was not reported.

Telephone and face-to-face interview and focus groups were used in five studies to capture experiences.\textsuperscript{33, 38, 40, 42, 49} Survey methods with opportunity for free text or open responses were used on their own in three studies\textsuperscript{19, 41, 60} and used in conjunction with interviews by Campbell and colleagues.\textsuperscript{38}

The views of service users were captured in seven studies,\textsuperscript{19, 33, 38, 40-43, 46, 49} including two focusing on the experiences of black and minority ethnic service users.\textsuperscript{40, 49} Appointed NR or NPs were only specifically sampled in the study by Banks et al.\textsuperscript{33} Other family or carers (i.e. not necessarily in any formal statutory role) contributed views in five studies.\textsuperscript{19, 38, 41, 42, 49} Mental health professionals, including Approved Mental Health Professionals and Approved Social Workers were sampled in six studies.\textsuperscript{19, 33, 38, 41, 49, 60}
<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Aim or focus of paper (from paper)</th>
<th>Sample</th>
<th>Data collection and analytic approach</th>
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</thead>
<tbody>
<tr>
<td>Banks 2016</td>
<td>England</td>
<td>Understand experiences of CTO practise within the context of the personalisation agenda; in particular, aspects of person-centred support</td>
<td>Total n=72: service users (n=21); practitioners (n=35 of which: care coordinators n=16, responsible clinicians n=10, AMHPs n=9); Nearest Relatives (n=7); service (supported housing) providers (n=9)</td>
<td>Thematic analysis of semi-structured interviews</td>
</tr>
<tr>
<td>Campbell 2001; Manktelow 2002</td>
<td>Northern Ireland</td>
<td>Reports on the first extensive survey of ASW activity in Northern Ireland. The research aimed to explore the training, practise and management of ASWs</td>
<td>Total n=282: service users/carers (n=28); ASW managers (n=11); ASWs (n=243 survey respondents)</td>
<td>Thematic analysis of semi-structured interviews conducted via telephone, face to face or in focus groups. Additional postal survey of ASWs</td>
</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>Aim or focus of paper (from paper)</td>
<td>Sample</td>
<td>Data collection and analytic approach</td>
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<tr>
<td>De Maynard 2007⁴⁰</td>
<td>England</td>
<td>Seeks to examine the experiences of black men detained under the Mental Health Act of 1983</td>
<td>Total n=8: BME men (specifically African or African Caribbean descent) living with severe mental illness</td>
<td>Grounded theory approach to analysis of qualitative interviews</td>
</tr>
<tr>
<td>Department of Health 2015⁴¹</td>
<td>England</td>
<td>The Department of Health consulted people and organisations about strengthening the rights and choices of people to live in the community, especially people with learning disabilities, autism or mental health conditions. This document summarises the main trends in responses to the consultation</td>
<td>Total n=468: n=219 responses from individuals: service users (48%); carers, family or friends of service users (25%)*; health and social care professionals, support workers and advocates and others. n=221 responses from various organisations; n=28 from other groups</td>
<td>50 item ‘agree/disagree’ questionnaire, with space for open comments. Content analysis of open responses</td>
</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>Aim or focus of paper (from paper)</td>
<td>Sample</td>
<td>Data collection and analytic approach</td>
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<tr>
<td>Gault 2009⁴²; Gault 2013⁴³</td>
<td>England</td>
<td>Describes people’s experience of being compliant or non-compliant with treatment, their experience of compulsory treatment and how they feel they should be encouraged to comply</td>
<td>Total n=19: service users (n=11); carers (n=8)</td>
<td>Two largely unstructured focus groups 10 or 12 months apart, coded with a grounded theory approach</td>
</tr>
<tr>
<td>Mental Health Alliance 2017¹⁹</td>
<td>England</td>
<td>The survey focused on the underlying principles of the Mental Health Act and how people’s rights are currently protected, where it is working well and what could be changed and improved</td>
<td>Total n=8631 survey responses from service users, carers and mental health professionals</td>
<td>Questionnaire with opportunity for free text responses</td>
</tr>
<tr>
<td>Raibee 2013⁴⁹</td>
<td>England</td>
<td>This paper examines the views and experiences of using and providing mental health services from the perspectives of black African and black African Caribbean mental health professionals</td>
<td>Total n=65: BME service users (n=25); carers (n=24); a range of statutory mental health professionals (n=16)</td>
<td>Grounded theory approach to analysis of telephone interviews, face to face interviews and focus groups</td>
</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>Aim or focus of paper (from paper)</td>
<td>Sample</td>
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<td>health service users, their carers, voluntary services and a range of statutory mental health professionals and commissioners in Birmingham, UK</td>
<td>Total n=14 AMHPs</td>
<td>50 item questionnaire, with opportunity for open comments</td>
</tr>
<tr>
<td>Taylor 2013</td>
<td>England</td>
<td>Sets out the views of AMHPs on the impact of SCT on their work and their service users’ lives in the community</td>
<td>*data from respondents who provided demographic information (n=198 individuals); AMHP=Approved Mental Health Professional; ASW=Approved Social Worker; BME=Black Minority Ethnic; CTO=Community Treatment Order; SCT=Supervised Community Treatment</td>
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3.2.1 Eligible sources retrieved late

Three additional records were identified at title and abstract screening as being eligible for inclusion in the review, but could not be retrieved in time to be considered for data extraction or synthesis, due to the rapid review timeline. These consisted of i) a PhD thesis acquired via expert recommendation, about approved mental health practice in England and Wales, ii) a journal article identified through database searches and retrieved via the British Library about service users’ experiences of compulsion under the MHA 1983 and iii) a report by The Social Services Inspectorate, part of the Social Care Group in the Department of Health, that provided relevant data about the involvement of social workers in the care and treatment of involuntarily detained service users. Of the three additional records, only the PhD thesis by would have been eligible for inclusion in the framework synthesis, based on the volume of relevant data presented.

3.2.2 Critical appraisal

The quality of the 12 studies included in the framework synthesis, is shown in Table 4. Overall studies scored well in several domains. All studies provided a clear question and subsequently used appropriate study designs to answer them. Findings were always substantiated by data and largely generalised to an appropriate degree. Reflexivity was only explicitly considered in two studies and as such they were the only studies where it was possible to determine the effect of the authors’ ideological or theoretical perspective on their findings. In terms of the reporting of methods, the context or setting was only described well in five of 12 studies. Samples were usually appropriate, or their limitations acknowledged. For the description of data collection, three studies did not provide enough information to be able to reproduce the data collection setting while there was insufficient evidence of rigorous data collection in two studies that only described the use of an interview schedule. Other studies described the use of additional markers of rigorous methods, such as the use of audio recordings, checked transcripts and supplementary note taking. Four studies were judged to have lacked evidence of rigorously conducted data analysis. In order to score positively for this outcome, studies needed to have included an explicit description of the process of qualitative data analysis, for example the pathway from initial coding of transcripts.
to the development of final themes. Finally, there was no explicit reference to ethical issues, ethics approval, or confidentiality issues in three studies.\textsuperscript{44, 47, 57}
Table 4. Quality appraisal of studies included in framework synthesis

<p>| Study         | Is the research question clear? | Is the theoretical or ideological perspective of the author or funder (or design, methods or research findings)? | Has this influenced the study design, methods or research findings? | Is the study design appropriate to answer the question? | Is the context or setting adequately described? | Was the data collection adequately described? | Was data collection rigorously conducted to ensure confidence in the findings? | Was there evidence that the data analysis was rigorously conducted to ensure confidence in the findings? | Are the findings substantiated by the data? | Has consideration been given to any limitations of the methods or data that may have affected the results? | Do any claims to generalisability follow logically and theoretically from the data? | Have ethical issues been addressed and confidentiality respected? |
|---------------|--------------------------------|----------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------|------------------------------------------------|------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| Berzins 2009a&lt;sup&gt;31&lt;/sup&gt; | Yes                           | Yes                                                             | Yes                                                                 | Yes                                               | Yes                                                | Yes                                                | Yes                                                                                      | Yes                                                                                      | Yes                                               | Yes                                                | Yes                                                    | Yes                                                    |
| Campbell 2008&lt;sup&gt;37&lt;/sup&gt;   | Yes                           | No                                                              | CT                                                                  | Yes                                               | No                                                  | Yes                                                | No                                                                                       | No                                                                                       | Yes                                               | Yes                                                | Yes                                                    | Yes                                                    |
| Dawson 2009&lt;sup&gt;32&lt;/sup&gt;     | Yes                           | No                                                              | CT                                                                  | Yes                                               | No                                                  | No                                                  | No                                                                                       | Yes                                                                                      | Yes                                               | Yes                                                | Yes                                                    | Yes                                                    |
| Henderson 2002&lt;sup&gt;44&lt;/sup&gt;  | Yes                           | No                                                              | CT                                                                  | Yes                                               | No                                                  | No                                                  | No                                                                                       | Yes                                                                                      | Yes                                               | Yes                                                | Yes                                                    | No                                                     |</p>
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CT = Can’t tell; Green shading indicates a positive assessment; yellow shading indicates lack of information needed to assess; red shading indicates a negative assessment.
3.3 Framework synthesis

Four themes were identified. These were: 1) Issues regarding the identification of the Nearest Relative/Named Persons, 2) Confidentiality and information sharing, 3) Enabling use of the NR/NP role and 4) Importance of maintaining relationships.

The first two of these themes are descriptive in nature and closely reflect our research objectives. The final two themes ‘Enabling use of the NR/NP role’ and ‘Importance of maintaining relationships’ are more interpretative and arose from the thematic analysis. This is because it was felt that themes directly based on our remaining research objectives (‘Exploring issues related to care during detention and after discharge’ and ‘Exploring issues related to service users having access to support from carers’) would not be very meaningful and thus further interpretation by the reviewers was required. Within this synthesis, ‘Importance of maintaining relationships’ is considered to be a theme underpinning the other three themes. Where there is overlap in the concepts between themes, this has been acknowledged.

The relationship between the four themes identified and our research objectives is detailed in Table 5 below, which also provides an overview of the studies which contributed towards the development of each theme. Table 5 also highlights which population groups provided data towards each theme.

The second order construct data which contributed towards each theme, along with reviewer interpretation of this data, are discussed within each section and are supported by quotes from the study participants. Each quote is accompanied by a label within square brackets to acknowledge the type of participant providing the quote and, where possible, their relationship to the service user e.g. [Carer and Mother]. Where it is clear that the participant is a NR, this has been indicated. Where the status of a carer or relative as an NR is unclear, the participant is referred to as a carer. For a breakdown of the quotes and author ideas which contributed to each theme, please refer to Supplementary Materials 1.
<table>
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<th>Participant group</th>
<th>Identification of NR/NP (1&amp;2)*</th>
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Ridley (2009) [2007-08] [49]
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<table>
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<td>Campbell (2008)\textsuperscript{37} [NS] [Author views]</td>
<td>Berzins (2009a)\textsuperscript{36} [Policy influencer, 9]</td>
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Black text = studies conducted with regard to the MHA 1983 (England and Wales), Blue = studies conducted with regard to MHCT (Scotland) Act, Green = study conducted with regard to MH(NI) Order. NS=Not Stated. *First author of study (publication date) [Year of data collection] [Type of respondent where available , N interviewed]
Theme 1: Issues with the identification of the Nearest Relative/Named Persons

Four subthemes were identified; Subtheme 1 ‘Service user vulnerability’ explores how the hierarchical nature of the NR provision in England can leave service users vulnerable to abuse and biased care. Subtheme 2 ‘Not representative of real relationships’ reflects on how the NR provision in England is not always representative of the family circumstances of service users and those involved with supporting them. Subtheme 3 ‘Displacement’ details service users’ experiences of changing their NR or NP. Subtheme 4 ‘Service user isolation’ discusses how both the NR provision in England and the NP in Scotland do not fully support the needs of individuals who do not have and/or do not wish to have an identified NR/NP. Author and participant views from eight studies support this theme (see Table 5).

