

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

Liz Shaw, Michael Nunns, Simon Briscoe, Rob Anderson and Jo Thompson Coon



***National Institute for
Health Research***

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Declared competing interests of authors: Rob Anderson is a current member of the National Institute for Health Research Health Services and Delivery Research (HSDR) (researcher-led) Prioritisation Panel. However, this panel has no role in the allocation of review and research topics to the Exeter HSDR Evidence Synthesis Centre.

Published December 2018

DOI: 10.3310/hsdr06390

This report should be referenced as follows:

Shaw L, Nunns M, Briscoe S, Anderson R, Thompson Coon J. Experiences of the 'Nearest Relative' provisions in the compulsory detention of people under the Mental Health Act: a rapid systematic review. *Health Serv Deliv Res* 2018;**6**(39).

Health Services and Delivery Research

ISSN 2050-4349 (Print)

ISSN 2050-4357 (Online)

This journal is a member of and subscribes to the principles of the Committee on Publication Ethics (COPE) (www.publicationethics.org/).

Editorial contact: journals.library@nihr.ac.uk

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This report presents independent research funded by the National Institute for Health Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health and Social Care. If there are verbatim quotations included in this publication the views and opinions expressed by the interviewees are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health and Social Care.

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Abstract

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

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Background: Service users detained for assessment and/or treatment under the Mental Health Act 1983 (MHA 1983) are allocated a 'Nearest Relative' (NR). The NR 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 NR.

Objectives: To examine the experiences of service users, carers and relevant professionals of the NR provisions of the MHA 1983, and the equivalent Named Person (NP) provisions in Scotland. Five research objectives were defined: understanding the experiences of and issues associated with (1) the identification of the NR, (2) the displacement of the NR, (3) confidentiality and information-sharing, (4) access to support from carers and (5) making decisions about treatment or care.

Data sources: Seven bibliographic databases were searched: MEDLINE (via Ovid), MEDLINE In-Process & Other Non-Indexed Citations (via Ovid), PsycINFO (via Ovid), Social Policy and Practice (via Ovid), Health Management Information Consortium (via Ovid), Cumulative Index to Nursing and Allied Health Literature (via EBSCOhost) and Applied Social Sciences Index and Abstracts (via ProQuest). Citation searching, author contact and grey literature searches were conducted.

Review methods: A rapid systematic review was conducted in 6 weeks. Evidence published after 1998 from the UK pertaining to the experiences of those involved in compulsory detention under the MHA 1983 (or UK variants), including service users, carers, family members, NRs, NPs, mental health professionals, policy-makers and lawyers, was sought. Study selection, data extraction and critical appraisal were completed independently by two reviewers. We looked for data about experiences, which were obtained through qualitative means or surveys. Included studies containing several paragraphs of participant quotations and/or author interpretations were entered into a framework synthesis; the rest were summarised descriptively. The framework synthesis was based on the five research objectives and refined using the findings of key studies from England and Scotland and an inductive thematic analysis.

Results: Twenty studies were included with 12 prioritised for framework synthesis. Four themes emerged: (1) issues regarding the identification of the NR/NP, (2) confidentiality and information-sharing, (3) enabling the use of the NR/NP role and (4) the importance of maintaining relationships. The involvement of service users in choosing their representative and the role of services in supporting the NR/NP 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 time scale; 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 NR provisions of the MHA 1983 are complex and of significant importance to individuals detained under the Mental Health 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 focused on the perceived and actual use and impact of the NR provisions in England and Scotland.

Study registration: This study is registered as PROSPERO CRD42018088237.

Funding: The National Institute for Health Research Health Services and Delivery Research programme.

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Glossary

Approved mental health professional An individual responsible for the assessment and hospital admission of people who have been detained under the Mental Health Act 1983 (Great Britain. *Mental Health Act 1983*. London: The Stationery Office; 1983). Approved mental health professionals were introduced in the 2007 amendment to the Mental Health Act 1983 and replaced the role of approved social workers. They include social workers, nurses, occupational therapists and psychologists.

Community treatment order An order allowing 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 readmitted to hospital.

Forensic detention The detention of an individual under the Mental Health Act 1983 by any of the forensic services, for example police or a court of law.

Mental Health Act 1983 A UK Act of Parliament that 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 Act was amended in 2007.

Mental Health (Care and Treatment) (Scotland) Act 2003 An Act that replaced the Mental Health (Scotland) Act 1984. As per the 1984 Mental Health Act, it is primarily concerned with the detention of people with mental health disorders.

Mental health officer An individual responsible for the assessment and hospital admission of people who have been sectioned under the Mental Health (Scotland) Act 1984. The role is broadly similar to that of approved mental health professionals in England and Wales.

Mental Health (Scotland) Act 1984 The Act that replaced the Mental Health (Scotland) Act 1960 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 tribunal A legal proceeding that people who are sectioned under the Mental Health Act 1983 can apply for in order to be discharged. It 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 An individual who is chosen by a person who is detained under the Mental Health (Scotland) Act 1984 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 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 user A service user who is involuntarily admitted to hospital under the criminal pathway of the Mental Health Act 1983 and who is subject to a 'restriction order'. Among 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 sections 2 or 3 is sometimes described as 'sectioned'.

Supervised community treatment Takes place under a community treatment order.

List of abbreviations

AMHP	approved mental health professional	MHA 2007	Mental Health Act 2007
ASSIA	Applied Social Sciences Index and Abstracts	MHCT	Mental Health (Care and Treatment) (Scotland) Act 2003
ASW	approved social worker	MHO	mental health officer
CINAHL	Cumulative Index to Nursing and Allied Health Literature	MHWM	Mental Health (Wales) Measure 2010
CTO	community treatment order	NIHR	National Institute for Health Research
DHSC	Department of Health and Social Care	NP	Named Person
HSDR	Health Services and Delivery Research	NR	Nearest Relative
MCA	Mental Capacity Act	PRISMA	Preferred Reporting Items for Systematic reviews and Meta-Analyses
MHA 1983	Mental Health Act 1983	SCT	supervised community treatment

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 the relative or carer 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 carried out 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 were 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.

Scientific summary

Background

Under the Mental Health Act 1983 (MHA 1983), 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 1983 states that they are eligible to receive support from an assigned 'Nearest Relative' (NR). The NR is a statutory role within these processes 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 receiving confidential and potentially sensitive information about the service user's care.

The NR is an important role; however, issues over the identification, displacement and powers of the NR have been raised. Under the MHA 1983, the NR is identified from a hierarchical list by an approved mental health professional (AMHP). The AMHP goes through the list, which begins with a partner of > 6 months (including civil partners), through children, parents, siblings, grandparents, grandchildren, uncles or aunts and nephews or nieces, until a person aged > 18 years and 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, 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, 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 1983.

There is an alternative to the NR role currently in use within the UK. In Scotland, the Mental Health (Care and Treatment) (Scotland) Act 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 its intention to commission an independent review of the MHA 1983. To inform the independent review of the MHA 1983, this systematic review was commissioned by the Department of Health and Social Care (DHSC) in January 2018 to explore how the legislation is being used in practice 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 1983 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 service users, family members, carers and relevant professionals of the use of the NR provisions in the compulsory detention and ongoing care of people under the MHA 1983?

This included five objectives from the perspective of service users, family members, carers and relevant professionals. These were to explore:

1. experiences relating to the identification of the NR in the care of an individual who has been compulsorily detained under the MHA 1983
2. 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
3. issues relating to service user confidentiality and information-sharing, relating to all aspects of compulsory detention
4. issues relating to decisions about care during detention and after discharge, including discharge to a community treatment order (CTO)
5. 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 6 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), Health Management Information Consortium (via Ovid), Cumulative Index to Nursing and Allied Health Literature (via EBSCOhost) and Applied Social Sciences Index and Abstracts (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 1983 (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, NRs/NPs, 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. Owing to time restrictions, data were extracted, critically appraised and entered into a framework synthesis from only the studies that included the greatest quantity of qualitative data. This was a pragmatic step that considered both the quality and the quantity of relevant evidence available in each record, such that those containing several paragraphs or more of relevant data 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 undertake a framework synthesis, which involved four stages. First, relevant data extracted from prioritised studies were entered into a framework that had been developed based on the five research objectives. In the second stage of synthesis, the studies that 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 were 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, 12 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, and 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 after the 2007 amendments to the MHA 1983. 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: (1) issues regarding the identification of the NR/NP, (2) confidentiality and information-sharing, (3) enabling the use of the NR/NP role and (4) importance of maintaining relationships. The first two of these themes were more descriptive, mapping onto our research objectives, whereas the second 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, and 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 provision 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 that 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 that the carers had access to the support they needed, while 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 that they would like to improve the processes that would enable them to discuss information about a service user with professionals. They highlighted that, although 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 third 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 1983. 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 enables 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 fourth 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 the second theme, and also empower service users and carers and thus act as a protective factor against abuse of the service user and carer burnout.

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 when professionals worked closely with carers to optimise the care that 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 1983 in 2018. Although similar experiences were seen across studies, the entire synthesis was based on only 12 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 1983 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 the assessment or treatment of mental health problems. This included those with experience of the NR provisions of the MHA 1983 in England and the NP provisions of the MHCT in Scotland. We identified a number of common experiences across our 12 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 1983 and related professional practice, 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 findings of this review are that the topic of the NR provisions of the MHA 1983 is complex, of significant importance to individuals detained under the Act and their carers and has not been studied in great detail to date. In order to better understand the NR provisions of the MHA 1983 and their influence on individuals involved in their application, more high-quality primary research must be undertaken that is

specifically focused 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 the light of the most recent legislative changes throughout the UK.
- Further research 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.
- Consideration of the experiences of those who are not married or in a civil partnership.
- Better representation of the views of mental health professionals and advocates.
- Greater evidence relating to the specific experiences of the NR/NP provisions from the perspective of ethnic minorities.
- Qualitative methods to be the most appropriate means of eliciting data about experiences of the NR/NP provisions of the MHA 1983 and MHCT. However, reporting of methodological considerations should be improved.

Study registration

This study is registered as PROSPERO CRD42018088237.

Funding

Funding for this study was provided by the Health Services and Delivery Research programme of the National Institute for Health Research.

Chapter 1 Background

This report is concerned with the 'Nearest Relative' (NR) provisions of the Mental Health Act 1983 (MHA 1983).¹ The work was commissioned by the National Institute for Health Research (NIHR) Health Services and Delivery Research (HSDR) programme. The following sections provide a brief overview of the key features of the MHA 1983¹ and the NR provisions contained within it, or as amended since 1983. Perceived problems regarding the use of the NR provisions are briefly discussed, and the relevant legislative changes that 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.

The Nearest Relative provisions of the Mental Health Act 1983

The Mental Health Act 1983

The MHA 1983¹ is a piece of UK legislation that 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 1983¹ outlines the process by which individuals may be detained and treated, their rights to appeal and the rights of those receiving aftercare. The MHA 1983¹ also outlines the rights of the family and carers of the person being detained. The MHA 1983¹ 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 1983¹ states that a person may be involuntarily admitted to hospital for a period of assessment of 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' (contains public sector information licensed under the Open Government Licence v3.0.) and it is in the interests of the health or safety of the service user or for the protection of the public.¹

A person can be involuntarily admitted to hospital under section 3 of the MHA 1983¹ for treatment for a period of up to 6 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.¹

The MHA 1983¹ 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 section 2 or 3 of the MHA 1983,¹ 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 or not to apply to a hospital to detain the service user.¹ An emergency detention can be sought under section 4 or 5 of the MHA 1983¹ when seeking an assessment by a second medical professional may 'involve undesirable delay'. A section 4 detention can be converted to a section 2 or 3 detention if a second assessment, by a different medical professional, is conducted within 72 hours.

A service user sectioned under section 2 or 3 of the MHA 1983¹ 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 in accordance with which section has been used to detain the service user in hospital.¹

The Nearest Relative provision

The NR provision of the MHA 1983¹ was intended as another safeguard to protect the rights of a service user who is being involuntarily 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 and 3 and a section 7 guardianship order.

Although 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 1983¹ defines and differentiates 'Relatives' and 'Nearest Relatives'. 'Relative' means anyone in the following hierarchical list:

1. husband, wife or civil partner
2. son or daughter
3. father or mother
4. brother or sister
5. grandparent
6. grandchild
7. uncle or aunt
8. niece or nephew.

Under the MHA 1983,¹ 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 > 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 for > 6 months.¹ Ex-partners who have permanently separated from the service user cannot be considered for the role. In circumstances in which 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 Nearest Relative 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 because of 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 1983¹ 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

Legislative amendments influencing the Nearest Relative provisions

The NR role emerged in the Mental Health Act 1959³ and was largely unchanged in the 1983 Act.⁴ However, since 1983 elements of the MHA 1983¹ have been amended or influenced by the development of other legislation and codes of practice, which has influenced how the NR provisions are implemented. The key legislative changes are summarised below.

The Mental Health (Northern Ireland) Order, 1986

This legislation is broadly similar to the MHA 1983.¹ 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).⁵ The role of the NR is similar to that detailed by the MHA 1983.¹

The Human Rights Act 1998

The Human Rights Act 1998⁶ outlines the rights and freedoms that everyone in the UK is entitled to.⁶ These rights are set out in a series of 12 articles, each of which details a different right. Such rights include the right to life, the right to privacy, freedom from torture and inhumane or degrading treatment, and the right to a fair trial.⁶ The Act means that people in the UK can seek justice in court if they feel that their rights have been violated and that public bodies, such as hospitals, courts and the police, must respect people's rights.⁷ 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.⁶ Because all health legislation post 1998 must be compliant with the Human Rights Act,⁶ we believe that it is of central importance for interpreting and implementing the MHA 1983.¹

The National Service Framework for Mental Health 1999

The National Service Framework for Mental Health⁸ 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 on 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.

The Mental Capacity Act 2005

The Mental Capacity Act (MCA)⁹ is intended to protect individuals aged ≥ 16 years 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 of that person.¹⁰

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

The Mental Health (Care and Treatment) (Scotland) Act 2003 (MHCT)¹¹ 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 Mental Health (Scotland) Act 1984, which included NR provision as set out in the MHA 1983.^{1,12} 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 or the potential for abuse of powers.¹³

Under the MHCT, the powers of the NP are reduced, and the service user has choice over who is appointed and can revoke the NP in writing.¹¹ 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 Mental Health Act 2007 (MHA 2007)].^{1,14} Key differences between the NR and NP are shown in *Table 1*.

TABLE 1 Key differences between the NR and NP roles

Application of act	NR (MHA 2007) ^{1,14}	NP (MHCT) ¹¹
Region	England and Wales	Scotland
Appointment	By default, in accordance with hierarchy of 'nearness' of relatives set out in MHA 1983 ¹	Nominated by service user. In absence of nomination, defaults to primary carer, then in accordance with the hierarchy of 'nearness' of relatives set out in MHA 1983 ¹
Displacement	Via application to a County Court	Can be revoked in writing by the service user. Can be challenged by a mental health professional if deemed inappropriate
Option to decline	Powers can be delegated by the NR to another eligible relative	Can be declined by the NP
Rights to information	<ul style="list-style-type: none"> • 'Can be' consulted before a decision is made about compulsory detention for assessment or treatment • 'Can be' consulted when a CTO is being considered to be: <ul style="list-style-type: none"> ○ told the reasons for detention ○ informed about decisions relating to treatment ○ informed if the service user is placed on a CTO or placed under guardianship ○ informed when a section, CTO or guardianship order is renewed or changed ○ informed when a service user is discharged from detention or from a CTO • A detained service user may request that information is withheld from the NR 	<p>To:</p> <ul style="list-style-type: none"> • be consulted when a short-term detention or CTO is under consideration • be informed of any orders that have been made and any subsequent changes • receive a copy of a compulsory treatment application • attend and provide evidence at tribunals • be informed of cross-border transfers and hospital transfers (the latter only when the service user challenges the transfer)
Discretionary powers	<p>To:</p> <ul style="list-style-type: none"> • request an assessment of the service user for compulsory detention • apply to detain the service user in hospital for assessment or treatment • request reception of the service user into guardianship • seek to have the service user discharged from an assessment section 2 or treatment order section 3 • apply to a mental health tribunal to appeal against the service user's detention 	<p>To:</p> <ul style="list-style-type: none"> • request an assessment of need for mental health care or community care services • appeal to the sheriff principal and thereafter to the Court of Session

The Mental Health Act 2007

The MHA 1983¹ was revised in 2007,¹⁴ leading to a number of significant changes to the Act. These include changes to professional roles, such as introducing the AMHP to replace the ASW, introducing CTOs to replace supervised discharge, certain definitions, interaction with the Mental Capacity Act 2005 and the structure of mental health tribunals.¹⁴ Of direct relevance to the NR provisions were the following amendments:

- When identifying the NR, those in civil partnerships were considered as being of equal status to people who were married.
- Service users were given the power to displace the NR on grounds of unsuitability. Applications were to 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 and Social Care (DHSC) publication¹⁵ discusses the rights of service users to know about the information that 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.¹⁵ The document also acknowledges the role that carers may play in providing information to services. It recommends criteria that should be fulfilled when sharing information regarding a service user between different parties.

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

The Mental Health (Wales) Measure (MHWM) 2010¹⁶ 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 Wales all have a care and treatment plan. 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 care and treatment plan, and their carers and 'significant others' should be involved when appropriate.¹⁷

The NHS Five Year Forward View 2014

This policy document¹⁸ 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 that 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 for any other individuals whom the patient wishes to share this information with.

The Mental Health Act Code of Practice 2015

The Code of Practice provides guidelines for professionals on their roles and responsibilities under the MHA 1983.^{1,2} Revisions to the Code were made in 2015, in the 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 1983¹ should be used instead of the MCA and vice versa.²

Issues regarding the Nearest Relative provisions

Despite amendments to the MHA 1983¹ (in 2007)¹⁴ and the introduction of a revised Code of Practice (2015)² to give guidance in applying the MHA 1983,¹ 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.¹⁹ Others have highlighted how the system for involving partners, carers and family members in the care service users receive under the NR provision of the MHA 1983¹ is inflexible, and does not always represent either the wishes of the service user or the person identified as their NR.²⁰ This is despite the amendments to the MHA 1983¹ in 2007, which recognised same-sex relationships within the NR hierarchy and enabled detained service users to displace people who they felt were inappropriate to act for them within the NR role.¹⁴

In 2017, the government commissioned an independent review of the MHA 1983,¹ to focus on how the legislation is being used in practice and examine its impact on service users, families and carers.²¹

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 1983¹ 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 NR provisions in the compulsory detention and ongoing care of people under the MHA 1983?¹

This included objectives, from the perspective of service users, family members, carers and relevant professionals. These were to explore:

- experiences relating to the identification of the NR in the care of an individual who has been compulsorily detained under the MHA 1983¹
- 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
- issues relating to service user confidentiality and information-sharing, relating to all aspects of compulsory detention
- issues relating to decisions about care during detention and after discharge, including discharge to a CTO
- issues relating to service users having access to support from individuals who they want to be involved with or informed about their care.

Chapter 2 Methods

This systematic review was conducted in 6 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.²² Reporting of the methods and results was consistent with Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) reporting guidelines²³ and Enhancing Transparency in Reporting the synthesis of Qualitative Research (ENTREQ) checklist guidelines.²⁴ A protocol was registered on the PROSPERO database (PROSPERO CRD42018088237).

Search strategy

Background scoping searches were carried out to help develop a bibliographic database search strategy for the identification of evidence. This predominantly consisted of basic keyword searching in Google (Google Inc., Mountain View, CA, USA) and Google Scholar. Whenever possible, we ensured that relevant papers 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. medical subject headings 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.²⁵ We also included search terms for 'questionnaires' and 'surveys' in order to complement 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 1998⁶ for interpreting and implementing the MHA 1983.¹ The final search strategy was translated for use in seven bibliographic databases, which were 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), Cumulative Index to Nursing and Allied Health Literature (CINAHL) (via EBSCOhost) and Applied Social Sciences Index and Abstracts (ASSIA) (via ProQuest). The bibliographic database search strategies are reproduced in *Appendix 1, Bibliographic databases*.

Forward citation-chasing (identifying papers that cite our included studies) was conducted using Web of Science, Scopus and Google Scholar. Backward citation-chasing (inspecting the reference lists of included studies) was carried out manually by reviewers. The reference lists of previously conducted systematic reviews on topics related to the NR provision of the MHA 1983¹ were also inspected.

The websites of several relevant organisations that 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, Website searches*. Finally, authors of relevant studies were contacted with regard to unpublished or unobtainable studies.

Inclusion and exclusion criteria

The following inclusion criteria and exclusion criteria, in accordance with the Population, phenomenon of Interest and Context (PICo)²⁶ categories were applied to the studies identified through the search strategy.

Population

This was defined as people detained under section 2 or 3 of the MHA 1983,¹ their family and carers and the individuals involved with their care who work within the remit of the MHA 1983.¹

More specifically, the population 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 officers.

Studies were included if the individuals were:

- a service user who has experience of being compulsorily detained under section 2 or 3 of the MHA 1983¹
- carers, relatives related professionals (listed above).

Studies were excluded if the individuals were:

- people who have agreed to a voluntary admission and carers, relatives and relevant professionals involved in their care
- people with mental health difficulties not leading to compulsory detention under the MHA 1983.¹

Phenomenon of interest

This was defined as experiences of, or attitudes towards, the application of the NR provisions of the MHA 1983.¹ 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.

Studies were included if data about experiences were obtained through:

- qualitative means (e.g. interview, focus group)
- a survey or questionnaire.

Context

This was defined as the use of the NR provisions of the MHA 1983¹ within the UK only.

Studies were included if:

- detention took place under the jurisdiction of England, Wales, Scotland or Northern Ireland
- data were from any time since the publication of the Human Rights Act 1998.