Subtheme 1.1: Service user vulnerability

This subtheme discusses how the hierarchical nature of the selection process of the NR may leave service users vulnerable to abuse and violation of their privacy. The impact of unconscious carer bias on the process of involuntary detention is also explored, with comparisons made to the NP provision in Scotland.

Vulnerability to abuse

Authors of five studies30,32, 44, 48 acknowledged the potential of the NR/NP provisions to allow for the disclosure of information to a person who has abused, or is at risk of abusing, the service user. Three of these studies30, 44, 48 were conducted before the 2007 amendment of the Act which allowed service users to displace people they did not want to act as their NR. Rapaport30 provided several examples which illustrate how the disclosure of sensitive personal information to the NR can be harmful to service users, as illustrated by one 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[...] Particularly if one’s feeling that there is a link between that experience in childhood and the illness that they throw out really

[ASW]30(Unpublished)
Pinfold and colleagues advise caution with respect to sharing information with carers and relatives, suggesting that the quality of the service user’s relationship with the person with whom the intervention was being shared needs to be considered prior to disclosure. However, the acquisition of knowledge regarding the service user’s current and historical social context takes time and may not be available to social workers, or other professionals, when required.

Other issues which may influence information sharing between service users, carers and professionals are discussed below within the theme ‘Confidentiality and information sharing’.

Berzins acknowledges that the NP provision in Scotland permits the service user to choose a person they feel is best suited to role; whether that was a friend they felt was familiar with their wishes or a close relative they perceive could withstand the pressure/stress associated with the role. One service user talking about the prospect of nominating a NP stated that they would not worry about their prospective NP receiving personal information about them, as they felt their NP would know it all anyway:

*Any friend that I would have nominated I've probably told them everything anyway. It's probably something that I've talked about* [Service user] (p162)

Here the service user highlights how they would choose someone to support them who was already familiar with their personal information, who they knew they could trust. However, the NP provision does not prevent the service user from appointing a person that other people may view as unsuitable to the role, and this may leave them vulnerable to abuse or manipulation. This was illustrated by Dawson who provided an example of a service user appointing their drug-dealer as their NP.

Until the Scottish MHCT was amended in 2015 (as discussed within ‘Service user isolation’ below), in situations where a NP had not yet been appointed, the system defaulted to a primary carer, and then to the hierarchical system currently still used in England. In first instances of acute mental illness, it is unlikely that a service user will have nominated a NP and may not be well enough or have the time available to choose one immediately following an emergency admission. There are a number of additional issues influencing whether people identify their NP in advance of them being needed, as well as the potential implications of their choice for
the relationship between SU and their carers. These are discussed further under the theme ‘Importance of maintaining relationships’.

Caregiver bias

The potential for abuse is not the only risk associated with the prescriptive nature of the NR selection process and the use of this hierarchy when identifying an NP when none has been nominated in advance. The pressures associated with caring for someone prior to an involuntary admission (as discussed below within the theme ‘Importance of maintaining relationships’) may affect the ability of the carer to act according to the best interests of the service user within their role as the NR/NP. Author views from three studies\textsuperscript{30, 48, 59} highlight how the carer’s own needs may affect their decision making in relation to the NR role. Pinfold and colleagues\textsuperscript{48} highlight how carers may be deterred from seeking help for themselves, and by extension the patient, because they rely on the patient to meet their own needs. In another study, one clinician describes how a patient’s daughter did not enlighten her mother around the rules associated with a CTO:

\ldots if people really understand what it’s about they would recognise that it doesn’t have any teeth [...] The daughter of the [patient] did get it but she knew that what the system was effectively doing was tricking her mother into thinking that we could compel her to have medication [Responsible Clinician]\textsuperscript{59}(p.48)

Amendments to the MHA in 2007 mean that family and carers in England and Wales who have been assigned to the role of NR can now delegate the position to someone else if they do not want the responsibility of the role.\textsuperscript{13} In Scotland, revisions to the MHCT Act in 2015 mean that carers can choose to apply through the tribunal process to represent adults who lack the capacity to make decisions about their care.\textsuperscript{63} We suggest that these changes may go some way towards alleviating the influence of carer stress on their decision making. The 2007 amendments to the MHA represent a partial response to this issue, by allowing service users and/or the professionals involved in their care to apply to the country court to displace their allocated NR
on grounds of unsuitability. The issues surrounding the process of the displacement of the NR are discussed below in the subtheme ‘Displacement’.

Subtheme 1.2: Not representative of real relationships
This subtheme discusses how selection of the person to fulfil the NR role in England may not be representative of a service user’s family circumstances and may inhibit information sharing with individuals closest to them or who support them.

Author views from three studies conducted in England suggest that service users, their carers and the professionals involved with supporting them during involuntary admissions did not find the pre-determined hierarchy a convenient or useful method of identifying the most appropriate NR. One service user gives her views on how the NR provision distinguishes between the rights of full and half-blood siblings:

*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 am concerned they’re all my brothers and sisters* [Service user](Unpublished)

The above quote provides an example of how the hierarchy used to identify the NR in England may not always represent the service user’s family circumstances. This is further illustrated by a quote from an ASW interviewed in the same study:

*[…] her father only lived 200 yards away and he was the nearest relative as defined by the Act. But the social worker used the mother as the nearest relative on the basis that she was actually offering the care and because it was her mother and so on[…]*. [ASW](Unpublished)

The above quote illustrates how the concept of “Nearest” relative may not always equate to the person who is usually involved with their care. As well as causing difficulty in the identification of the NR, the use of the strict NR hierarchy can also create difficulties with the sharing of information. One woman expresses her frustration with the way information sharing was restricted to her alone in the quote below:
Restricting information sharing to only one carer/NR has important implications for the level of expectation and responsibility placed upon carers by professionals. This may impact on the support they feel able to offer the service user and undermine their relationship with professionals, as discussed further under the themes ‘Importance of maintaining relationships’ and ‘Confidentiality and Information sharing’ below.

In summary, family structures in the UK in the 21st century are highly diverse and often quite removed from either the simple or the reliably harmonious and caring relationships between close blood-relatives that the NR provisions presume. Furthermore, as well as the presumption of the importance of blood-relatives in the service user’s life, the NR provisions imply that there is one person who is at the same time (i) their primary or sole carer/usual support (ii) the person the service user would trust to act in their best interests (iii) the person who they would trust with personal or sensitive information about them.

Subtheme 1.3: Displacement

The 2007 amendments to the MHA mean that the service user, a relative, anyone living with the service user or an AMHP can apply to the County Court to displace a person who is unsuitable for the role and nominate someone who they feel would be more appropriate.13 Issues discussed within this subtheme include how the displacement process can be exploited by both NR and professionals and how the displacement process in Scotland can provide service users with an opportunity for choice and autonomy over the care they receive. Four studies contributed towards the development of this theme.30, 31, 55, 56

Of the studies relevant to the NR provision in England, only Rapaport30 contributed significantly to this theme. This paper was published prior to the 2007 amendments of the MHA, which meant that at this time, the service user could not apply to the County Court for the displacement of their NR. This study highlights how some professionals viewed the process of displacing an unsuitable person from the role of the NR as time-consuming, expensive and
having the potential to jeopardise their working relationships with carers. The author also indicates how the tribunal system could be misused by individuals who did not want to be displaced. One ASW illustrated this by discussing how her team had struggled to displace one woman who had inherited the NR role from another person:

*She [NR] got the original nearest relative to sign them over to her brother, so she was out of the legal loop [...] He continued to object although he was really doing it by proxy for her. She was still pulling all the strings.*

(Unpublished)

In this example, the NR managed to use the tribunal system and use their influence within the wider family to retain influence over the service user’s care. Overall, the lack of available evidence regarding experiences of displacing the NR in England, particularly after the 2007 amendments of the MHA, limits the conclusions that can be drawn.

In Scotland, service users can make a written application to displace (i.e. change) their NP under the MHCT 2003. This seems to be viewed positively by service users, as shown by the quote below:

*You might nominate a friend who you're very friendly with but they might turn out to be totally unsuitable... At least you're not stuck with someone who's against you and they can always be revoked* [Service user]

This quote illustrates how the process for displacing a NP in Scotland can both avoid the involvement of someone the service user does not have a good relationship with, or who they feel would not support them in a way which is consistent with their wishes. The displacement process was also viewed positively by the individuals involved with creating government policy interviewed in the same study, as illustrated by the following quote:

* [...] revisiting of it is important and we stress that... just because someone ends up with someone who's down as the default named person that should*
be reviewed and discussed with the person as soon as they’re in a position to do that and not just set in stone. [Policy Influencer]31(p.120)

The above quote acknowledges that under some circumstances (e.g. an emergency admission), a service user may need to be allocated a named person using the default process. The ability to revisit the decision when they are able provides an important opportunity for the service user to exercise choice and autonomy.

Ridley and colleagues55 reflect that by the time participants in their study were interviewed for a second time one year later almost a quarter of the service users had changed their NP. Amongst the reasons given was that the NP had disagreed with the service user’s wishes. The authors report that carers found the process of being displaced unsettling and that it made them uncertain of their rights and responsibilities.55 We suggest that this may have important implications for the provision of consistent care and/or maintaining working relationships with professionals in the longer term.

Subtheme 1.4 Service user isolation

This subtheme aims to highlight the issues encountered by service users who may not be able, or may not wish to, have someone appointed as a NR in relation to their care/detention.

Author30-32, 55, 59 and participant30-32, 55 views from five studies indicated that the NR provision of the MHA did not account for the fact that some service users may not have a person to act as their NR. Issues this situation may arise because of include; family estrangement59 and relatives living outside of the country.30 A quote from one service user illustrates how the process of identifying the NR does not account for poor family-relationships:

...this seems to be geared for, you know, nice families as it were (LAUGHING) you know[...]families where the mother comes round and comes into hospital and says “how are you son? [Service user]30(Unpublished)

Here the advantages of the NP provision used in Scotland are easily identifiable, in that service users without a partner or family member to act as their NR can choose to nominate a friend
instead. Following the introduction of the Scottish MHCT Act, some service users and professionals disliked the necessity of a service user having to identify a named person. This is illustrated by two quotes, one from a service user and one from the perspective of a person involved in influencing government, or “policy influencer”, in this area:

*If it's the patient's right to name a named person than that's their right. If they say: 'I don't want anything to do with that, ’ then that's it. End of story* [Service user](p.157)

In 2015, amendments were made to the Scottish MHCT Act which meant that the service user would no longer have to nominate a NP and that one would no longer be allocated to them by default. These changes started to be phased in during June 2017 and, whilst they have the potential of resolving some of the issues discussed in this subtheme, this review did not identify any evidence evaluating these changes.

**Summary**

In England, Wales and Northern Ireland, the NR is allocated by default, based on a defined hierarchy. Several issues with this process were identified:

- There were occasions when the assigned NR was a person with a history of an abusive relationship with the service user
- The arbitrary allocation of a NR may lead to the identification of someone who, in the context of individual family situation and relationships, is not best placed to fulfil the role
- The role of NR may be allocated to someone who is not involved with the care of the service user

Introduction of the NP provisions in Scotland has given service users the option to identify a NP of their choice. Experience of the NP provision in Scotland has revealed the following issues:
• That it is beneficial to be able to allocate a friend or carer of a service user’s choice, and easily displace a default nomination

• The choice to opt for no NP or NR was considered favourably. Amendments to the MHCT Act in Scotland now allow for this, but no evidence was identified to allow discussion of the relative merits and drawbacks of this approach

**Theme 2: Confidentiality and information sharing**

This theme relates to the third objective of this review, which was to: “Explore issues relating to patient confidentiality and information sharing, relating to all aspects of compulsory detention”. This encompasses the value of confidentiality to both service users and carers, alongside the tension this can create with the need for professionals and carers to share information with each other about the service user and their care. Examples are provided of how professionals work flexibly within the legal framework of the MHA 1983 to provide carers with the support they need whilst respecting the service user’s right to privacy. The section ends by highlighting the need for professionals working with service users and their families to consider the wider family and historical context of the service user when considering issues of confidentiality and information sharing. Nine studies contributed evidence within this theme (see Table 5).