Studies were excluded if:

- detention was not under the jurisdiction of England, Wales, Scotland or Northern Ireland
- detention of an individual was undertaken by forensic services.

Study design

Studies were included if data came from:

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

Studies were excluded if data came from:

- blogs or social media posts
- commentaries, opinion pieces and editorials
- case studies
- conference abstracts
- case law.

Study selection

Searches were undertaken and all results were downloaded into EndNote [EndNote X8; Clarivate Analytics (formerly Thomson Reuters), Philadelphia, PA, USA] for removal of duplicate records. A pilot screening exercise was carried out on a sample ($n = 100$) of bibliographic database search results in order to calibrate inclusion/exclusion judgments for all reviewers (MN, LS and SB) and refine the clarity of inclusion criteria. Decisions were discussed in a face-to-face meeting to ensure consistent application of criteria. When necessary, inclusion and exclusion criteria were revised to reflect reviewer interpretation and judgment.

The revised inclusion and exclusion criteria were then applied to the title and abstract of each identified citation independently by two reviewers (MN and 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 on exclusion.

The full text of each source taken forward from title and abstract screening was assessed independently for inclusion by two reviewers (LS, MN or SB). 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 flow chart (see *Figure 2*).²³

Data extraction

A data extraction form was developed using Microsoft Excel® (Microsoft Corporation, Redmond, WA, USA), piloted by Michael Nunns, Liz Shaw and Simon Briscoe 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 done and themes or ideas presented relevant to the research question.

Critical appraisal strategy

Critical appraisal was carried out on studies prioritised for synthesis only ('top tier'). Critical appraisal was done by one reviewer (LS or MN) during data extraction using the Wallace checklist²⁷ and checked by a second reviewer (MN or LS). Disagreements were resolved through discussion. Critical appraisal did not influence eligibility for inclusion or synthesis, but was intended to provide context to findings.

Methods of data synthesis

Owing 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 the quantity of relevant evidence available in each record. All included studies were rated by two reviewers (MN and LS) based on the number 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 were not prioritised as there were no free-text responses to open questions presented. Disagreements on the classification of studies were resolved with discussion. Studies that 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.²⁸

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 on a thorough understanding of relevant background literature and related theory (e.g. see Dixon-Woods²⁹). However, our background scoping and preliminary searches did not identify any accessible theory or framework that 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 the research question(s)

Participant quotations illustrating the views of service users, carers and NRs and the author interpretation of these views (known as first- and second-order construct data, respectively³⁰) were extracted from the results section of each 'top tier' article. The information was placed within a framework based on our five research objectives by one reviewer (LS or MN), and checked by a second reviewer (MN or LS) using Microsoft Excel®. This information was used to identify which papers 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 and MN) 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 England³¹ and two were conducted in Scotland.^{32,33} One reviewer (LS) selected the themes presented in each article that 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 included studies 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 that appeared to be discussing similar or related concepts were grouped together. This formed the beginnings of descriptive subthemes. The data contained under these subthemes were moved both within and across existing subthemes to reflect changes in their content. Preliminary subthemes were divided and 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 and RA), whose feedback was incorporated into the developing themes and subthemes to ensure that 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 and JTC). The data synthesis process is summarised in *Figure 1*.

End-user involvement

One carer with experience of the NR provisions provided feedback on the themes and subthemes identified by the synthesis and commented on the write-up of the results within this report.

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 and LS), an information specialist (SB) and a health economist (RA) with prior experience of conducting systematic reviews for the National Institute for Health Research. This prior experience meant that the team aimed to maintain a rigorous methodology throughout the review, despite the limited time frame available. This is reflected in the decision to retain searching across multiple databases, double screening of references at both title/abstract and full-text level, 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 able to quickly identify a method to prioritise the studies for inclusion in the main synthesis.

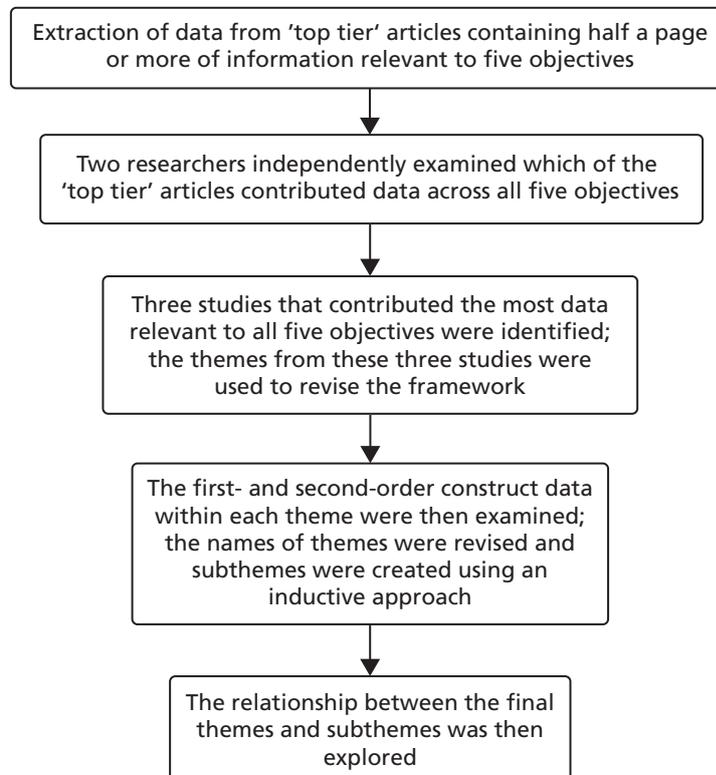


FIGURE 1 Framework synthesis process for prioritised studies.

The focus of the review was novel for most members of the team. This meant that 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 because of previous projects and the experience of one reviewer (LS) of working alongside individuals detained under the MHA 1983¹ and working in accordance with the MCA. This reviewer utilised her prior experience and knowledge gained through her training as a clinical psychologist and of conducting qualitative synthesis within this review. Her 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 (MN) and incorporation of views from other members of the team and a carer with experience of the MHA 1983.¹ 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.

Chapter 3 Results

Study selection

The PRISMA flow 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 that 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%). Following full-text screening, 124 papers were excluded for the reasons specified in *Figure 2*. Half of the excluded papers ($n = 62$) were excluded because they did not report relevant data. Other common reasons for exclusion included being a non-UK study ($n = 22$) and having no primary study data ($n = 21$). A smaller number of papers were not about compulsory detention

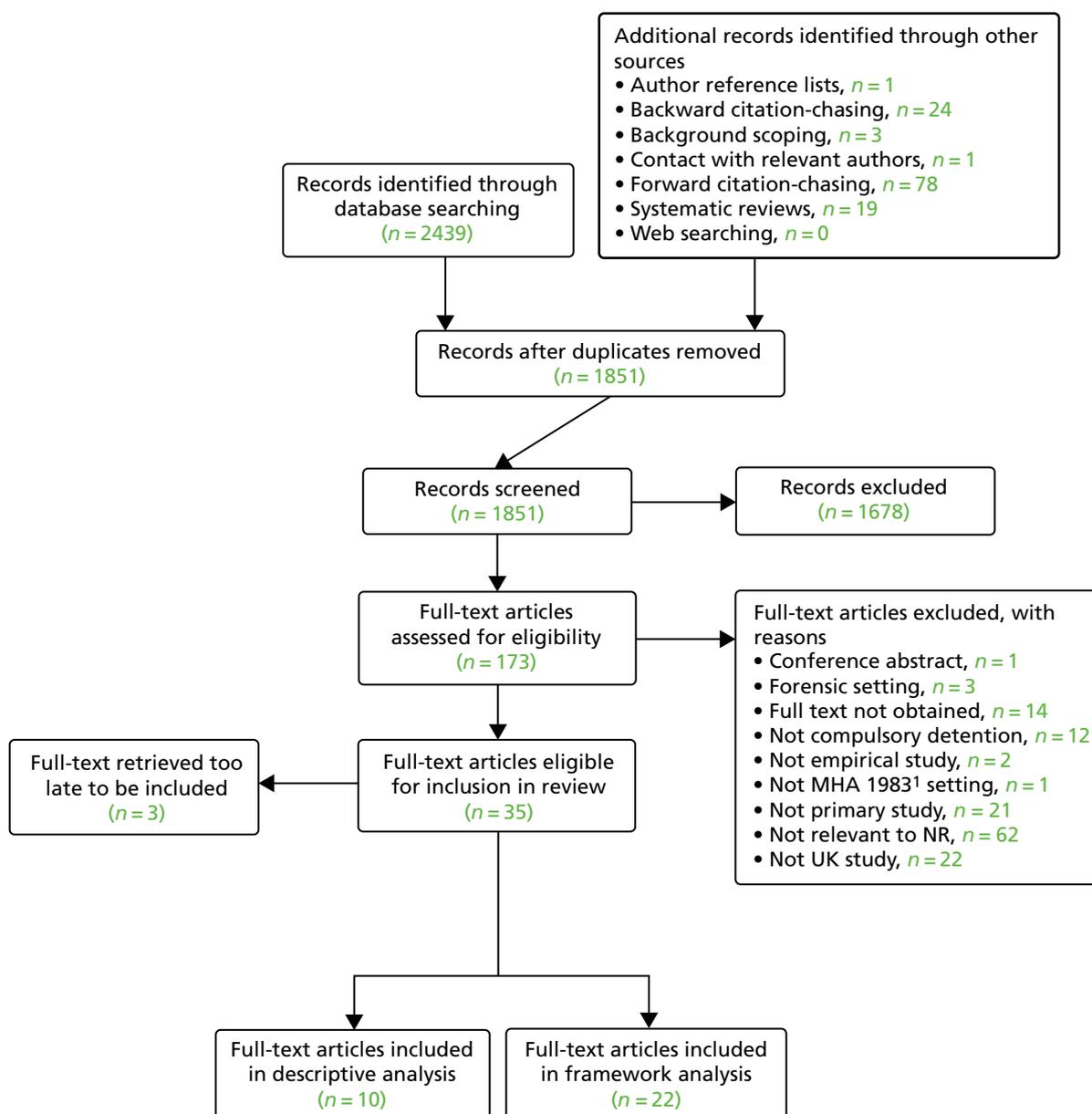


FIGURE 2 The PRISMA flow chart.

($n = 12$), were not about the MHA 1983¹ or a relevant section of the MHA 1983¹ ($n = 1$ 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 1983.¹ The citations of these records are listed in *Appendix 3*. These were not full-text screened and are not included in any further analysis.

In total, 35 papers^{4,20,31-63} were identified that met our inclusion criteria: 22 papers via searching bibliographic databases and 13 papers via supplementary search methods.

As described in *Chapter 2, Inclusion and exclusion criteria*, papers that met our inclusion criteria were categorised in accordance with the number of relevant primary data presented. Papers with several paragraphs or more of data were prioritised into the 'top tier' of included studies for synthesis, and studies that did not meet this rating were retained in the 'second tier' of studies for narrative description.

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,^{4,31-33,36-38,40,45,46,48,49,51-60} that contained enough relevant and usable data for inclusion in the framework synthesis. *Table 2* contains a summary of the foci, sample characteristics and qualitative data collection and analytic methods employed in these studies.

Among the 'top tier' studies, there were two PhD theses^{31,32} and four reports.^{33,49,56,60} The three studies from Scotland^{32,33,56} consisted solely of government reports and subsequent publications in peer-reviewed journals, all focusing on the implementation of the MHCT, with specific regard to the NPs provisions. One study³⁸ 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,^{57,60} interactions with various mental health professionals^{49,58} or perceptions of the MHA 1983¹ and the NR provisions and their implications for care.^{31,45,46,48}

All of the 'top tier' studies collected data using interviews. Other data collection methods used included administering questionnaires with space for open responses,^{31,38,49} observation of group discussions,^{45,49} and workshop events or group exercises.^{31,48,49} There was a mixture of national and local sampling approaches, resulting in sample sizes ranging from 21 carers⁴⁵ to 998 survey respondents.⁴⁹ Interviews were conducted with samples ranging from 21⁴⁵ to 115⁵⁶ individuals, from a range of perspectives. Analysis was described as 'thematic analysis' (eight studies),^{32,36-38,46,48,49,57-60} 'grounded theory' (two studies)^{33,45} or 'framework analysis' (two studies).^{4,31,51-56}

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.^{20,34,39,41-44,47,50,61} *Table 3* contains a summary of the aims, sample characteristics and methods for these 10 papers.

There were eight peer-reviewed journal articles reporting six primary studies^{34,39,41,43,44,47,50,61} and two survey-based reports.^{20,42} Eight papers reported research conducted in England and/or Wales,^{20,34,41-44,50,61} and two reported research conducted in Northern Ireland.^{39,47} The papers by Campbell *et al.*³⁹ and Manktelow *et al.*⁴⁷ were based on survey data collected in 1998-9, in the context of the Mental Health (Northern Ireland) Order (1986).⁵ Of the studies conducted in England and Wales, only the study by De Maynard⁴¹ may have been conducted prior to the 2007 amendments to the MHA 1983,^{1,14} although the date of data collection was not reported.

TABLE 2 Description of studies included in framework synthesis

First author, year of publication	Country	Publication type	Study focus	Qualitative data collection method (date of data collection)	Participants providing qualitative data	Study context and sampling	Type of qualitative data analysis
Berzins, 2009; ³² 2009; ³⁷ and 2010 ³⁶	Scotland	D; JP; JP	Perceptions of NP provisions	Semistructured telephone (carers) and face-to-face (service users) interviews (data collected 2005–7)	Total, <i>N</i> = 46: service users, <i>n</i> = 20; carers, <i>n</i> = 10 (as potential NPs, <i>n</i> = 3; already NPs, <i>n</i> = 4; considering, <i>n</i> = 3; not considering, <i>n</i> = 0); MHOs, <i>n</i> = 7 (social workers); professionals with influence on government policy, <i>n</i> = 9	MHOs from local authorities, service users and carers recruited from voluntary organisations, policy influencers recruited at national level. Direct contact/newsletter	Thematic analysis
Campbell, 2008 ³⁸	Northern Ireland	JP	Nature of legal advocacy services available after compulsory admission	Focus group interviews and questionnaires (date of collection NR)	Total, <i>N</i> = 44 respondents from five mental health service user groups: carer group, lawyers, mental health review tribunal member, professional advocacy service managers, hospital administrators	Questionnaires posted to solicitors and hospital administrators in Northern Ireland. Focus group recruitment NR	Thematic analysis
Dawson, 2009 ³³	Scotland	R	Perceptions of NP provisions	Face-to-face interviews, telephone interviews and focus groups (data collected 2007–8)	Total, <i>N</i> = 44: service users, <i>n</i> = 2; NPs, <i>n</i> = 4; tribunal members, <i>n</i> = 13; MHOs, <i>n</i> = 14; nurse, <i>n</i> = 1; legal reps, <i>n</i> = 3; independent advocates, <i>n</i> = 5; tribunal clerks, <i>n</i> = 2	Four local authority areas and their associated health board across Scotland. Contact with voluntary sectors, written invitations, bespoke events with stakeholder groups	Framework analysis
Henderson, 2002 ⁴⁵	England	JP	Service users' experiences of mental health care after compulsory admission	Semistructured interviews and observation of group discussions (data collected 2001)	Total, <i>N</i> = 21: carers, <i>n</i> = 11; service users, <i>n</i> = 10	Participants had to be or have been in a relationship in which one partner has a diagnosis of bipolar disorder	Phenomenological framework analysis

continued

TABLE 2 Description of studies included in framework synthesis (*continued*)

First author, year of publication	Country	Publication type	Study focus	Qualitative data collection method (date of data collection)	Participants providing qualitative data	Study context and sampling	Type of qualitative data analysis
Jankovic, 2011 ⁴⁶	England	JP	Experiences of family caregivers of relatives involuntarily admitted to psychiatric hospital	In-depth, semistructured interviews (date of collection NR)	Total, $N = 31$ family caregivers	Contact by letter or telephone. Service users recruited in larger national multicentre study on Outcomes of Involuntary Hospital Admission in England provided informed written consent to approach their family caregivers	Thematic analysis
Marriott, 2001 ⁴⁸	England	JP	Opinions about the MHA 1983 ¹ from those subjected to or affected by it	Focus group, telephone interviews, consensus meeting or written responses (date of collection NR)	Total $N = 85^a$ in three groups. Group 1, $n = 40$: mental health nurses, $n = 9$; ASWs, $n = 10$; general psychiatrists, $n = 4$; MHA 1983 ¹ administrators, $n = 5$; service users, $n = 5$; carers, $n = 7$. Group 2, $n = 19$: hospital managers, $n = 2$; 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 3, $n = 26$, consisting of people leading organisations representing groups 1 and 2: including a number of national organisations representing users and carers and professional groups affected by or using the Act	Initial nominations made by national experts or representative organisations. Contacted by telephone or in writing	Thematic analysis

First author, year of publication	Country	Publication type	Study focus	Qualitative data collection method (date of data collection)	Participants providing qualitative data	Study context and sampling	Type of qualitative data analysis
Pinfold, 2004 ⁴⁹	England	R	Identify examples of good practice, or issues with information-sharing between mental health practitioners and carers	Telephone interviews, face-to-face group discussions, multidisciplinary workshop events, open-ended survey questions (date of collection NR)	Survey, <i>N</i> = 998: service users, <i>n</i> = 168; professionals, <i>n</i> = 212; carers, <i>n</i> = 496; carer support workers, <i>n</i> = 93; young carers; <i>n</i> = 29. Interviewed, <i>n</i> = 34: service users, <i>n</i> = 5; professionals working in mental health and ageing, <i>n</i> = 5; professionals working in adult mental health services, <i>n</i> = 9; carers for people with severe mental illness, <i>n</i> = 7; carers supporting people with dementia, <i>n</i> = 5; carer support workers <i>n</i> = 3	National advertising. Convenience, purposive and snowball sampling techniques. Purposive sample recruited via services in mental health charities Rethink Mental Illness and Mind	Thematic analysis of interview data and content analysis of open responses
Rapaport, 1999; ⁵¹ 2002; ³¹ 2003; ⁵² 2004; ⁴ and 2012 ⁵³	England	JANP; D; JP; JP; JP	Investigate conceptual and ethical issues and carers' and service users' perspectives of NR provisions	Focus group interviews, role information, vignettes and group exercises, questionnaires (data collected 1997–9)	Total, <i>N</i> = 79: carers, <i>n</i> = 34; service users, <i>n</i> = 19; ASWs, <i>n</i> = 26	Recruited through local groups. Invited by letter, followed up by telephone and visit. All had to have experience of NR provisions	Comparative content analysis of historical data. Grounded theory and multiple case design analysis of contemporary data
Ridley 2009; ⁵⁶ 2010; ⁵⁵ and 2013 ⁵⁴	Scotland	R; JP; JP	Experiences and views of the early implementation of MHCT	Focus group and telephone interviews (data collected 2007–9)	Total, <i>N</i> = 120: service users, <i>n</i> = 49; carers, <i>n</i> = 33; professionals, <i>n</i> = 38, of which <i>n</i> = 15 representatives of organisations and <i>n</i> = 23 individual practitioners (general practitioners, psychiatrists, community psychiatric nurses, nurses, psychologists, MHOs, lawyers and advocacy workers)	Purposive sampling from four health board areas in Scotland, chosen to reflect rural, urban and mixed geographical areas (Dumfries and Galloway, Fife, Greater Glasgow and Clyde) and the state hospital	Grounded theory

continued

TABLE 2 Description of studies included in framework synthesis (*continued*)

First author, year of publication	Country	Publication type	Study focus	Qualitative data collection method (date of data collection)	Participants providing qualitative data	Study context and sampling	Type of qualitative data analysis
Rugkåsa, 2017; ⁵⁷ and Canvin, 2014 ⁴⁰	England	JP; JP	Experiences of carers and involvement of family in CTOs	Interviews (data collected 2012)	Total, <i>n</i> = 24 family carers	Family carers of service users with experience of CTOs	Thematic analysis
Smith, 2015 ⁵⁸	England	JP	NR's experiences of mental health crises, identifying improvements that could be made to AMHP practice	Telephone interviews (data collected 2014)	Total, <i>n</i> = 32 NRs	NRs in contact with ASWs in the south of England	Inductive thematic analysis
Stroud, 2013; ⁶⁰ and 2015 ⁵⁹	England	R; JP	Service user and practitioner experiences of the use of CTOs	In-depth semistructured interviews (data collected 2011–12)	Total, <i>N</i> = 72: service users, <i>n</i> = 21; NRs, <i>n</i> = 7; care co-ordinators, <i>n</i> = 16; responsible clinicians, <i>n</i> = 10; AMHPs, <i>n</i> = 9; service providers, <i>n</i> = 9	Consulted CTO records from Sussex Partnership NHS Trust, approached by letter of invitation	Thematic analysis

AMHP, approved mental health practitioner; D, dissertation/thesis; JANP, journal article not peer reviewed; JP, journal article peer reviewed; MHO, mental health officer; NR, not reported; R, report.