Under the MHA and MHCT (Scotland) Act, both the NR and NP are privy to confidential information about the service user. This can potentially lead to unwanted sharing of information and, in some cases, cause harm or distress to the service user (as discussed within the theme ‘Issues regarding the identification of NR/NPs).

Six studies highlighted how much service users valued being able to choose who received information about them and the healthcare they were receiving. Mental health service users interviewed as part of an English nationwide study and service users with experience of involuntary inpatient admission felt that consent should be sought from service users before any information regarding their care was shared with carers. Service users felt that this helped preserve their sense of autonomy and identity, factors which could be perceived as contributing towards service users’ empowerment within their relationship with professionals.
and carers and within the wider mental health system. One woman diagnosed with bi-polar disorder, who had experienced involuntary admission under the MHA 1983, explained why she did not wish for her husband to know about the care she was receiving:

*He often says “just let me get involved, I don't understand what's going on”.*
*I don’t want him to understand what’s going on, I don't want it taken away from me. It's my life, my illness, if you like* [...]*[Service user]*44(p.41)

The above quote illustrates how for this service user, limiting the amount her partner knew about the care she was receiving enabled her to take ownership of her own mental health and provided her with a sense of control. The sense of control may be especially important for people undergoing the process of an involuntary admission. Service users in Scotland, giving their views on the NP,10 indicated that it gave them the control to ensure that their information was not shared with people who did not know them or with whom they did not get on.32 This clearly has potential to act as a protective factor against service users’ vulnerability to abuse, or the sharing of information with people who may not act in their best interest, in the context of the hierarchical allocation of the NR utilised in England and Wales, as discussed above in subtheme ‘Service user vulnerability’. As one service user points out, once information is shared, there “is no going back”.48 The perceived impact of confidentiality on the relationship between carers/NR and professionals is discussed below in theme 4 ‘Importance of maintaining relationships’.

Four studies also highlighted that carers also had a need for confidentiality.30, 45, 55, 56 Carers stated that they would value having time alone with a professional, where they could talk about any concerns, without the worry that the person they support would feel criticised or undermined.45, 56, 57 One carer highlights how talking with professionals about their concerns may put their relationship with the service user at risk:

*I don’t want to know what (name of the patient) is telling them[...] I just want them to listen to what I’ve got to say about how I think he is without telling him, because he says, oh you’ve been talking to the nurses* [Carer]45(p.4)
Carers appreciated being able to talk confidentially with professionals about the service user they were supporting.⁴⁵, ⁵₆, ⁵⁷ They were also concerned about personal family information, shared in confidence with members of the professional team, being passed on to their relative when they did not want it to be³, ³⁰ and the implications of providing information within a tribunal setting which disagreed with a service user’s wishes on their relationship with their friend or relative. This is discussed further within the theme ‘Importance of maintaining relationships’ below.

Five studies discussed the importance of professionals sharing information with their carers.³⁰, ⁴⁵, ⁴⁸, ⁵⁵, ⁵⁶ Carers appeared to appreciate the need for the people they support to maintain a degree of confidentiality, but highlighted how they still required some information if they were expected to continue supporting a person³⁰, ⁴⁵, ⁴⁸ or if the service user’s behaviour may put themselves as a carer at risk.⁴⁵ In their study conducted before the 2007 review of the MHA 1983, Rapaport³⁰ highlights information sharing between professionals and carers/NRs did not always take place due to concerns about confidentiality. In a later study evaluating the implementation of the MHCT 2003 in Scotland,⁵⁵ one NP observed that despite the additional rights conveyed by the 2003 Act, information sharing was still dependent on a decision being made by a professional:

> It’s up to them if they want to change it but you can be totally discarded ... I don’t know how that sits because ... you’re still the carer, but you’re not going to find anything out unless they tell you themselves. I don’t know how you can fix that [Carer/NP]⁵⁵(p.77)

This quote indicates that even when there are laws and guidelines in place to support information sharing, the implementation of these may be variable and carers/NR/NPs may not always receive the information they are entitled to.

While some carers wanted to receive more information in certain circumstances, data from five studies³⁰-³², ⁵⁵, ⁵⁹ indicates that it was possible for carers and NR/NP to feel overwhelmed by too much information, especially when it was in a format they found inaccessible⁴⁵, ⁵⁹ or contained distressing personal information pertaining to the service users which they may not
wish to know about.\textsuperscript{31,32} Relatives also acknowledged that at times of distress they may not be able to take on board information which was offered to them.\textsuperscript{57}

Professionals supporting service users appear to experience a dilemma between preserving service user confidentiality and autonomy and providing carers/NRs with enough information so that they are able to support the person. This is illustrated by a quote from a carer below:

\begin{quote}
...the rights of the nearest relative versus the fact that he’s an adult in his own right....in the end we kind of found out what we wanted to know [...] But it was quite a shock to find out we were ... not being told anything
\end{quote}

[Carer]\textsuperscript{30}(Unpublished)

Here the carer talks about their experience of trying to obtain information from a professional care team about their son who had been involuntarily admitted to hospital. A need for additional explanation for service users\textsuperscript{31} and carers\textsuperscript{48} and training for professionals\textsuperscript{55} has been proposed to ensure that all parties understand the rights of carers to receive certain information, which may facilitate the information sharing process. While the MHA 1983 Code of Practice dictates that informal patients should have their legal positions and rights explained to them\textsuperscript{2}(s31.5), this may not be consistently applied and may be impractical in certain situations. Additionally, the complexity of the NR provisions may not be retained by service users, carers or professionals alike, particularly in distressing circumstances.

Three studies provide examples of the professionals who support individuals involuntary detained in hospital or on CTOs working flexibly to allow carers to discuss their concerns freely, but also ensuring the privacy of service users is protected.\textsuperscript{31,45,56} Some professionals deliberately tempered information they knew would be copied to NP/NR\textsuperscript{31,32} or provided carers with a confidential space to share concerns.\textsuperscript{56} This is illustrated by a carer describing a psychologist’s willingness to talk with her confidentially regarding her concerns about her son, who is on a CTO:

\begin{quote}
...it means that the psychologist may phone him or drop a note through the door. Yes it does make it easier. But it’s also made easier by the psychologist
\end{quote}
agreeing not to say “hello (patient), your mother rang me, I hear you’re not too well [Carer]\textsuperscript{56}(p.771)

Pinfold and colleagues\textsuperscript{48} and Henderson\textsuperscript{44} highlight the importance of professionals working with service users to consider the wider and historical family context and the quality of the relationship between the service user and their NR/NP before sharing information with carers/NRs. Whilst historical abuse is an important issue to consider, there are also other factors which may influence the quality of this relationship and thus the decision to share sensitive information with NR/NP. These are discussed in more detail within the overarching theme below.

Summary

This theme is concerned with issues of confidentiality and the sharing of information about compulsorily detained patients. The NR is entitled to receive certain information about the care of the patient, while other individuals, who may in reality the main carer or the closest family member, are not. As discussed in theme 1 ‘Issues with the identification of the NR’ there is the potential through the default identification of the NR to lead to information being shared with an undesirable recipient, in the eyes of the service user. However, even when the NR or NP is identified in line with the wishes of the patient, the following issues were identified:

- Service users valued the opportunity to exercise their right to withhold certain information from their NR, as this gave some sense of control

- Information shared can be complicated, sensitive and unpleasant. There is a certain level of information that some carers felt was necessary to receive in order to be able to carry out their duties, but it was felt by service users, carers and professionals alike that it might not be beneficial to share too much information

- There was desire to improve processes by which carers are involved in discussing information about a patient with professionals. Carers wanted to be able to provide what they felt was useful information about the service user. However, they didn’t always want the patient to know about such conversations, as this could damage their relationship
• It was considered useful when professionals took a flexible approach to information sharing with carers, in particular when this considered the wider context of family dynamics

• It was also noted that the rights of carers, service users and professionals are complicated and not easily explained

**Theme 3: Enabling use of the NR/NP role**

This theme encompasses three subthemes: Being heard, Need for information and Proactive support and engagement. The theme relates to the research objective to explore issues relating to decisions about care during detention and discharge and issues relating to service users having access to support from carers. The first subtheme, ‘Being heard’, describes how the NR provision supports carers and service users to have their say during an involuntary admission and factors which may prevent them from expressing their views. The second subtheme, ‘Need for information’, describes the type of information service users, carers, NRs and professionals need to fulfil their roles in the patient’s care. The final subtheme, ‘Proactive support and engagement’, illustrates the type of support required from professionals to ensure carers and service users are able to make use of the information they are given about the NR role. Together, the concepts explored within these subthemes can empower all stakeholders to make full use of the NR provisions of the MHA. Eleven studies contributed towards the development of this theme (see Table 5).

**Subtheme 3.1: Being heard**

Evidence under this subtheme conveys how carers and NRs value the NR provision of the MHA as something which empowers them to ask for information and challenge the views of the professionals regarding the care they provide. Nearest Relatives also perceive their opinions to carry more weight with professionals than as a regular carer.

Five studies highlighted several ways in which the NR/NP provisions enhanced carers’ involvement in planning the care of service users. First, authors of three studies noted how the NR/NP provisions improved carers access to information about service users’ current or past care and treatment. This is illustrated by a NP, discussing how their relative’s
detention under the MHCT Act meant that they received more information from services within their role as NP:

*Until we had the compulsory order you really were largely on your own and the information didn’t come to you, you had to seek it out and it was hard to come by [...] [NP]*\(^5\)\(^5\)\(^5\)\(^5\)\(^5\)(p.74)

Participants from three studies\(^3\)\(^0\), \(^4\)\(^4\), \(^5\)\(^9\) highlighted how their NR/NP status increased their say in the care their relatives received. One example of this was provided by a man discussing how he managed to prevent the involuntary admission of his partner:

* [...] They seemed to need my word, I can never remember exact details, but they seemed to need a yes from me before they could go ahead. The last time it was actually me who refused to give it and made a determined effort to keep Elaine at home [...] (Partner and carer)*\(^4\)\(^4\)(p.40)

A NR from another study perceived that professionals appeared to be more responsive to her requests:

*I’ve dealt with something [...] I’ve got the right ... what I felt about a situation that they were in. And it was responded to, it was wonderful ... I also had the right then to say that I’ve got the right not to have to keep chasing [...] [NR]*\(^3\)\(^0\)(Unpublished)

This quote suggests that the legislation outlined by the NR provision of the MHA can enhance the confidence of those within the NR role to give their views on the care of the person they support. However other individuals did not always use the opportunity to discuss, endorse or object that the NR/NP is intended to provide them with. Berzins\(^3\)\(^6\) suggested that the class, race and gender of people nominated as NPs may influence their ability to carry out their role. One MHO illustrates this by talking about the development of a DVD, presumably to support individuals detained under the MHCT Act and their carers:
Those tensions again around disadvantage, around class, race and gender come up and bite you. Have you seen the HUG DVD which is a group of fantastically articulate middle-class people [...] but there is a bit where the middle-class are incredibly adept at appropriating things for themselves [MHO]31 (p.143)

The above quote suggests that the class and/or education level of service users and their carers may affect their ability to firstly understand the information which is given to them and, secondly, then being able to make use of this information to make their voices heard.