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

TABLE 3 Description of studies included in the review but not prioritised for framework synthesis

First author, year of publications	Country	Aim or focus of paper (from paper)	Sample	Data collection and analytic approach
Banks, 2016 ³⁴	England	Understand experiences of CTO practice within the context of the personalisation agenda, in particular, aspects of person-centred support	Total, <i>N</i> = 72: service users, <i>n</i> = 21; practitioners (<i>n</i> = 35, of whom, care coordinators, <i>n</i> = 16; responsible clinicians, <i>n</i> = 10; AMHPs, <i>n</i> = 9); NRs, <i>n</i> = 7; service (supported housing) providers, <i>n</i> = 9	Thematic analysis of semistructured interviews
Campbell, 2001; ³⁹ and Manktelow, 2002 ⁴⁷	Northern Ireland	Reports on the first extensive survey of ASW activity in Northern Ireland. The research aimed to explore the training, practice and management of ASWs	Total, <i>N</i> = 282: service users/carers, <i>n</i> = 28; ASW managers, <i>n</i> = 11; ASWs, <i>n</i> = 243 survey respondents	Thematic analysis of semistructured interviews conducted via telephone, face to face or in focus groups. Additional postal survey of ASWs
De Maynard, 2007 ⁴¹	England	Seeks to examine the experiences of black men detained under the MHA 1983 ¹	Total, <i>n</i> = 8: BME men (specifically of African or African Caribbean descent) living with severe mental illness	Grounded theory approach to analysis of qualitative interviews
Department of Health and Social Care, 2015 ⁴²	England	The Department of Health and Social Care 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	Total, <i>N</i> = 468. Responses from individuals, <i>n</i> = 219: service users (48%); carers, family or friends of service users (25%); ³ health and social care professionals, support workers and advocates and others (27%). Responses from various organisations, <i>n</i> = 221; other groups, <i>n</i> = 28	50-item 'agree/disagree' questionnaire, with space for open comments. Content analysis of open responses
Gault, 2009; ⁴³ and Gault, 2013 ⁴⁴	England	Describes people's experience of being compliant or non-compliant with treatment, their experience of compulsory treatment and how they feel that they should be encouraged to comply	Total, <i>N</i> = 19: service users, <i>n</i> = 11; carers, <i>n</i> = 8	Two largely unstructured focus groups 10 or 12 months apart, coded with a grounded theory approach
Mental Health Alliance, 2017 ²⁰	England	The survey focuses on the underlying principles of the MHA 1983 ¹ and how people's rights are currently protected, where it is working well and what could be changed and improved	Total, <i>n</i> = 8631: survey responses from service users, carers and mental health professionals	Questionnaire with opportunity for free-text responses
Rabiee, 2013 ⁵⁰	England	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	Total, <i>N</i> = 65: BME service users, <i>n</i> = 25; carers, <i>n</i> = 24; a range of statutory mental health professionals, <i>n</i> = 16	Grounded theory approach to analysis of telephone interviews, face-to-face interviews and focus groups

continued

TABLE 3 Description of studies included in the review but not prioritised for framework synthesis (*continued*)

First author, year of publications	Country	Aim or focus of paper (from paper)	Sample	Data collection and analytic approach
Taylor, 2013 ⁶¹	England	Sets out the views of AMHPs on the impact of SCT on their work and their service users' lives in the community	Total, <i>n</i> = 14 AMHPs	50-item questionnaire, with opportunity for open comments

BME, black and minority ethnic; SCT, supervised community treatment.
 a Data from respondents who provided demographic information (*n* = 198 individuals).

Telephone and face-to-face interview and focus groups were used in five studies to capture experiences.^{34,39,41,43,50} Survey methods with opportunities for free-text or open responses were used on their own in three studies^{20,42,61} and used in conjunction with interviews by Campbell *et al.*³⁹

The views of service users were captured in seven studies,^{20,34,39,41–44,47,50} including two focusing on the experiences of black and minority ethnic service users.^{41,50} Appointed NR or NPs were specifically sampled only in the study by Banks *et al.*³⁴ Other family members or carers (i.e. not necessarily in any formal statutory role) contributed views in five studies.^{20,39,42,43,50} Mental health professionals, including AMHPs and ASWs, were sampled in six studies.^{20,34,39,42,50,61}

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 because of the rapid review timeline. These consisted of (1) a PhD thesis,⁶² acquired via expert recommendation, about approved mental health practice in England and Wales; (2) a journal article,³⁵ identified through database searches and retrieved via The British Library, about service users' experiences of compulsion under the MHA 1983;¹ and (3) a report by the Social Services Inspectorate,⁶³ part of the Social Care Group in the Department of Health and Social Care (DHSC), 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 thesis⁶² would have been eligible for inclusion in the framework synthesis, based on the quantity of relevant data presented.

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 explicitly considered only in two studies,^{31,32} and for this reason they were the only studies in which it was possible to determine the effect of the authors' ideological or theoretical perspectives on their findings. In terms of the reporting of methods, the context or setting was described well in only 5 out of 12 studies.^{31,32,46,49,56} 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,^{33,45,60} and there was insufficient evidence of rigorous data collection in two studies that described only the use of an interview schedule.^{38,46} Other studies described the use of additional markers of rigorous methods, such as the use of audio-recordings, checking transcripts and supplementary note-taking. Four studies were judged to have lacked evidence of rigorously conducted data analysis.^{38,45,58,60} 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.^{45,48,58}

TABLE 4 Quality appraisal of studies included in framework synthesis

First author, year of publication	Is the research question clear?	Is the theoretical or ideological perspective of the author (or funder) explicit?	Has this perspective influenced the study design, methods or research findings?	Is the study design appropriate to answer the question?	Is the context or setting adequately described?	Is the sample adequate to explore the range of subjects and settings, and has it been drawn from an appropriate population?	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, 2009 ³²	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Campbell, 2008 ³⁸	Yes	No	CT	Yes	No	Yes	Yes	No	No	Yes	Yes	Yes	Yes
Dawson, 2009 ³³	Yes	No	CT	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Henderson, 2002 ⁴⁵	Yes	No	CT	Yes	No	No	No	Yes	No	Yes	Yes	Yes	No
Jankovic, 2011 ⁴⁶	Yes	No	CT	Yes	Yes	CT	Yes	No	Yes	Yes	Yes	Yes	Yes
Marriott, 2001 ⁴⁸	Yes	No	CT	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Pinfold, 2004 ⁴⁹	Yes	No	CT	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Rapaport, 2002 ³¹	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ridley, 2009 ⁵⁶	Yes	No	CT	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Rugkåsa, 2017 ⁵⁷	Yes	No	CT	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Smith, 2015 ⁵⁸	Yes	No	CT	Yes	No	Yes	Yes	Yes	No	Yes	No	No	No
Stroud, 2013 ⁶⁰	Yes	No	CT	Yes	No	Yes	No	Yes	No	Yes	No	Yes	Yes

CT, cannot tell.

Dark-green shading indicates a positive assessment, light-green shading indicates lack of information needed to assess and blue shading indicates a negative assessment.

Framework synthesis

Four themes were identified. These were (1) issues regarding the identification of the NR/NP, (2) confidentiality and information-sharing, (3) enabling the use of the NR/NP role and (4) the importance of maintaining relationships.

The first two of these themes are descriptive in nature and closely reflect our research objectives. Themes 3 and 4 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. When 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*, which also provides an overview of the studies that contributed towards the development of each theme. *Table 5* also highlights which population groups provided data for each theme.

The second-order construct data that contributed towards each theme, along with reviewer interpretation of these data, are discussed within each section and are supported by quotations from the study participants. Each quotation is accompanied by a label to acknowledge the type of participant providing the quotation and, when possible, their relationship to the service user (e.g. carer and mother). When it is clear that the participant is a NR, this has been indicated. When the status of a carer or relative as a NR is unclear, the participant is referred to as a carer. For a breakdown of the quotations and author ideas that contributed to each theme, please contact the corresponding author of this report.

TABLE 5 Map of studies contributing different stakeholder views pertaining to the five research objectives

Participant group	Themes (research objectives) ^a			
	Identification of NR/NP (1 and 2)	Confidentiality and information-sharing (3)	Enabling use of the NR/NP role (4 and 5)	Importance of maintaining relationships (4 and 5)
Service users	Berzins (2009) ³² [2005–7] [20]			
	Henderson (2002) ⁴⁵ [2001] [11]	Henderson (2002) ⁴⁵ [2001] [11]	Dawson (2009) ³³ [2007–8] [2]	Campbell (2008) ³⁸ [NS] [NS]
	Rapaport (2002) ³¹ [1997–9] [19]	Pinfold (2004) ⁴⁹ [NS] [5]	Rapaport (2002) ³¹ [1997–9] [19]	Dawson (2009) ³³ [2007–8] [2]
	Ridley (2009) ⁵⁶ [2007–8] [49]	Rapaport (2002) ³¹ [1997–9] [19]	Ridley (2009) ⁵⁶ [2007–8] [49]	Henderson (2002) ⁴⁵ [2001] [11]
	Stroud (2013) ⁶⁰ [2011–12] [21]	Ridley (2009) ⁵⁶ [2007–8] [49]		Rapaport (2002) ³¹ [1997–9] [19] Ridley (2009) ⁵⁶ [2007–8] [49] Stroud (2013) ⁶⁰ [2011–12] [21]

TABLE 5 Map of studies contributing different stakeholder views pertaining to the five research objectives (continued)

Participant group	Themes (research objectives) ^a			
	Identification of NR/NP (1 and 2)	Confidentiality and information-sharing (3)	Enabling use of the NR/NP role (4 and 5)	Importance of maintaining relationships (4 and 5)
NRs	Rapaport (2002) ³¹ [1997–9] [NS]	Rapaport (2002) ³¹ [1997–9] [NS]	Henderson (2002) ⁴⁵ [2001] [NS]	Rapaport (2002) ³¹ [1997–9] [NS]
	Smith (2015) ⁵⁸ [2014] [32]	Smith (2015) ⁵⁸ [2014] [32]	Rapaport (2002) ³¹ [1997–9] [NS]	Smith (2015) ⁵⁸ [2014] [32]
		Stroud (2013) ⁶⁰ [2011–12] [7]	Smith (2015) ⁵⁸ [2014] [32]	Stroud (2013) ⁶⁰ [2011–12] [7]
		Stroud (2013) ⁶⁰ [2011–12] [7]		
NPs	Berzins (2005–7; 2009) ³² [3]	Berzins (2009) ³² [2005–7] [7]	Berzins (2005–7; 2009) ³² [3]	Berzins (2009) ³² [2005–7] [3]
	Campbell (2008) ³⁸ [NS] [NS]	Dawson (2009) ³³ [2007–8] [4]	Dawson (2009) ³³ [2007–8] [4]	Campbell (2008) ³⁸ [NS] [NS]
	Dawson (2009) ³³ [2007–8] [4]	Ridley (2009) ⁵⁶ [2007–8] [NS]	Campbell (2008) ³⁸ [NS] [NS]	Dawson (2009) ³³ [2007–8] [4]
			Ridley (2009) ⁵⁶ [2007–8] [NS]	Ridley (2009) ⁵⁶ [2007–8] [NS]
Carers other than statutory NPs or NRs	Berzins (2009) ³² [2005–7] [7]	Berzins (2009) ³² [2005–7] [7]	Berzins (2009) ³² [2005–7] [7]	Berzins (2009) ³² [2005–7] [7]
	Henderson (2002) ⁴⁵ [2001] [11]	Jankovic (2011) ⁴⁶ [NS] [31]	Campbell (2008) ³⁸ [NS] [NS]	Henderson (2002) ⁴⁵ [2001] [11]
	Rapaport (2002) ³¹ [1997–9] [34]	Pinfold (2004) ⁴⁹ [12]	Pinfold (2004) ⁴⁹ [NS] [12]	Jankovic (2011) ⁴⁶ [NS] [31]
		Rapaport (2002) ³¹ [1997–9] [34]	Rapaport (2002) ³¹ [1997–9] [34]	Pinfold (2004) ⁴⁹ [NS] [12]
		Ridley (2009) ⁵⁶ [2007–8] [33]	Ridley (2009) ⁵⁶ [2007–8] [33]	Rapaport (2002) ³¹ [1997–9] [34]
		Rugkåsa (2017) ⁵⁷ [2012] [24]	Rugkåsa (2017) ⁵⁷ [2012] [24]	Ridley (2009) ⁵⁶ [2007–8] [33]
		Rugkåsa (2017) ⁵⁷ [2012] [24]		
AMHPs, ASWs and MHOs	Berzins (2009) ³² [7]	Berzins (2009) ³² [7]	Berzins (2009) ³² [7]	Berzins (2009) ³² [7]
	Dawson (2009) ³³ [2007–8] [14]	Pinfold (2004) ⁴⁹ [NS] [NS]	Rapaport (2002) ³¹ [1997–9] [26]	Dawson (2009) ³³ [2007–8] [14]
	Rapaport (2002) ³¹ [1997–9] [26]	Rapaport (2002) ³¹ [1997–9] [26]	Rapaport (2002) ³¹ [1997–9] [26]	Rapaport (2002) ³¹ [1997–9] [26]
Ridley (2009) ⁵⁶ [2007–8] [NS]				
Legal professionals	Dawson (2009) ³³ [2007–8] [solicitor, 3]	Dawson (2009) ³³ [2007–8] [solicitor, 3]	Campbell (2008) ³⁸ [lawyers, NS]	Dawson (2009) ³³ [2007–8] [solicitor, 3]
		Dawson (2009) ³³ [2007–8] [solicitor, 3]		