Subtheme 3.2: Need for Information

This subtheme discusses the information that service users, carers/NRs/NPs and professionals require in order for the service user to benefit from the intended function of the NR/NP provision. The section discusses how carers need some knowledge regarding the different section of the MHA as well as more specific information regarding the NR/NP role. Authors of three studies31, 55, 56 indicated the need for service users and carers to be more informed about the MHA in both England and Wales or the MHCT in Scotland. The quote below highlights one carer’s lack of knowledge regarding the implementation of a CTO:

[…]I couldn’t get a clear grip on that “if you don’t do A then B will happen”, what B was. That they would within 24 hours come and chase him? Or that they would call him on the phone... [Mother and Carer]56(p769)

Here the carer wishes to know more about the consequences of a service user not adhering to the conditions associated with their CTO. This viewpoint is contradicted by one example presented by Stroud59 who interviewed a service user who felt that they did not need to know the finer details associated with the use of a CTO. This stance may reflect the more limited role of the NR in the implementation of CTOs and also suggests that the level of information provided may need to be tailored to the individual circumstances of the carer/service user.
In addition to improving knowledge about the different sections of the MHA, and the different levels of care they define, the authors of five studies\textsuperscript{30-32,37,55} highlight that service users and/or carers needed more information about the role of the NR/NP.

\textit{Are they new may I ask? Or is it that they’ve always been there but hardly anyone knows about it? Because I’m only recently hearing about it as though it’s a new piece of legislation?} [Carer\textsuperscript{52}(Unpublished)]

The above two quotes suggest that service users and carers need a working knowledge of the parts of the MHA that are relevant to their circumstances, and may need to be informed of how the NR role can support them in this context. Authors from two studies\textsuperscript{31,32} highlight how knowledge of the NP role among service users and carers may be particularly limited if the service user has not had a previous involuntary hospital admission. The need for accessible information about the NR/NP role was noted by participants and authors of five studies,\textsuperscript{30,32,37,55,59} although NR/NPs may not always understand the information that they are given regarding their responsibilities, as illustrated by one policy influencer commenting on the nomination of a NP following an emergency admission:

\textit{[...] you appear at some sort of meeting and somebody says: ‘Do you want to be your son’s named person?’ but you’re not really listening as you’re far too distressed. You realise it’s something quite important and you care about your son so you say yes...} [Policy influencer\textsuperscript{31}(p.119)]

This relates to information presented within the theme ‘Confidentiality and Information sharing’, which cautions against overburdening carer and NR/NPs with information about the care the service user is receiving.

Finally, authors of two studies\textsuperscript{47,55} indicate that in some cases, the professionals involved with supporting service users and carers may benefit from more knowledge regarding the NR/NP role and how to incorporate it into the care they provide. This is illustrated by one woman talking about her involvement as a NP:
It’s made the professionals feel they don’t really know what to do with us as Named Persons ... now they’ve got to find a place for us, but they’re still not sure about what that is [NP, friend]54(p.76)

This suggests that professionals involved with supporting service users and their NR during an involuntary admission process could benefit from training and support on what the NR/NP role is how to inform NR/NP of their rights and involving them, where appropriate, in the care of the service user they support.

Subtheme 3.3: Proactive support and engagement

This subtheme discusses the need for professionals to be proactive in identifying the needs of carers which may affect their ability to provide support to the service user within their NR role. The advantages and disadvantages of the approach by professionals used in Scotland to encourage individuals to identify a NP in advance are also explored.

Authors of three studies30, 31, 48 acknowledged the importance of identifying the needs of the carers and NR involved with providing support to service users. In addition to the need for information (highlighted above in the previous subtheme), Pinfold48 reflects upon the important role professionals have in providing emotional support and comfort to carers during times of distress, although the demands placed upon professionals’ time may not always allow for this.30 Carers also welcomed practical support, such as guidance with filling in forms and referral to services for their own needs.48

Authors of two studies in Scotland31, 32 highlighted the proactive approach used by some professionals to encourage service users, carers and other professionals to think about nominating a NP in advance. This is illustrated by a member of one tribunal panel discussing how MHO play an important role in advertising the NP role in Scotland:

The mental health officers, [...] have really stepped up to the mark in terms of this work I think, and my experience of mental health officers is that they’re very actively out there in the community talking to the people who are concerned with the care of people [Tribunal member]32 (p.53)
Whilst this approach was seen as positive by some professionals, others felt that it represented a potential conflict of interest; and felt that professionals should not become involved in what they regarded as a private agreement between the service user and their nominated NP. One MHO reflects on the potential impact any reluctance from professionals to support the process of an NP:

 [...]If that's the message then you're not going to get a high take up.' You've got to be quite proactive to get people thinking about it [MHO]

Whilst this quote illustrates the perception that a proactive approach used by professionals may encourage people to nominate a NP, it conflicts with information presented under the theme 'Importance of maintaining relationships’ that indicates that some service users may not wish to think about the possibility of being ill in the future. Professionals appear to play an important role in recognising when it may be an appropriate time to discuss the nomination of an NP with a service user. We would suggest that factors which may influence this decision include the length of time they have supported them, the quality of the relationship and the service user’s mental health at the time.

Finally, three studies also indicated that carers and NP may require additional support during the Tribunal process to enable them to fulfil their role, including the provision of accessible information, as indicated within the above subtheme ‘Information’ and explicit encouragement to share their views. Two studies noted that the scheduling of Tribunals during the working days could sometimes exclude carers from taking part (Dawson 2009, Ridley 2009). One NP stated:

 It’ll go ahead regardless of whether me as named person can go [NP] (Ridley 2009 p81)

We suggest that the above statement indicates that the lack of flexibility in scheduling tribunals according to NP’s could lead to the views of carers and NR/NPs being overlooked within the Tribunal process and contribute to NR/NPs feeling unheard and undervalued, as discussed within the subtheme ‘Carer/Professional relationships’ below. This highlights the
need for organisers of the Tribunal process to be proactive in ensuring that family members, carers and NR/NPs are supported to attend where appropriate.

Summary
The ‘Enabling use of the NR/NP role’ theme discusses the ways in which support is needed and can be provided with respect to the compulsory detention of a service user, and the role of the NR in their care. The following key points emerged from the evidence:

- The role of the NR or NP is complex and may be poorly understood by service users, carers and professionals alike
- It should be recognised that the NR or NP, as well as other relatives and carers without statutory roles in the admission or ongoing care, may require emotional and informational support at various stages throughout the process of detention and treatment, and that professionals involved in these processes are well placed to deliver it
- Carers reflected that being recognised as a NR or NP enabled them to be able to offer better support to the service user, through their improved awareness of their rights under the NR/NP provision and the recognition of these by professionals

Theme 4: Importance of maintaining relationships
Three subthemes contributed towards this theme: Service user/carer relationships, Service user/professional relationships and Carer/professional relationships explore the issues which can influence the development and maintenance of good relationships between each of the three main stakeholder groups involved in the process of involuntary hospital admission. These relationships may influence the balance between protecting the service user’s confidentiality and information sharing as discussed within theme 2, and also empower service users and carers and thus act as a protective factor against abuse and carer burn-out. Data from 12 studies contributed towards the evidence within this theme (see Table 5).
Subtheme 4.1: Service user/Carer relationships

This subtheme discusses issues which may affect the relationship between service users and their carers and NR/NP. The issues include the impact on the carer of the responsibility of taking on the NR/NP role, the ability of NR/NP to act in the best interests of the service user and how the duties associated with the NR/NP role may be a source of conflict between service users and their carers.

The responsibility of caring for someone with mental health difficulties can be very physically and emotionally challenging for the carer at times, as evidenced by authors and participant views included within this review. The additional responsibility associated with the NR/NP role can contribute towards the stress of responsibility experienced by carers. Authors from five studies indicate that carers and NR/NP can feel daunted by the responsibility of their role. This is illustrated by a MHO discussing about how some carers experience the process of contributing within a Tribunal:

[...] people generally appreciate that sense of, kind of empowerment but not always the case but usually so. Again because I’m mainly involved with older people sometimes people feel a bit frightened by the process...I think for those people who would actually feel frightened rather than empowered by an involvement [MHO] (p.47)

One service user discussed how they would use the flexibility associated with the Named Persons provision in Scotland (MHCT 2003) to choose a friend as their NP in order to relieve the responsibility from family members:

You know, it’s about taking the pressure off them and that could be beneficial for the family member as well, as they can be so busy caring [Service user] (p.138)

Under the NR provisions of the MHA, the service user cannot choose who is involved in decision making. This means that service users may feel they have to place extra responsibility on carers without wanting to, or discuss issues with people they find it hard to communicate
with. This has clear implications for service users, who may have to accept care or treatment conditions if their NR/NP perceives them to be in their best interests.

Authors of three studies conducted in Scotland\textsuperscript{31, 32, 55} highlight the importance of the NP being able to understand, respect and carry out the wishes of the service user, which is clearly related to the quality of their personal relationship. In Scotland, some service users selected friends to be their NP because they perceived them to be more ‘equal’ in terms of their relationship\textsuperscript{55} and trusted that they would be more aware and supportive of their wishes when it came to being offered certain treatments.\textsuperscript{31} However, some service users were concerned with the possible impact the NP role would have on their relationships with friends and felt that the closeness associated with good family relationships was necessary to undertake the NP role.\textsuperscript{55}

Authors of two studies highlighted concerns that both service users and NP did not fully understand the level of information that would be shared with the NP.\textsuperscript{32, 36} We suggest that this has the potential to place strain on the services user’s relationship with their NP. The need for adequate information about the NR/NP role is discussed further under the theme ‘Enabling use of the NR/NP role’ above. Participant and author views from seven studies\textsuperscript{30, 32, 36, 44, 45, 55, 56} indicates that another factor which may affect the quality of the service user-NR relationship was when the NR felt they needed to express views which conflicted with the service user’s either during a tribunal,\textsuperscript{31, 32, 56} prior to admission\textsuperscript{44, 45} or whilst on CTO.\textsuperscript{56} This is illustrated by the observation of two people involved with influencing government policy:

\begin{quote}
Their care and friendship is with the person [service user] but they are certainly allowed to have an independent view and that is exactly why they don’t want to go to the tribunal and say it to the person, for fear of the reaction [Policy influencer]\textsuperscript{31}(p.154)
\end{quote}

\begin{quote}
It’s most awkward at the tribunal stage where there’s tension between the user and the apparent named person, where the MHO has imposed one and, where that happens, there’s still a great deal of bad feeling, I think, and it really doesn’t seem to suit either party [Policy influencer]\textsuperscript{31}(p.159)
\end{quote}
**Subtheme 4.2: Service user/professional relationships**

This subtheme discusses how the disclosure of information to NR against the service user’s wishes can challenge their relationship with the ASWs, psychiatrists and other service staff who support them. Other issues which may affect the service user’s relationship with services, such as the identification of a NP and preparation of an Advance Statement, are also explored.

Drawing on some of the information presented earlier within ‘Confidentiality and information sharing’, author views from two studies indicate how the sharing of information without the consent of the service user has resulted in feelings of anger or distress. One service user felt that a request by the service user to not share information with their NR should be respected, even at times when they lacked the capacity to make a fully informed decision:

*If a service user thinks the carer is the devil, even if this is false, it is clear it will distress the service user to inform the carer. The approach here is to wait until the paranoia has passed. My view here is to follow the service user wishes [...] [Service user]*

This contrasts with the view by a psychiatrist interviewed in the same study who stated:

*...I think there are times when you really want to tell relatives about the patient’s behaviour. Sometimes you have to say ‘I can’t let you go home unless I tell them this’ [Psychiatrist]*

This conflict between the desire of the service user to retain their autonomy and the professional obligation of the services who support them to protect both the service user and members of the public from harm could have an undesirable impact on the service user’s future willingness to share information with care professionals or to access services. This interpretation is supported by four service users interviewed by Berzins and colleagues who said that they provided their psychiatrist with the minimum level of information necessary:

*I haven't told the psychiatrist a lot of things. I don't really tell them very much at all, just a quick how it's going and how's the medication, and this is why I...*
Service user and author views from two studies indicate that some professionals were reluctant to discuss issues relating to the possibility of a future hospital admission, including the nomination of a NP, for fear of damaging their relationship with the service user. Author views from two studies also indicate that there may be issues around staff knowledge on how to implement or access advance statements. This is discussed further in the theme ‘Enabling use of the NR/NP role’ above.

Subtheme 4.3: Carer/Professional relationships

This subtheme explores how the relationship between carers and the professionals who support service users can be influenced by the degree carers feel listened to, valued and involved in the care of the service users.

Four studies present the views of participants and authors which indicate that carers and NR/NP do not always feel that professionals consider their needs or views when supporting service users. This appears to be an issue at different stages of the service user’s involuntary hospital admission, including pre-admission and discharge, as illustrated by two carers and a NR below:

When I’ve known he’s going downhill and I have felt that I wasn’t really being listened to enough then and I had tried to speak to the doctor but I’ve never been able to [Nearest Relative]  

We were shattered … I didn’t really want him to come and spend the night at home already, and one day I went in and it took me completely by surprise Dr X wanted him released that day… [Mother and carer] 

[the psychiatrist] said at the last meeting was “I am going to keep you on your CTO.” And I asked why because I said “to be honest with you I don’t
want him to go back into hospital [through recalls]. [...] And she wasn’t taking him off it [Mother and carer]56(p.768)

Author views from four studies30, 44, 47, 55 indicate that carers can feel excluded from the decisions being made about the care of service users during an involuntary admission. This is illustrated by one carer talking about the admission of their partner to hospital:

[…] You don't always know at the hospital that this is going to happen. I've had times when yes, they're talking about sectioning and then the next thing I know I get a letter in the post saying it's happened...They've decided after I've gone home[...] [Partner and carer]44(p.39)

Author and participant views from five studies30, 48, 55-57 indicate that carers may experience the need to protect service users’ right to privacy as a barrier to their own working relationship with professionals. Whilst carers perceived that information may not be passed on to them due to the automatic assumption by professionals that service users would not want information their information to be shared,57 some carers perceived that confidentiality was used by professionals to deliberately exclude them from discussions about a service users care.48, 56 One ASW discusses how the potential for conflict between the views of NR and ASW limited the information NRs were given about their role:

[…] we have a competing element which may not in our view, be the best interests of the particular client. [...] I think that’s the real issue, and that’s the nitty-gritty. I wonder sometimes whether we fully inform nearest relatives about their, about their powers, given the kind of practical conflict [ASW]30(Unpublished)

The perceived power imbalance between carers and professionals was also discussed in relation to carers’ experiences of taking part in tribunals in Scotland.31, 32, 55 In addition to the intimidating tribunal setting,31, 55 carers noted that whilst the tribunal system provided the
opportunity for them to air their views and feel listened to, they also perceived that professional voices carried more weight.\textsuperscript{31, 32, 55} One solicitor observed:

\begin{quote}
I think Named Persons feel as though, in relation to the tribunal process, they've got a powerful voice but when it comes with wanting to meet with doctors and to speak to other professionals, sometimes they feel as though that voice isn't quite as powerful in relation to that \cite{Solicitor}^{32}(p.44)
\end{quote}

Author views from two studies indicate that carers may refrain from complaining about any treatment to themselves or actions on behalf of the service user they perceive to be unfair because they fear damaging their relationships with professionals.\textsuperscript{30, 56} However, the same studies provide examples of where, when a mutually respectful and open relationship is cultivated between carers/NR and professionals, they can work together to have a meaningful impact on the care that service users receive.\textsuperscript{30, 56, 59} Some examples of the benefits of carers/NRs and professionals working together include; preventing the inappropriate recall from a CTO of service user back to hospital\textsuperscript{56} and the delivery of a person-centred care package to prevent an involuntary hospital admission.\textsuperscript{30}

This subtheme brings together evidence about perceived power imbalances between professionals and carers, including issues regarding maintaining service user confidentiality, and how these imbalances may have an impact on the ability for professionals and carers to work together to support the service user leading up to and during a hospital admission. However, by creating opportunities for professionals to listen to the views of carers and NRs, either through creating opportunities to meet with them privately (as discussed within ‘\textit{Consent and Information sharing}’) or through the Tribunal system, may help create a mutually respectful working relationship.

\textbf{Summary}

This theme is concerned with the relationships between professionals, carers (Nearest Relatives or otherwise) and service users during the treatment of individuals subjected to compulsory detention and treatment. Relationships with professionals can have a significant bearing on the experiences of care, while the relationships between service users and carers may last a
lifetime. The experience of being compulsorily detained places strain on these relationships. There was evidence of experience of a heavy responsibility on carers and a NR or NP alike, and data from this theme highlighted some of the circumstances where vital relationships can become strained. The following issues emerged:

- The role of NR confers a lot of responsibility and in some cases, where the NR is the primary carer, this can be overwhelming
- Disagreements over treatment decisions, carers feeling ignored or cut out, and conflicts with mental health professionals are some of the ways in which relationships can be placed under significant strain
- Another perceived benefit of the NP provision over the NR provision was the flexibility to choose a friend as a NP, because the service user felt that they would be more aware of, and more likely to implement, their wishes than certain family members
- There were positive reflections on instances where professionals worked closely with carers to optimise care outcomes

The different factors which may support the development of a constructive working relationship between service users, carers and professionals are discussed under the theme ‘Enabling use of the NR/NP role’.

**Overall synthesis summary: How do the themes relate to one another?**

This section presents how we believe the four themes identified through the framework synthesis may influence one another. The proposed links should be interpreted in the context of the limited number of studies contributing towards the overall synthesis. The proposed relationship between the themes is suggested in Figure 3 below.
Figure 3. Proposed relationship between the four themes identified by the framework synthesis

Whilst not directly relating to the NR provision of the MHA, we view the interaction between the three types of relationship identified within the theme ‘Importance of maintaining relationships’ as underpinning each of the other three themes. Firstly, the tension between maintaining service user confidentiality and the need to share certain information with the carers/NRs who support them, as discussed in the theme ‘Confidentiality and Information sharing’, may be mediated by the quality of the relationships between service users, carers/NRs and professionals. For example, service user confidentiality may be prioritised in situations...
where the relationship between the service user and their carer/NR is strained. Alternatively, in situations where the working relationship between carers/NRs and professionals is not cultivated, appropriate information sharing may not take place. The balance between maintaining service user confidentiality and information sharing may also affect these relationships. The relationship between carers/NRs and professionals may be adversely affected when carers perceive that they are being excluded from the decision making. A lack of appropriate information may also add to carer/NR stress, which may reduce their ability to support the service user and their ability to fulfil the role of NR. Finally, when any miscalculation between information sharing and respecting the privacy of service users by professionals, such as disclosing information to a NR the service user does not get on with, may distress the service user. This may have a negative influence on their relationship with the professionals who support them. In short, the quality of the relationships between service users, carers/NRs and professionals can influence the balance between the need to respect service user privacy and the need to share information with the carers/NRs who support them. How this balance is achieved (or not) may in turn influence the quality of these relationships.

It seems likely that this interaction between the themes ‘Confidentiality and Information sharing’ and ‘Importance of maintaining working relationships’ described above may influence the issues described within the theme ‘Issues regarding the identification of the NR’. Inadequate information sharing and involvement with decision making from the point of view of carers/NRs may increase feelings of carer stress, which may introduce bias into how they fulfil the role of NR. This, along with any perceived violation of the service user’s privacy, may influence the desire to apply to displace the NR through the County Court. Any efforts to displace the NR have the potential to negatively affect the relationship between them and the service user they support and/or the professionals who support them.

Information sharing, a good relationship between carers/NRs and professionals and reduced carer stress may in turn help carers and NR to feel more confident within their role, as described within the theme ‘Enabling use of the NR/NP role’. NR and NP who feel more able to fulfil their role in supporting the service user may have a positive influence on the relationships described within ‘Importance of maintaining relationships’. Increased carer empowerment
through receipt of adequate information about their role and rights conveyed by the NR/NP role may also reduce the impact of carer bias on decision making as described within ‘Issues regarding the identification of the NR’ and reduce the desire of service users to displace their NR/NPs. Finally, the right for service users to displace their NR/NPs who they view as ‘unsuitable’ can be viewed as one way in which service users can make their voices heard and thus contribute towards the theme ‘Enabling use of the NR/NP role’.
4 Discussion

4.1 Summary of findings

This rapid systematic review of qualitative evidence seeks to answer the overarching review question:

*What are the experiences of services users, family members, carers and relevant professionals of the use of the ‘Nearest Relative’ provisions in the compulsory detention and ongoing care of people under the Mental Health Act (1983)?*

In addition, we sought to fulfil the following specific research objectives, from the perspective of service users, family members, carers or relevant professionals:

- Explore experiences relating to the identification of the NR in relation to the care of an individual who has been compulsorily detained under the MHA
- Explore the experiences of requesting displacement of the assigned Nearest Relative, including the process of going through a tribunal and issues associated with this, such as influences on ongoing care
- Explore issues relating to patient confidentiality and information sharing, relating to all aspects of compulsory detention
- Explore issues related to decisions about care during detention and after discharge, including to a Community Treatment Order
- Explore issues related to service users having access to support from those carers who they want to be involved with or informed about their care.

We identified 32 sources reporting on 20 studies, before prioritising 12 studies from 22 sources which contained the richest and most relevant evidence reflecting a range of perspectives, for analysis in a framework synthesis. Within these 12 studies was evidence from across the UK, allowing comparisons to be drawn between experiences of the NR provisions (MHA, England, Wales and Northern Ireland) and the NP provisions (MHCT). Some of the studies conducted in England reflected experience of the NR provisions from before the 2007 amendments to the MHA. Only one study was identified from...
Northern Ireland and none were conducted in Wales, so our findings generally reflect the experience of legislation as it applies in England or Scotland. The views of service users, the NR or NP, carers, professionals, lawyers and policy influencers were represented in the synthesis.

Evidence was initially mapped using a framework based on the five research objectives, before being refined into themes. Four themes emerged from the framework synthesis: Issues with identification of the NR; Confidentiality and information sharing; Enabling the use of the NR/NP role; Importance of maintaining relationships.

The theme ‘Issues with the identification of the Nearest Relative’ highlighted various problems with the prescriptive appointment of the NR under the MHA, including situations where someone with a history of an abusive relationship with the service user is appointed, and the appointment of someone not involved with care of the service user. In contrast, under the MHCT in Scotland, service users can nominate a NP or, since 2017, can opt to have no NP. While we found no evidence pertaining to experiences of the option to forgo having a NP, the MHCT legislation was discussed in three sources. Under the first theme of the synthesis, service users and professionals considered the option to nominate a NP as a positive development, as it allowed the flexibility to take pressure away from primary caregivers, or nominate individuals such as trusted friends.

Another benefit of the MHCT in Scotland was the relative ease with which service users could displace (i.e. change) their nominated or, in the absence of a nomination, their allocated NP. This was summarised in the subtheme, ‘Displacement’. Since the 2007 amendments to the MHA, service users can apply to County Court to have their NR displaced on grounds that they were an inappropriate choice. The equivalent process in the Scottish system is simpler, requiring the service user to make a (witnessed) written declaration to revoke their chosen NP, or apply in writing to request displacement of a tribunal-appointed NP. There was no evidence from England about the experiences of applications to displace the NR since 2007, with only one study contributing evidence under this theme from England since 1998. Service users reported negative experiences of the system, reporting the threat of a tribunal as a deterrent, or
reflecting that ways to circumvent a court order could be more easily achieved than going through the tribunal system.

Although we found no evidence relating to displacement of the NR since the MHA amendments in 2007, the evidence from Scotland revealed that service users welcomed the ease with which they could displace their NP, and professionals considered this a positive move where the NP was considered inappropriate. Carers however, found it unsettling that they could be easily displaced if they disagreed with the service user, and subsequently omitted from important decisions about care. The right to be involved in decisions about care was both valued and considered a heavy responsibility by NRs and NPs, these contrasting sentiments often mentioned across themes.