continued

TABLE 5 Map of studies contributing different stakeholder views pertaining to the five research objectives (*continued*)

Participant group	Themes (research objectives) ^a			
	Identification of NR/NP (1 and 2)	Confidentiality and information-sharing (3)	Enabling use of the NR/NP role (4 and 5)	Importance of maintaining relationships (4 and 5)
Tribunal members	Dawson (2009) ³³ [2007–8] [tribunal member, 15]	Dawson (2009) ³³ [2007–8] [tribunal member, 15]	Campbell (2008) ³⁸ [NS] [1] Dawson (2009) ³³ [2007–8] [tribunal member, 15]	Campbell (2008) ³⁸ [NS] [1]
Health professionals (e.g. general practitioners, nurses)	Stroud (2013) ⁶⁰ [2011–12] [responsible clinician, 10]	Pinfold (2004) ⁴⁹ [NS] [psychiatrist, NS, GP, NS]	Dawson (2009) ³³ [2007–8] [5]	Ridley (2009) ⁵⁶ [2007–8] [psychiatrist]
Mental health advocates				Dawson (2009) ³³ [2007–8] [5]
Other	Berzins (2009) ³² [policy influencer, 9] Marriott (2001) ⁴⁸ [NS] [mix, NS]	Berzins (2009) ³² [policy influencer, 9] Campbell (2008) ³⁸ [NS] [author views]	Berzins (2009) ³⁷ [policy influencer, 9] Campbell (2008) ³⁸ [NS] [NS] Marriott (2001) ⁴⁸ [NS] [mix, NS]	Berzins (2009) ³⁷ [policy influencer, 9] Marriott (2001) ⁴⁸ [NS] [mix, NS]

NS, not stated.

^a First author of study (publication date) [year(s) of data collection] [type of respondent when available, *n* interviewed]. Black text = studies conducted with regard to the MHA 1983¹ (England and Wales); blue = studies conducted with regard to MHCT; green = study conducted with regard to Mental Health (Northern Ireland) Order.

Theme 1: issues with the identification of the Nearest Relative/Named Person

Four subthemes were identified. Subtheme 1.1, ‘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 1.2, ‘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 1.3, ‘displacement’ details service users’ experiences of changing their NR/NP. Subtheme 1.4, ‘service user isolation’, discusses how both the NR provision in England and the NP provision 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 with the NP provision in Scotland.

Vulnerability to abuse

Authors of five studies^{31–33,45,49} 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 studies^{31,45,49} were conducted before the 2007 amendment of the Act that allowed service users to displace people they did not want to act as their NR. Rapaport³¹ provided several examples that 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 antitherapeutic 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.³¹ Reproduced with permission from Dr Joan Rapaport, Anglia Ruskin University, 2018, personal communication

Pinfold *et al.*⁴⁹ 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. They suggest an approach to appropriate and timely information-sharing based upon a series of decisions balancing the needs of carers and service users. 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.³¹ Other issues that may influence information-sharing between service users, carers and professionals are discussed within *Theme 2: confidentiality and information-sharing*.

Berzins³² acknowledges that the NP provision in Scotland permits the service user to choose a person they feel is best suited to the role, whether that is a friend who they feel is familiar with their wishes or a close relative whom 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 that 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 user³² (p. 162). Reproduced with permission from Dr Kathryn Berzins, University of Glasgow, 2018, personal communication

Here the service user highlights how they would choose someone to support them who was already familiar with their personal information, whom they knew they could trust. However, the NP provision does not prevent the service user from appointing a person whom other people may view as unsuitable to the role, and this may leave them vulnerable to abuse or manipulation. This was illustrated by Dawson *et al.*,³³ who provided an example of a service user appointing their drug dealer as their NP.

When a NP has not been appointed, the system defaults 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 as they may not be well enough³³ or have the time available³² to choose one immediately following an emergency admission. There are a number of additional issues influencing whether or not people identify their NP in advance of them being needed, as well as the potential implications of their choice for the relationship between service users and their carers. These are discussed further in *Theme 4: 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 a NP when none has been nominated in advance. The pressures associated with caring for someone prior to an involuntary admission (as discussed within *Theme 4: importance of maintaining relationships*) may affect the ability of the carer to act in accordance with the best interests of the service user within their role as the NR/NP. Author views from three studies^{31,49,60} highlight how the carer's own needs may affect their decision-making in relation to the NR role. Pinfold *et al.*⁴⁹ indicate

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:

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 clinician⁶⁰ (p. 48). Reproduced with permission from Dr Julia Stroud, University of Brighton, 2018, personal communication

Amendments to the MHA 1983¹ in 2007 mean that family members 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.¹⁴ In Scotland, revisions to the MHCT¹¹ 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.⁶⁴ 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 1983^{1,14} represent a partial response to this issue, by allowing service users and/or the professionals involved in their care to apply to the County Court to displace their allocated NR on grounds of unsuitability. The issues surrounding the process of the displacement of the NR are discussed in *Subtheme 1.3: 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 with those who support them.

Author views from three studies conducted in England suggest that service users,³¹ their carers^{48,58} and the professionals³¹ involved with supporting them during involuntary admissions did not find the predetermined hierarchy a convenient or useful method of identifying the most appropriate NR. One service user gave her views on how the NR provision distinguishes between the rights of full and half 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.³¹ Reproduced with permission from Dr Joan Rapaport, Anglia Ruskin University, 2018, personal communication

The above quotation 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 quotation 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.³¹ Reproduced with permission from Dr Joan Rapaport, Anglia Ruskin University, 2018, personal communication

The above quotation illustrates how the concept of NR may not always equate to the person who is usually involved with the service user's care.⁵⁸ 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.^{49,58} One woman expresses her frustration with the way information-sharing was restricted to her alone:

After the assessment another social worker contacted us for an update but would not speak with my husband because I am legally the Nearest Relative, it was upsetting at such a difficult time.

NR⁵⁸

Restricting information-sharing to only one carer/NR has important implications for the level of expectation and responsibility placed on carers by professionals. This may have an impact on the support they feel able to offer the service user and undermine their relationship with professionals, as discussed further in *Theme 2: confidentiality and information-sharing* and *Theme 4: importance of maintaining relationships*.

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 (1) their primary or sole carer/usual support, (2) the person the service user would trust to act in their best interests and (3) the person whom they would trust with personal or sensitive information about them.

Subtheme 1.3: displacement

The 2007 amendments to the MHA 1983^{1,14} 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 whom they feel would be more appropriate. Issues discussed within this subtheme include how the displacement process can be exploited by both NRs and professionals and how the displacement process in Scotland can provide service users with an opportunity for choice and autonomy over the care that they receive. Four studies contributed towards the development of this subtheme.^{31,32,56,57}

Of the studies relevant to the NR provision in England, only Rapaport³¹ contributed significantly to this subtheme. This paper was published prior to the 2007 amendments of the MHA 1983,^{1,14} which means that at this time service users 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.

ASW.³¹ Reproduced with permission from Dr Joan Rapaport, Anglia Ruskin University, 2018, personal communication

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 1983,^{1,14} 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.¹¹ This seems to be viewed positively by service users:

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 user³² (p. 130). Reproduced with permission from Dr Kathryn Berzins, University of Glasgow, 2018, personal communication

This quotation illustrates how the process for displacing a NP in Scotland can avoid the involvement both of someone the service user does not have a good relationship with, or who they feel would not support them in a way that 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:

... 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 influencer³² (p. 120). Reproduced with permission from Dr Kathryn Berzins, University of Glasgow, 2018, personal communication

This quotation acknowledges that under some circumstances (e.g. an emergency admission), a service user may need to be allocated a NP 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 *et al.*⁵⁶ reflect that by the time participants in their study were interviewed for a second time 1 year later almost one-quarter of the service users had changed their NP. Among 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.⁵⁶ 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.

Author^{31–33,56,60} and participant^{31–33,56} views from five studies indicated that the NR provision of the MHA 1983¹ did not account for the fact that some service users may not have a person to act as their NR. Issues with this situation may arise because of family estrangement⁶⁰ and relatives living outside the country.³¹ A quotation 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.³¹ Reproduced with permission from Dr Joan Rapaport, Anglia Ruskin University, 2018, personal communication

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 MHCT, some service users^{32,56} and professionals^{6,32,33} disliked the necessity of a service user having to identify a NP. This is illustrated by two quotations, one from a service user and one from the perspective of a person involved in influencing government, or 'policy influencer',³² 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 user³² (p. 157). Reproduced with permission from Dr Kathryn Berzins, University of Glasgow, 2018, personal communication

... Because otherwise it just gets very silly and stops being about the person's best interests and starts being about obeying the letter of the law ... and at the end of the day is that going to help the individual?

Policy influencer³² (p. 135). Reproduced with permission from Dr Kathryn Berzins, University of Glasgow, 2018, personal communication

In 2015, amendments were made to the MHCT that meant that service users would no longer have to nominate a NP and that one would no longer be allocated to them by default.⁶⁴ These changes started to be phased in during June 2017 and, although 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 Scotland¹¹ 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:

- It is beneficial to be able to allocate a friend or carer of a service user's choice, and to easily displace a default nomination.
- The choice to opt for no NP or NR was considered favourably. Amendments to the MHCT⁶⁴ 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 1983¹ to provide carers with the support they need while also 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 1983¹ and MHCT,¹¹ both the NR and the 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 *Theme 1: issues regarding the identification of Nearest Relatives/Named Persons*).

Six studies^{31–33,45,49,56} highlighted how much service users valued being able to choose who received information about them and the health care that they were receiving. Mental health service users interviewed as part of an English nationwide study⁴⁹ and service users with experience of involuntary inpatient admission³¹ 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,⁴⁹ factors that 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 with bipolar disorder who had experienced

involuntary admission under the MHA 1983¹ 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 user⁴⁵

The above quotation 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,¹¹ 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.³³ This clearly has the 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 in *Subtheme 1.1: service user vulnerability*. As one service user points out, once information is shared, there 'is no going back'.⁴⁹ The perceived impact of confidentiality on the relationship between carers/NRs and professionals is discussed in *Theme 4: importance of maintaining relationships*.

Five studies highlighted that carers also had a need for confidentiality.^{31,46,56,57} Carers stated that they would value having time alone with a professional in which they could talk about any concerns, without the worry that the person they support would feel criticised or undermined.^{46,57,58} 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'.

Carer⁴⁶

Carers appreciated being able to talk confidentially with professionals about the service user they were supporting.^{46,57,58} 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 be^{4,31} and the implications of providing information within a tribunal setting that disagreed with a service user's wishes on their relationship with their friend or relative.^{32,57} This is discussed further within *Theme 4: importance of maintaining relationships*.

Five studies discussed the importance of professionals sharing information with their carers.^{31,46,49,56,57} 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 person^{31,46,49} or if the service user's behaviour may put themselves as a carer at risk.⁴⁶ In the study conducted before the 2007 review of the MHA 1983,¹ Rapaport³¹ highlights that information-sharing between professionals and carers/NRs did not always take place because of concerns about confidentiality. In a later study evaluating the implementation of the MHCT in Scotland,⁵⁶ 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 . . . 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/NP⁵⁶

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

Although some carers wanted to receive more information in certain circumstances, data from five studies^{31–33,56,60} indicate that it was possible for carers and NRs/NPs to feel overwhelmed by too much information, especially when it was in a format they found inaccessible^{31,60} or contained distressing personal information pertaining to the service users that they may not wish to know about.^{32,33} Relatives also acknowledged that at times of distress they may not be able to take on board information that was offered to them.⁵⁸

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 quotation from a carer:

... 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.

Carer.³¹ Reproduced with permission from Dr Joan Rapaport, Anglia Ruskin University, 2018, personal communication

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 users³² and carers⁴⁹ and training for professionals⁵⁶ has been proposed to ensure that all parties understand the rights of carers to receive certain information, which may facilitate the information-sharing process. Although the MHA 1983¹ Code of Practice dictates that informal patients should have their legal positions and rights explained to them,² this may not be consistently applied and may be impractical in certain situations. In addition, the complexity of the NR provisions may not be retained by service users, carers or professionals, particularly in distressing circumstances.

Three studies provide examples of the professionals who support individuals involuntarily detained in hospital or on CTOs working flexibly to allow carers to discuss their concerns freely, but also ensuring that the privacy of service users is protected.^{32,46,57} Some professionals deliberately tempered information they knew would be copied to a NP/NR^{32,33} or provided carers with a confidential space to share concerns.⁵⁷ 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:

... 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 agreeing not to say 'hello [patient], your mother rang me, I hear you're not too well'.

Carer⁵⁷

Pinfold *et al.*⁴⁹ and Henderson⁴⁵ 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. Although historical abuse is an important issue to consider, there are also other factors that may influence the quality of this relationship and thus the decision to share sensitive information with a NR/NP. These are discussed in more detail within *Theme 3: enabling use of the Nearest Relative/Named Person role* and *Theme 4: Maintaining relationships*.

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, whereas other individuals, who may in reality be the main carer or the closest family member, are not. As discussed in *Theme 1: issues with the identification of the Nearest Relative*, there is the potential through the default

identification of the NR to lead to information being shared with a recipient who is undesirable 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 a 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 did not 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 Nearest Relative/Named Person role

This theme encompasses three subthemes: (3.1) being heard, (3.2) need for information and (3.3) proactive support and engagement. The theme relates to the research objective of exploring 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 that 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 that 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 1983.¹ 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 1983¹ as something that empowers them to ask for information and challenge the views of the professionals regarding the care that they provide. NRs also perceive their opinions to carry more weight with professionals than those of a regular carer.

Five studies^{31,32,45,56,60} highlighted several ways in which the NR/NP provisions enhanced carers' involvement in planning the care of service users. First, authors of three studies^{31,32,56} 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 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 . . .

NP⁵⁶

Participants from three studies^{31,45,60} 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 carer⁴⁵

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.³¹ Reproduced with permission from Dr Joan Rapaport, Anglia Ruskin University, 2018, personal communication

This quotation suggests that the legislation outlined by the NR provision of the MHA 1983¹ 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 make use of the opportunity to discuss, endorse or object that the NR/NP is intended to provide them with. Berzins³⁷ suggested that the class, race and gender of people nominated as NPs may influence their ability to carry out their role. One mental health officer (MHO) illustrates this by talking about the development of a DVD (digital versatile disc), presumably to support individuals detained under the MHCT 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.

MHO³² (p. 143). Reproduced with permission from Dr Kathryn Berzins, University of Glasgow, 2018, personal communication

The above quotation suggests that the class and/or education level of service users and their carers may affect their ability to first understand the information that is given to them and then make use of this information in order 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 sections of the MHA 1983¹ as well as more specific information regarding the NR/NP role. Authors of three studies^{32,56,57} indicated the need for service users and carers to be more informed about the MHA 1983¹ in both England and Wales or the MHCT¹¹ in Scotland. The quotation 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 carer⁵⁷

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 Stroud *et al.*,⁶⁰ 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 1983,¹ and the different levels of care they define, the authors of five studies^{31–33,38,56} highlight that service users and/or carers needed more information about the role of the NR/NP:

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.³¹ Reproduced with permission from Dr Joan Rapaport, Anglia Ruskin University, 2018, personal communication

The above two quotations suggest that service users and carers need a working knowledge of the parts of the MHA 1983¹ 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^{32,33} 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,^{31,33,38,56,60} although NRs/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:

... 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 influencer³² (p. 119). Reproduced with permission from Dr Kathryn Berzins, University of Glasgow, 2018, personal communication

This relates to information presented within *Theme 2: confidentiality and information-sharing*, which cautions against overburdening carers and NRs/NPs with information about the care the service user is receiving.

Finally, authors of two studies^{48,56} 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 that 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, friend⁵⁵

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 the NR/NP of their rights and involving them, when 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 that 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 studies^{31,32,49} 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), Pinfold *et al.*⁴⁹ reflect on the important role professionals have in providing emotional support and comfort to carers during times of distress, although the demands placed on

professionals' time may not always allow for this.³¹ Carers also welcomed practical support, such as guidance with filling in forms and referral to services for their own needs.⁴⁹

Authors of two studies in Scotland^{32,33} 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 MHOs play an important role in advertising the NP role in Scotland:

... 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 member³³ (p. 53). © Crown copyright 2009. Contains public sector information licensed under the Open Government Licence v3.0

Although 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.³² One MHO reflects on the potential impact of any reluctance from professionals to support the process of a 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.

MHO³² (p. 147). Reproduced with permission from Dr Kathryn Berzins, University of Glasgow, 2018, personal communication

Although this quotation illustrates the perception that a proactive approach used by professionals may encourage people to nominate a NP, it conflicts with information presented in *Theme 4: 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 a NP with a service user. We would suggest that factors that 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 NPs may require additional support during the tribunal process to enable them to fulfil their role, including the provision of accessible information,^{38,56} as indicated within *Subtheme 3.2: need for information*, and explicit encouragement to share their views.^{33,56} Two studies noted that the scheduling of tribunals during the working day could sometimes exclude carers from taking part (Dawson *et al.*,³³ Ridley *et al.*⁵⁶). One NP stated:

It'll go ahead regardless of whether me as Named Person can go.

NP⁵⁶

We suggest that the above statement indicates that the lack of flexibility in scheduling tribunals according to NPs could lead to the views of carers and NRs/NPs being overlooked within the tribunal process and contribute to NRs/NPs feeling unheard and undervalued, as discussed within *Subtheme 4.3: carer/professional relationships*. This highlights the need for organisers of the tribunal process to be proactive in ensuring that family members, carers and NRs/NPs are supported to attend when appropriate.

Summary

This 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 them.
- Carers reflected that being recognised as a NR or NP enabled them to offer better support to the service user throughout the processes of detention/treatment under the MHA 1983¹ 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: (4.1) service user/carer relationships, (4.2) service user/professional relationships and (4.3) carer/professional relationships. This theme explores the issues that 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: confidentiality and information-sharing*, and also empower service users and carers and thus act as a protective factor against abuse and carer burnout. 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 that may affect the relationship between service users and their carers and NRs/NPs. The issues include the impact on the carer of the responsibility of taking on the NR/NP role, the ability of the 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 author and participant views included within this review.^{31,45,46,56,57} The additional responsibility associated with the NR/NP role can contribute towards the stress of responsibility experienced by carers. Authors from five studies^{31–33,38,56} indicate that carers and NRs/NPs can feel daunted by the responsibility of their role. This is illustrated by a MHO discussing how some carers experience the process of contributing within a tribunal:

People generally appreciate that sense of, kind of empowerment [. . .]. 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.

MHO³³ (p. 47)

One service user discussed how they would use the flexibility associated with the NP provision in Scotland (MHCT) 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 user³² (p. 138). Reproduced with permission from Dr Kathryn Berzins, University of Glasgow, 2018, personal communication

Under the NR provisions of the MHA 1983,¹ the service user cannot choose who is involved in decision-making. This means that service users may feel that 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^{32,33,56} 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 relationship⁵⁶ and trusted that they would be more aware and supportive of their wishes when it came to being offered certain treatments.³² 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.⁵⁶

Authors of two studies highlighted concerns that both service users and NPs did not fully understand the level of information that would be shared with the NP.^{33,37} We suggest that this has the potential to place strain on the service user's relationship with their NP. The need for adequate information about the NR/NP role is discussed further in *Theme 2: enabling use of the Nearest Relative/Named Person role*. Participant and author views from seven studies^{31,33,37,45,46,56,57} indicate that another factor that may affect the quality of the service user–NR relationship was when the NR felt that they needed to express views that conflicted with the service user's, during a tribunal,^{32,33,57} prior to admission^{45,46} or while on a CTO.⁵⁷ This is illustrated by the observation of two people involved with influencing government policy:

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 influencer³² (p. 154). Reproduced with permission from Dr Kathryn Berzins, University of Glasgow, 2018, personal communication

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 influencer³² (p. 159). Reproduced with permission from Dr Kathryn Berzins, University of Glasgow, 2018, personal communication

Subtheme 4.2: service user/professional relationships

This subtheme discusses how the disclosure of information to NRs against the service user's wishes can challenge their relationship with the ASWs, psychiatrists and other service staff who support them. Other issues that may affect the service user's relationship with services, such as the identification of a NP and preparation of an advance statement ('... a document "completed by a service user when they are well and judged to be able to make decisions for themselves"'). The documents state how the service user would like to be treated in the future if they later did not have the capacity to decide this for themselves⁶⁵) are also explored.