Issues regarding access to information about the patient and involvement in decisions about care were identified in theme 2, ‘Confidentiality and information sharing’. The sort of information that is shared about a service user’s compulsory detention and treatment can be highly sensitive and distressing for both service users and their carers. In some instances, service users saw the option to withhold information from their NR or NP as a means of gaining some control over their situation, and carers and professionals commented that it was not in the best interests of all parties to share all sensitive information. However, it was agreed a certain level of information must be shared in order for NR/NP to fulfil their roles as carers. NR/NP also felt wary of sharing information about the service user with professionals, for fear of that information being disclosed to the service user. Information about the role should be provided to service users and carers, and training of professionals improved, so that the intended benefits and powers associated with the role can be understood, realised and exercised.

In general, issues about confidentiality and information sharing were seen as complex, and there was confusion about the rights of carers and NR/NP to be given certain information. This sentiment was echoed in theme 3, ‘Enabling the use of the NR/NP role’ where it was clear that the complexities of the NR or NP provisions were not well explained to service users and carers, to the extent that this prevented the exercise of important rights and powers. The need for professionals to be better trained in communication was noted in themes 2 and 4.
The quality of the relationships between the carer or NR/NP and the service user, the professionals involved in care and the service user, and the professionals and carers or NR/NP were fundamental considerations throughout and were described in theme 4, ‘Importance of maintaining relationships’. The relationships between professionals involved in the care of service users and both the service user and their NR/NP were strengthened when professionals took a flexible approach to information sharing (theme 2 ‘Confidentiality and information sharing’) or worked closely to optimise patient outcomes (theme 4, ‘Importance of maintaining relationships’). However, there were instances where professionals were perceived as difficult to communicate with, and didn’t listen to the opinions of the NR/NP. Professionals also noted the challenge of knowing which information to share with carers about the service user, for fear of disrupting relationships.

Evidence from ‘Importance of maintaining relationships’ again emphasised that the role of NR or NP confers a heavy responsibility, particularly where the appointed individual is already the primary carer. The option in Scotland to appoint a different person (e.g. a friend or family member) as the NP was seen as a way of reducing the burden on the primary carer. This contrasts with some statements in theme 3, ‘Enabling the use of the NR/NP role’, where some carers appreciated the status of NR/NP. They felt the role conferred a number of positive benefits, such as feeling empowered and involved in treatment decisions, being recognised as an important person and getting proper access to information. It was noted in theme 4 however, that it would be useful for carers’ needs to be considered by professionals involved in the service user’s treatment. This included both informational needs, such as help with understanding reports and filling in forms, and emotional support throughout the process. These supportive actions by professionals may go some way towards easing the responsibility associated with the NP/NR role and therefore enabling people to fulfil the roles confidently and effectively.
4.2 Limitations of Review

Limitations of the evidence

This review identified and summarised a body of qualitative evidence about the experiences of those involved with the compulsory detention of people with mental health problems in the United Kingdom. After initially determining included studies, we prioritised and synthesised those studies which offered the most and the most relevant primary data. We identified 12 such studies, however when developing the framework, only six to seven contributed significantly (see Table 5). While experiences of the use of NP provisions in Scotland were represented by only three studies, these were arguably the richest, coming from a PhD thesis and two government reports commissioned to examine the implementation of the Act. Lengthier reports inevitably have scope to include richer accounts of interview participants, for example, than journal articles. Service user, carer, NP and professionals’ experiences of the NP provisions were all well represented by the evidence from Scotland. However there were no studies offering comparisons with the NR provisions of the MHA in England and Wales. Although the 2015 amendments to the MHCT allow the service user to opt not to have a NP, there was no evidence relating to this. The amended Act was only implemented in 2017, so published studies of its implementation would not be expected at the time of this report.

The evidence of experiences of the MHA in England and Wales came from eight studies however only four (including Jankovic) collected data after the implementation of the 2007 MHA amendments. These amendments were notable in that they introduced the option to withhold information from the NR, displace the NR through application to County Court, and gave civil partners equal status to married partners in the hierarchy of relatives. Those four studies represented the views of 55 family caregivers, 21 service users and 19 mental health professionals. Thirty-two NRs were interviewed by Smith and colleagues but little rich and relevant data from this study featured in our synthesis (Table 5), while seven NR were interviewed by Stroud and colleagues. Perspectives on current aspects (since 2007) of the NR provisions of the MHA in England and Wales are therefore represented by a very small number of participants and may not reflect wider experiences of the current legislation and related practises. The data pertaining to the MHA in England and Wales prior
to the 2007 amendments was mainly from three studies offering rich data that featured heavily in the synthesis. These studies represented the views of 57 carers, 34 service users and 43 mental health professionals through analysis of interview data, (NB. Pinfold and colleagues also conducted a questionnaire survey of 998 stakeholders).  

In summary, the limitations of the available evidence should be considered when drawing conclusions from this review. In particular, while a number of the included qualitative studies provided rich data about the experiences of a variety of stakeholders involved in compulsory detention under the MHA and MHCT, the samples drawn upon were predominantly from England and Scotland, and most evidence predated the 2007 MHA amendments; they may therefore not be completely representative of the wider population experiencing or providing such care in the UK in 2018. Nevertheless, while we cannot claim to have conducted an in-depth analysis that has reached conceptual ‘saturation’, there is reasonable analytical generalisability over time and between localities in terms of the recurrence of a considerable number of common plausible issues.

Experiences of the MHA in Northern Ireland were investigated in just one study included in the synthesis. The evidence from Scotland focused on experiences of implementation of the MHCT 2003, without direct comparison to older legislation or legislation in England and Wales. The evidence from England was again drawn from a handful of small studies, and in particular there was a dearth of evidence attempting to examine experiences of the NR provisions since the MHA was amended in 2007. At best, the evidence can be considered indicative of issues with the MHA and MHCT legislation that may be experienced by service users and carers in particular, rather than representative of the majority of experiences.

**Methodological limitations of the review**

This systematic review was conducted within a rapid timeframe (six weeks) and the following limitations resulting directly from this approach should be acknowledged:

- A pragmatic decision was made to prioritise studies which contained more than a few paragraphs of relevant primary qualitative data for inclusion in the framework.
 synthesis. With more time, all included studies would have been considered for inclusion in the synthesis.

- A framework approach was used for the synthesis of included studies. The period available for synthesis of the prioritised studies (one to two weeks) did not lend itself to the preferred method of synthesis, which would have used an iterative, inductive approach. As such, the findings of this review are largely descriptive in nature, and are not able to reflect upon the nuance and underlying issues identified by the included studies. In addition, it was not possible to include all coded data in the write-up of the synthesis.

- Citation chasing was performed only on those studies prioritised for inclusion in the synthesis. With more time, all eligible studies would have been searched.

- Critical appraisal was performed in full, but only for those studies included in the framework synthesis. This was deemed as an appropriate time-saving approach, as findings from the non-prioritised batch of studies were not synthesised and did not influence the conclusions of the review.

- Three studies, which may have contributed useful information to the synthesis, were retrieved too late for inclusion in the review.

Despite these limitations, the processes of searching, study selection and critical appraisal (for prioritised studies) were conducted rigorously and in line with published international standards. The findings of our synthesis should be considered in light of these restrictions, and the stated limitations of the evidence base.
5 Conclusions

This rapid review synthesised qualitative evidence regarding experiences of service users, carers and other stakeholders regarding the NR provisions of the MHA (in England) and the NP provisions of the MHCT in Scotland. We identify a number of common themes across a small number of included studies. Given the paucity of evidence available, the outcomes which emerged from the synthesis must be considered as examples or indicators of experiences, rather than representative of the experiences and impact of current legislation across the UK.

The research included in this review indicates that:

- The role of the NR under the MHA is important and can carry a heavy responsibility. It is important that the most suitable person is identified for the role, wherever possible. Possible issues to consider when trying to identify a suitable person to fulfil the NR role may include, but are not limited to:
  - Considering with the service user who they feel would be a suitable person to fulfil the NR role,
  - Confirming with the service user that they have a good relationship with the potential NR, with no past or ongoing abuse,
  - Confirm that the potential NR is both willing and able to support the service user within the NR role,
  - Ensuring the potential NR is aware of the service user’s wishes regarding future treatment and willing to act on them where appropriate,
  - Ensure that the potential NR has an adequate understanding of both the parts of the MHA relevant to the circumstances of the service user and their role as the NR,
  - Confirm that the potential NR is in receipt of appropriate support from services, both in terms of their own needs as a carer, and in order to fulfil their role as NR.

- Under the MHCT in Scotland, service users welcome the opportunity to choose their NP.

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• The power to easily displace the NR or NP is perceived as beneficial, but may be used in a manner that may be harmful to important long-term relationships between the service user and their relatives or carers.

• The rights, powers and responsibilities of the NR or NP appear poorly understood by some professionals, and are sometimes poorly communicated to service users and carers.

• Where possible, a flexible and positive approach to communication between professionals involved with care, service users and NR/NP may help to achieve agreed suitable levels of information sharing.

• While some carers value the opportunity to be involved with decisions about the care of the service user that the role of NR or NP confers, it should be understood that there are significant responsibilities that come with the role. The emotional and informational needs of carers in this situation should be considered and appropriate support provided.

**Implications and recommendations for research**

**Implications**

Evidence was scarce, much of it was over ten years old, and consisted of samples of individuals from a limited range of localities and services. Studies also suffered from lack of evidence of rigour when collecting or analysing qualitative data. Despite the general consistency of experiences which contributed to themes across studies, only 12 studies contributed to the synthesis. The timeline of this rapid review prevented further exploration of the evidence, however drawing further conclusions from the limited evidence pool may have exacerbated the potential for biased, unrepresentative experiences to be captured.

As such, the main implications of this review are that the topic of the NR provisions of the MHA is complex, of significant importance to individuals detained under the Act, and insufficiently studied to date.
**Recommendations for research**

It is imperative that high quality primary research is undertaken to explore the current issues around the NR provisions of the MHA in England and Wales. There is no population group which has been recently and rigorously sampled to inquire about their experiences of the NR provisions, particularly since the introduction of the 2007 amendments to the MHA. While all areas and topics related to the NR provisions of the MHA warrant further investigation, some of the specific directions for primary research include:

- Examination of experiences of the NR/NP in light of the most recent legislative changes throughout the UK. For example, the option to opt for no NP in Scotland

- Further research is warranted in all areas of the UK. There was very little evidence from Northern Ireland and none from Wales, and while the studies based in Scotland were of good quality, they were few in number and all commissioned by government. Despite the greater number of studies conducted in England, most of the useful evidence arose from a very small number of studies, and none of these had been conducted since key legislative amendments were made in 2007

- There has been a lack of consideration of the experiences of those who are not married or in a civil partnership

- The views of mental health professionals and mental health advocates were not well represented

- We uncovered a dearth of evidence relating to the specific experiences of the NR/NP provisions from the perspective of ethnic minorities

Qualitative methods may be the most appropriate means of eliciting data about experiences of the NR/NP provisions of the MHA. However, reporting of methodological considerations could be improved.
6 Acknowledgements

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Contribution of authors

Liz Shaw: involved in all stages of the review, including direction/conception, planning searches, screening, data extraction, critical appraisal, synthesis and write-up. Lead and directed framework synthesis and subsequent write-up.

Michael Nunns: involved in all stages of the review, including direction/conception, planning searches, screening, data extraction, critical appraisal, synthesis, and write-up. Involved in synthesis and validation of findings. Lead write-up of remaining sections of report.

Simon Briscoe: involved in direction/conception, designing and conducting database and supplementary searches, screening, data extraction, critical appraisal, and write-up. Managed reference library, commented on and edited draft sections of the report.

Rob Anderson: involved in guiding the direction of the review, advised on all stages of conducting the review, critically read and edited all sections of the report.

Jo Thompson Coon: involved in guiding the direction of the review, advised on all stages of conducting the review, critically read and edited all sections of the report. Guarantor of the report.
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Appendix 1. Literature search strategies

A1.1 Bibliographic databases

Database: MEDLINE and MEDLINE In-Process

Host: Ovid

Data Parameters: 1946 to January Week 2 2018 and January 22, 2018

Date Searched: 23/1/2018

Searcher: SB

Hits: 596

Strategy:

1. (famil* or relative or relatives or relation*).tw.
2. (husband* or wife or wives or "civil partner*" or son* or daughter* or father* or mother* or grandparent*).tw.
3. ("named person*" or carer* or caregiver*).tw.
4. ("approved mental health professional*" or AMHP*).tw.
5. ("social worker*" or "occupational therapist*" or psychologist* or psychiatrist* or police).tw.
6. (nurse* adj3 ("mental health" or psychiatric or "learning disabilit*" or "occupational health")).tw.
7. exp Family/
8. Caregivers/
9. psychiatric nursing/
10. Social Workers/
11. occupational health nursing/
12. *Psychiatry/
13. or/1-12

14. ((involuntary or forced or compulsory) adj3 (admission* or hospitali?ation* or care)).tw.

15. ((sectioned or sectioning or detain* or detention) adj14 (mental* or psychiatr* or hosptial*)).tw.

16. "Commitment of Mentally Ill"/

17. "mental health act".tw.

18. ("community treatment order" or "supervised community treatment").tw.


20. or/14-19

21. ((mental* or psychiatr*) adj3 (health* or care or ill or illness or disorder* or service*)).tw.

22. Mental Health/

23. exp Mental Disorders/

24. or/21-23

25. qualitative*.tw.

26. (interview* or experience* or view*).mp.

27. Qualitative Research/

28. ("focus group" or survey* or questionnaire*).tw.

29. Focus Groups/

30. "Surveys and Questionnaires"/

31. or/25-30

32. 13 and 20 and 24 and 31

33. limit 32 to english language
Database: PsycINFO
Host: Ovid
Data Parameters: 1806 to January Week 3 2018
Date Searched: 23/1/2018
Searcher: SB
Hits: 578
Strategy:

1. (famil* or relative or relatives or relation*).tw.
2. (husband* or wife or wives or "civil partner*" or son* or daughter* or father* or mother* or grandparent*).tw.
3. ("named person*" or carer* or caregiver*).tw.
4. ("approved mental health professional*" or AMHP*).tw.
5. ("social worker*" or "occupational therapist*" or psychologist* or psychiatrist* or police).tw.
6. (nurse* adj3 ("mental health" or psychiatric or "learning disabilit*" or "occupational health")).tw.
7. exp family members/
8. Caregivers/
9. psychiatric nurses/
10. social workers/
11. occupational therapy/
12. *psychiatry/
13. or/1-12
14. ((involuntary or forced or compulsory) adj3 (admission or hospitali?ation or care)).tw.
15. ((sectioned or sectioning or detain* or detention) adj14 (mental* or psychiatr* or hospital*)).tw.
16. "commitment (psychiatric)"/
17. "mental health act".tw.
18. ("community treatment order*" or "supervised community treatment*").tw.
19. "mental health tribunal*".tw.
20. or/14-19
21. ((mental* or psychiatr*) adj3 (health* or care or ill or illness or disorder*)).tw.
22. Mental Health/
23. exp Mental Disorders/
24. or/21-23
25. qualitative*.tw.
26. (interview* or experience* or view*).mp.
27. Qualitative Research/
28. ("focus group" or survey* or questionnaire*).tw.
29. questionnaires/
30. or/25-29
31. 13 and 20 and 24 and 30
32. limit 31 to english language

Database: Social Policy and Practice
Host: Ovid
Data Parameters: 201710
Date Searched: 23/1/2018
Searcher: SB
Hits: 179
Strategy:

1. (famil* or relative or relatives or relation*).tw.

2. (husband* or wife or wives or "civil partner*" or son* or daughter* or father* or mother* or grandparent*).tw.

3. ("named person*" or carer* or caregiver*).tw.

4. ("approved mental health professional*" or AMHP*).tw.

5. ("social worker*" or "occupational therapist*" or psychologist* or psychiatrist* or police).tw.

6. (nurse* adj3 ("mental health" or psychiatric or "learning disabilit*" or "occupational health")).tw.

7. or/1-6

8. ((involuntary or forced or compulsory) adj3 (admission* or hospitali?ation* or care)).tw.

9. ((sectioned or sectioning or detain* or detention) adj14 (mental* or psychiatr* or hospitl*)).tw.


11. ("community treatment order*" or "supervised community treatment*").tw.

12. "mental health tribunal".tw.

13. or/8-12
14. ((mental* or psychiatr*) adj3 (health* or care or ill or illness or disorder* or service*)).tw.
15. qualitative*.tw.
16. (interview* or experience* or view*).mp.
17. ("focus group" or survey* or questionnaire*).tw.
18. or/15-17
19. 7 and 13 and 14 and 18

Database: HMIC
Host: Ovid
Data Parameters: 1979 to November 2017
Date Searched: 23/1/2018
Searcher: SB
Hits: 139
Strategy: see Social Policy and Practice search strategy

Database: CINAHL
Host: EBSCO
Data Parameters: n/a
Date Searched: 23/1/2018
Searcher: SB
Hits: 362
Strategy:
1. TI (famil* or relative or relatives or relation*) OR AB (famil* or relative or relatives or relation*)

2. TI (husband* or wife or wives or "civil partner*" or son* or daughter* or father* or mother* or grandparent*) OR AB (husband* or wife or wives or "civil partner*" or son* or daughter* or father* or mother* or grandparent*)

3. TI ("named person*" or carer* or caregiver*) OR AB ("named person*" or carer* or caregiver*)

4. TI ("approved mental health professional*" or AMHP*) OR AB ("approved mental health professional*" or AMHP*)

5. TI ("social worker*" or "occupational therapist*" or psychologist* or psychiatrist* or police) OR AB ("social worker*" or "occupational therapist*" or psychologist* or psychiatrist* or police)

6. TI (nurse* N2 ("mental health" or psychiatric or "learning disabilit*" or "occupational health") ) OR AB (nurse* N2 ("mental health" or psychiatric or "learning disabilit*" or "occupational health") )

7. (MH "Family+")

8. (MH "Caregivers")

9. (MH "Psychiatric Nursing")

10. (MH "Social Workers")

11. (MH "Occupational Health Nursing")

12. (MM "Psychiatry")

13. S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12

14. TI ((involuntary or forced or compulsory) N2 (admission* or hospitali?ation* or care) ) OR AB ((involuntary or forced or compulsory) N2 (admission* or hospitali?ation* or care) )
15. TI ( (sectioned or sectioning or detain* or detention) N13 (mental* or psychiatr* or hospital*) ) OR AB ( (sectioned or sectioning or detain* or detention) N13 (mental* or psychiatr* or hospital*) )

16. (MH "Involuntary Commitment")

17. TI "mental health act" OR AB "mental health act"

18. TI ( "community treatment order*" or "supervised community treatment*" ) OR AB ( "community treatment order*" or "supervised community treatment*" )

19. TI "mental health tribunal*" OR AB "mental health tribunal*"

20. S14 OR S15 OR S16 OR S17 OR S18 OR S19

21. TI ( (mental* or psychiatr*) N2 (health* or care or ill or illness or disorder* or service*) ) OR AB ( (mental* or psychiatr*) N2 (health* or care or ill or illness or disorder* or service*) )

22. (MH "Mental Health")

23. (MH "Mental Disorders+")

24. S21 OR S22 OR S23

25. TI qualitative* OR AB qualitative*

26. TX ( interview* or experience* or view* ) OR TX ( interview* or experience* or view* )

27. (MH "Qualitative Studies+")

28. TI ( "focus group" or survey* or questionnaire* ) OR AB ( "focus group" or survey* or questionnaire* )

29. (MH "Focus Groups")

30. (MH "Surveys")

31. S25 OR S26 OR S27 OR S28 OR S29 OR S30

32. S13 AND S20 AND S24 AND S31
Notes: Limited to English language studies

Database: ASSIA

Host: ProQuest

Data Parameters: n/a

Date Searched: 23/1/2018

Searcher: SB

Hits: 585

Strategy:

1. ((TI,AB(famil* OR relative OR relatives OR relation* OR husband* OR wife OR wives OR "civil partner*" OR son* OR daughter* OR father* OR mother* OR grandparent* OR "named person*" OR carer* OR caregiver* OR "approved mental health professional*" OR AMHP* OR "social worker*" OR "occupational therapist*" OR psychologist* OR psychiatrist* OR police)) OR (nurse* NEAR/2 ("mental health" OR psychiatric OR "learning disabilit*" OR "occupational health"))) OR MAINSUBJECT.EXACT.EXPLODE("Families") OR MAINSUBJECT.EXACT("Carers") OR MAINSUBJECT.EXACT("Psychiatric nursing") OR MAINSUBJECT.EXACT.EXPLODE("Social workers") OR MAINSUBJECT.EXACT("Occupational health nursing") OR MAINSUBJECT.EXACT("Psychiatry")

2. (TI,AB((involuntary OR forced OR compulsory) NEAR/2 (admission* OR hospitalisation* OR care)) OR ((sectioned OR sectioning OR detain* OR detention) N13 (mental* OR psychiatrist* OR hospital*)) OR “mental health act” OR “mental health tribunal*” OR “community treatment order*” OR “supervised community treatment*”) OR MAINSUBJECT.EXACT("Sectioning")
3. (mental* OR psychiatr*) NEAR/2 (health* OR care OR ill OR illness OR disorder* OR service*) OR MAINSUBJECT.EXACT("Mental health") OR MAINSUBJECT.EXACT.EXPLODE("Psychiatric disorders")

4. (interview* or experience* or view*) OR TI,AB(qualitative* OR "focus group" OR survey* OR questionnaire*) OR MAINSUBJECT.EXACT("Qualitative methods") OR MAINSUBJECT.EXACT("Qualitative research") OR MAINSUBJECT.EXACT("Focus groups")

5. 1 AND 2 AND 3 AND 4

Notes: Limited to English language studies

A1.2 Website searches

Table 7 Searches of relevant websites identified in the background scoping searches

<table>
<thead>
<tr>
<th>Website</th>
<th>Search strategy</th>
<th>Limits</th>
<th>Date</th>
<th>Hits</th>
</tr>
</thead>
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<tr>
<td>Centre for Mental Health</td>
<td>Searched for “nearest relative” using website search function.</td>
<td>None</td>
<td>24/1/18</td>
<td>16</td>
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<td><a href="https://www.centreformentalhealth.org.uk/">https://www.centreformentalhealth.org.uk/</a></td>
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<tr>
<td>Mental Health Alliance</td>
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<td>24/1/18</td>
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<td>Mental Health Foundation</td>
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<tr>
<td><a href="https://www.mentalhealth.org.uk/publications/listing">https://www.mentalhealth.org.uk/publications/listing</a></td>
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<td>Organization</td>
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<td>Young Minds</td>
<td>Searched for (1) “nearest relative” and (2) “mental health act” using search function. Search limited to publications</td>
<td>1/2/18</td>
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A1.3 Forward citation chasing
Appendix 2. Identification of initial themes for framework synthesis

<table>
<thead>
<tr>
<th>Study</th>
<th>Research Objective 1</th>
<th>Themes (&amp; Subthemes)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Research Objective 2</td>
</tr>
<tr>
<td>Rapaport 2002³⁰</td>
<td>Recognition of patients without relatives</td>
<td>Nearest relative and ASW: 1) Powers and duties: assessment and detentions 2) Other powers and duties</td>
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<tr>
<td></td>
<td>Bias and abuse</td>
<td>Inflexible identification: 1) Discrimination 2) Real life 3) Cultural contrasts and complications</td>
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</table>

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<table>
<thead>
<tr>
<th>Study</th>
<th>Themes (&amp; Subthemes)</th>
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<tbody>
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<td>Research Objective 1</td>
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<tr>
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<td></td>
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<tr>
<td></td>
<td>Reasons for nominating someone as a named person: 1) Nominating relatives, 2) Nominating friends and partners, 3) Nominating a professionals as a named person</td>
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Berzins 2009a

Perceptions of the introduction of the named person

Autonomy and choice
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<th>Themes (&amp; Subthemes)</th>
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<th>Research Objective 3</th>
<th>Research Objective 4</th>
<th>Research Objective 5</th>
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<tr>
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<td>and social isolation</td>
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<td>Dawson</td>
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<td>200932</td>
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<td>Research Objective 3</td>
<td>Research Objective 4</td>
<td>Research Objective 5</td>
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<td></td>
<td>information, Timing of nominating a named person, hoping not to be ill again, Same result?</td>
<td>value and effectiveness of the role, 3) Named Persons within the Tribunal process 4) Impact of the Named Person and their</td>
<td>value and effectiveness of the role, 3) Named Persons within the Tribunal process</td>
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<td></td>
<td>The use of advance statements, 3) Risks associated with appoint-</td>
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<th>Study</th>
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<th>Research Objective 3</th>
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<th>Research Objective 5</th>
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<td>Compulsion or choice?</td>
<td>The requirement to have a named person,</td>
<td>relationship</td>
<td>their relationship</td>
<td>5) Factors that support or hinder the Named Person Role</td>
<td>5) Factors that support or hinder the Named Person Role</td>
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</table>

**Yellow Highlight:** selected themes used to revise stage 1 framework
Appendix 3. Abstracts of studies included in descriptive analysis

**Banks 2016**

The introduction of supervised community treatment, delivered through community treatment orders (CTOs) in England and Wales, contrasts with the policy of personalisation, which aims to provide service users autonomy and choice over services. This article draws upon findings from a primarily qualitative study which included 72 semi-structured interviews (conducted between January and December 2012) with practitioners, service users and nearest relatives situated within a particular NHS Trust. The article also refers to a follow-on study in which 30 Approved Mental Health Practitioners were interviewed. The studies aimed to develop a better understanding of how compulsory powers are being used in the community, within a policy context that emphasises personalisation and person-centred care in service delivery. Findings from the interview data (which were analysed thematically) suggest that service users were often inadequately informed about the CTO and their legal rights. Furthermore, they tended to be offered little, or no, opportunity to make choices and have involvement in the making of the CTO and setting of conditions. Retrospectively, however, restrictions were often felt beneficial to recovery, and service users reported greater involvement in decisions at review stage. Areas of good practise are identified through which person-centred care can be better incorporated into the making of CTOs.

**Campbell 2001**

This article reports on the first extensive survey of Approved Social Worker (ASW) activity in Northern Ireland. It begins with a review of literature that identifies the complexity of legal and professional functions expected of ASWs, in the context of mental health legislation in the UK. Findings include high levels of perceived competence reported by practitioners, but diversity in the management of the service, and some problems in multi-disciplinary working. The emergency, out-of-hours duty teams in which many ASWs were employed appeared to vary in organization and operation. Service users and carers were generally dissatisfied with the responses to crisis services and appealed for adequately funded community supports. At a time when the review of the Mental Health (England and Wales) Act, 1983, is taking place, the
authors suggest that ASWs can still perform an important statutory role, on condition that there is a more consistent approach to training, re-approval and funding of community-based services.

**De Maynard 2007**

**Background:** Despite changes in legislation to prohibit racial discrimination and improve race relations, Black men in the United Kingdom repeatedly find themselves confronted with limited situations from which there appears to be no avoidance or escape. **Material:** This qualitative study attempts to gain some understanding of the process of becoming ill from the interviewees' point of view. The study was conducted in two different mental health-care settings situated in the South London area. A grounded theory approach to the date collection and analysis was used to elucidate this experience. The criteria for inclusion were that participants had to identify themselves as being Black, male, over the age of 18, and living with severe mental illness. Eleven men who fulfilled the criteria agreed to be interviewed and have their interviews tape-recorded and transcribed. The transcriptions were analyzed thematically for constructs that indicated how they came to be detained under the Mental Health Act of 1983. **Discussion:** Seven themes are revealed within the narratives of participant patients, (i.e., place of origin, sex, age, family and friends, education, work, and initial and most recent admission to hospital). The narratives provide evidence in support of the view that black men detained under the Mental Health Act usually have great insight into the reality of their own lived-worlds, but they are less likely to receive psychological interventions to help clarify and resolve issues that had arisen and are, therefore, at risk of readmission. **Conclusions:** Black men detained under the Mental Health Act presented with psychological issues that might be best addressed by suitably trained psychological therapist as opposed to medication.

**Department of Health 2015**

Between March and May 2015, the Department of Health asked people and organisations to share their views about strengthening the rights and choices of people to live in the community, especially people with learning disabilities, autism or mental health conditions. This document summarises the main trends in responses to the consultation.

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Gault 2009

This paper reports on a qualitative study analyzing service user (SU) and carer perspectives on medication compliance and their experience of compulsory treatment. Eleven SUs and eight carers were interviewed. The research is set against the background of changes to mental health legislation in England, in the form of Supervised Community Treatment. This signals a change in community mental health practise and urges a reconsideration of concepts such as compliance, concordance and coercion. These concepts are discussed in the context of legislative changes and in relation to the perspectives of service-SUs and carers. Four themes emerged from qualitative interview data, analysed using an adapted form of grounded theory: loss of credible identity, playing the game, medicalization, therapeutic competence and incompetence and increased control. The findings suggest that SUs are initially reluctant to comply with mental health treatment, but do eventually accept the need for treatment; they also stress the significance of respectful relationships with professionals and the importance of communicative competence.

Gault 2013

AIM: To explore and analyze perceptions of service users and caregivers on adherence and nonadherence to medication in a mental health care context.

BACKGROUND: Mental health medication adherence is considered problematic and legal coercion exists in many countries.

DESIGN: This was a qualitative study aiming to explore perceptions of medication adherence from the perspective of the service user (and their caregiver, where possible).

PARTICIPANTS: Eighteen mental health service users (and six caregivers) with histories of medication nonadherence and repeated compulsory admission were recruited from voluntary sector support groups in England.

METHODS: Data were collected between 2008 and 2010. Using qualitative coding techniques, the study analyzed interview and focus group data from service users, previously subjected to compulsory medication under mental health law, or their caregivers.
RESULTS: The process of medication adherence or nonadherence is encapsulated in an explanatory narrative. This narrative constitutes participants' struggle to negotiate acceptable and effective routes through variable quality of care. Results indicated that service users and caregivers eventually accepted the reality of their own mental illness and their need for safety and treatment. They perceived the behavior of professionals as key in their recovery process. Professionals could be enabling or disabling with regard to adherence to medication.

CONCLUSION: This study investigated service user and caregiver perceptions of medication adherence and compulsory treatment. Participants described a process perceived as variable and potentially doubly faceted. The behavior of professionals was seen as crucial in collaborative decision making on medication adherence.

Manktelow 200246

This article reports on the first extensive survey of Approved Social Worker (ASW) activity under the Mental Health (Northern Ireland) Order 1986. The integrated health and social services organizational structure, the adverse effects on individual mental health of the legacy of thirty years of civil conflict and the move from hospital to community care are significant features which have influenced the delivery of mental health social work services locally. The practise and experience of ASWs was surveyed by postal questionnaire and user and carer experience of compulsory hospital admission was investigated by a series of focus groups. The study revealed that two-thirds of ASWs had experience of acting as an applicant in compulsory hospital admission during the past two years. Nearly half (42 per cent) of these ASWs had reported experience of between one and five admissions and one-tenth had completed over twenty admissions in the two-year period. In only a small minority of cases did joint face-to-face assessment with the General Practitioner (doctor) take place; nearly half of ASWs reported difficulties in obtaining transport; and only one-fifth of ASWs had experience of acting as a second approved social worker. Half of ASWs reported experience of guardianship, either as applicant or in making the recommendation. Both service users and carers reported a lack of understanding about the role of the ASW and complained about the lack of alternative resources that ASWs could use to prevent hospital admissions. These findings are discussed
and a number of recommendations are proposed for improvements to approved social worker practise.

**Mental Health Alliance 2017**

The Mental Health Alliance undertook the first national survey on attitudes towards the principles behind the Mental Health Act.

Over 8,000 individuals – people with personal experience of mental illness, professionals, carers, family and friends – responded to our survey.

The survey reveals deep concern that people’s dignity, autonomy and human rights are overlooked when the Mental Health Act applies. The Act is therefore failing the people who most need protecting.

Respondents told us that people are denied opportunities to be involved in their care, along with their family, friends and carers. It is clear that ‘Advance Decisions’ are not promoted and respected.

A majority of respondents agreed that compulsory treatment in hospital is sometimes necessary when people pose harm to themselves or others. However, they were clear that important principles are currently flouted, that genuine parity between physical and mental health is needed. They gave strong support to the prospect of Advance Decisions being respected under the Mental Health Act.

The survey showed that legislation is needed urgently to address unintended consequences of the Act. The outmoded ‘nearest relative’ allocation system, for example, causes intolerable misery and delay for people at their most vulnerable.

The Government must deliver a fundamental review of the Mental Health Act. The Act is now over 30 years old and not fit for purpose.

The sheer scale and range of responses to our survey shows the demand for reform. The questions not fully answered also underline the urgency for more research to be carried out with the people whose voices are too-often ignored.
The Mental Health Alliance believes reform is urgently needed and is committed to helping the Government to conduct a review of the Act.

Raibee 2007

This paper examines the views and experiences of using and providing mental health services from the perspectives of black African and black African Caribbean mental health service users, their carers, voluntary services and a range of statutory mental health professionals and commissioners in Birmingham, UK. Using a qualitative approach, data were collected through telephone interviews (n = 15), individual face-to-face (n = 20) and focus group interviews (n = 12), and analysed using Krueger's framework and Rabiee's guidelines. Findings showed differences in the experiences of mental health services amongst African Caribbean and their African counterparts, the impact of social inequality on mental health and the needs of asylum seekers and refugees. It highlighted the important role of voluntary organizations in provision of care and support, insufficient provision of psychological therapies and concerns about high dosage of medication. The implications for practise are discussed, particularly the role of health beliefs in help-seeking behaviour and barriers to accessibility of mental health services.

Taylor 2013

PURPOSE: This paper aims to set out the views of approved mental health professionals (AMHPs) on the impact of supervised community treatment (SCT) on their work and their patients' lives in the community.

DESIGN/METHODOLOGY/APPROACH: The study covered a total of 56 community treatment order (CTO)-related activities undertaken in 2010 in a local social services authority (LSSA) in the north west of England, and looked at data from the records of 25 CTO patients. Nine AMHPs responded to a CTO outcomes questionnaire and five participated in a focus group.

FINDINGS: The characteristics of CTO patients in this LSSA study were consistent with national data. AMHPs were often undecided about the benefits of CTOs to their patients. A majority agreed that CTOs could benefit patients by earlier identification of relapse, improving access to housing and reducing the risk of avoidable harm to self or others. However, a majority
also agreed that CTOs had not improved patients' access to employment, education, training or recreational activities; nor had they helped reduce the stigma and discrimination that patients faced.

RESEARCH LIMITATIONS/IMPLICATIONS: This was a relatively small-scale study. However, its findings are consistent with previous work in this area, and provide pointers to how SCT can be more effectively implemented across England.

ORIGINALITY/VALUE: There is very little published research into the impact of SCT in England. Although small in scale, this study provides valuable insights into the views of AMHPs, who play a core role in the CTO process.
### Appendix 4. List of excluded studies coded as ‘forensic’ during title and abstract and full-text screening

<table>
<thead>
<tr>
<th>Study Description</th>
<th>Reference</th>
</tr>
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https://doi.org/http://dx.doi.org/10.1080/09585189908402142


Lea S, Callaghan L, Eick S. The management of individuals with enduring moderate to severe mental health needs : a participatory evaluation of client journeys and the
interface of mental health services with the criminal justice system in Cornwall. Health Services and Delivery Research 2015;3.


https://doi.org/http://dx.doi.org/10.1108/14777271111104565


https://doi.org/http://dx.doi.org/10.1002/cbm.350