Along with some of the information presented earlier within *Theme 2: 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.^{31,49} 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 user⁴⁹ (p. 110). © NCCSDO. Reproduced with permission

This contrasts with the view of a psychiatrist interviewed in the same study:

... 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'.

Psychiatrist⁴⁹ (p. 115). © NCCSDO. Reproduced with permission

This conflict between the desire of the service user to retain their autonomy and the professional obligation of those 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,³² 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 think they're not always the best person to make a judgement about your situation.

Service user³² (p. 163). Reproduced with permission from Dr Kathryn Berzins, University of Glasgow, 2018, personal communication

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.^{31,32} Author views from two studies also indicate that there may be issues around staff knowledge on how to implement or access advance statements.^{49,56} This is discussed further in *Theme 1: enabling use of the Nearest Relative/Named Person role*.

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 that carers feel listened to, valued and involved in the care of the service users.

Four studies^{33,45,46,57} present the views of participants and authors that indicate that carers and NRs/NPs 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.

NR⁶⁰ (p. 57). Reproduced with permission from Dr Julia Stroud, University of Brighton, 2018, personal communication

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 carer⁴⁶

[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 carer⁵⁷

Author views from four studies^{31,45,48,56} 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 carer⁴⁵

Author and participant views from five studies^{31,49,56–58} indicate that carers may experience the need to protect service users' right to privacy as a barrier to their own working relationship with professionals. Although carers perceived that information may not be passed on to them because of the automatic assumption by professionals that service users would not want their information to be shared,⁵⁸ some carers perceived that confidentiality was used by professionals to deliberately exclude them from discussions about a service user's care.^{49,57} One ASW discusses how the potential for conflict between the views of the 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 . . . I wonder sometimes whether we fully inform Nearest Relatives about their, about their powers, given the kind of practical conflict.

ASW.³¹ Reproduced with permission from Dr Joan Rapaport, Anglia Ruskin University, 2018, personal communication

The perceived power imbalance between carers and professionals was also discussed in relation to carers' experiences of taking part in tribunals in Scotland.^{32,33,56} In addition to the intimidating tribunal setting,^{32,56} carers noted that, although 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.^{32,33,56} One solicitor observed:

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.

Solicitor³³ (p. 44)

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.^{31,57} However, the same studies provide examples of where, when a mutually respectful and open relationship is cultivated between carers/NRs and professionals, they can work together to have a meaningful impact on the care that service users receive.^{31,57,60} Some examples of the benefits of carers/NRs and professionals working together include preventing the inappropriate recall from a CTO of a service user back to hospital⁵⁷ and the delivery of a person-centred care package to prevent an involuntary hospital admission.³¹

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, opportunities for professionals to listen to the views of carers and NRs, either through creating opportunities to meet with them privately (as discussed within *Theme 2: confidentiality and information-sharing*) or through the tribunal system, may help create a mutually respectful working relationship.

Summary

This theme is concerned with the relationships between professionals, carers (NRs 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, whereas 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 in which vital relationships can become strained. The following issues emerged:

- The role of NR confers a lot of responsibility and, in some cases in which 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 when professionals worked closely with carers to optimise care outcomes.

The different factors that may support the development of a constructive working relationship between service users, carers and professionals are discussed in *Theme 1: enabling use of the Nearest Relative/ Named Person 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*.

Although not directly relating to the NR provision of the MHA 1983,¹ 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. First, the tension between maintaining service user confidentiality and the need to share certain information with the carers/NRs who support them, as discussed in *Theme 2: 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 in which the relationship between the service user and their carer/NR is strained. Alternatively, in situations in which 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 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 fulfil the role of NR. Finally, 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.

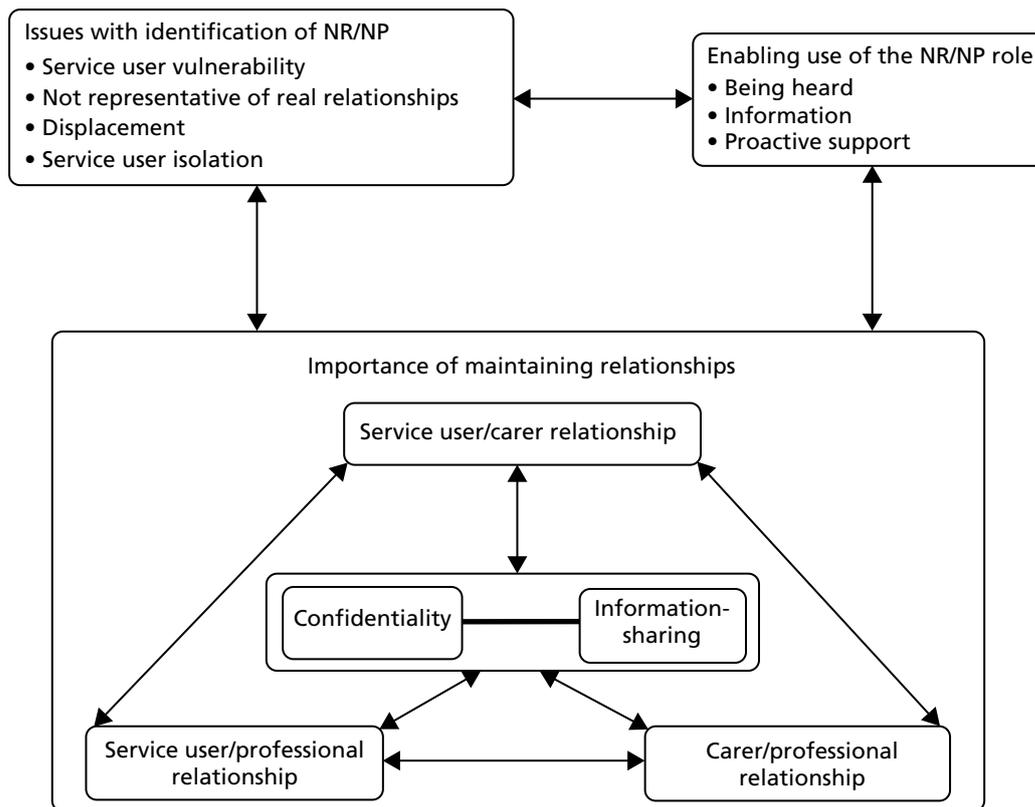


FIGURE 3 Proposed relationship between the four themes identified by the framework synthesis.

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 *Theme 3: issues regarding the identification of the Nearest Relative*. 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 NRs to feel more confident within their role, as described within *Theme 1: enabling use of the Nearest Relative/Named Person role*. NRs and NPs who feel more able to fulfil their role in supporting the service user may have a positive influence on the relationships described within *Theme 4: 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 *Theme 3: issues regarding the identification of the Nearest Relative* and reduce the desire of service users to displace their NR/NP. Finally, the right of service users to displace their NR/NP 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'.

Chapter 4 Discussion

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 NR provisions in the compulsory detention and ongoing care of people under the MHA 1983?¹

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 1983.¹
- 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 patient confidentiality and information-sharing, relating to all aspects of compulsory detention.
- Explore issues relating to decisions about care during detention and after discharge, including to a CTO.
- Explore issues relating 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^{4,20,31–34,36–61} reporting on 20 studies, before prioritising 12 studies from 22 sources^{4,31–33,36–38,40,45,46,48,49,51–60} that 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 1983,¹ England, Wales and Northern Ireland) and the NP provisions (MHCT, Scotland). Some of the studies conducted in England reflected experiences of the NR provisions from before the 2007 amendments to the MHA 1983.¹ Only one study was identified from Northern Ireland³⁸ and none was conducted in Wales, so our findings generally reflect the experience of legislation as it applies in England and 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: (1) issues with identification of the NR, (2) confidentiality and information-sharing, (3) enabling the use of the NR/NP role and (4) 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 1983,¹ including situations in which 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.⁶⁴ Although we found no evidence pertaining to experiences of the option to forgo having a NP, the MHCT legislation was discussed in three sources.^{32,33,56} 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 is the relative ease with which service users can 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 1983,¹ service users can apply to County Courts to have their NR displaced on grounds that they were an inappropriate choice.¹⁴ 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 1998.³¹ 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 the displacement of a NR since the MHA 1983¹ amendments in 2007,¹⁴ 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 when 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 be 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 that a certain level of information must be shared in order for NRs/NPs to fulfil their roles as carers. NRs/NPs also felt wary of sharing information about the service user with professionals, for fear of that information being disclosed to the service user. Failure to adequately inform service users and carers about the powers and potential benefits of the NR role, as well as evidence of poor understanding by some professionals, may hinder its application.

In general, issues about confidentiality and information-sharing were seen as complex, and there was confusion about the rights of carers and NRs/NPs to be given certain information. This sentiment was echoed in theme 3, 'enabling the use of the NR/NP role', in which 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 it 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 carer 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 when professionals were perceived as difficult to communicate with, and did not 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 *Theme 4: importance of maintaining relationships* again emphasised that the role of NR or NP confers a heavy responsibility, particularly when 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 use of the Nearest Relative/Named Person role, in which some carers appreciated the status of NR/NP. They felt that 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.

Limitations of the 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 UK. After initially determining included studies, we prioritised and synthesised those studies that offered the most abundant and the most relevant primary data. We identified 12 such studies; however, when developing the framework, only six or seven contributed significantly (see *Table 5*).^{31–33,45,46,56,57} Although experiences of the use of NP provisions in Scotland were represented by only three studies, these were arguably the richest, coming from a PhD thesis³² and two government reports commissioned to examine the implementation of the MHCT.^{33,56} Lengthier reports inevitably have scope to include richer accounts of interview participants, for example, than journal articles. Service users', carers', NPs' 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 1983¹ in England and Wales. Although the 2015 amendments to the MHCT allow the service user to opt to not 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 1983¹ in England and Wales came from eight studies;^{31,45,46,48,49,57,58,60} however, only four^{46,57,58,60} collected data after the implementation of the 2007 MHA 1983¹ amendments.¹⁴ These amendments were notable in that they introduced the option to withhold information from the NR or to displace the NR through application to County Courts, and gave civil partners equal status to married partners in the hierarchy of relatives. Those four studies represented the views of 55 family caregivers,^{46,57} 21 service users and 19 mental health professionals.⁶⁰ Thirty-two NRs were interviewed by Smith,⁵⁸ but few rich and relevant data from this study featured in our synthesis (see *Table 5*), and seven NRs were interviewed by Stroud *et al.*⁶⁰ Perspectives on current aspects (since 2007) of the NR provisions of the MHA 1983¹ 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 practices. The data pertaining to the MHA 1983¹ in England and Wales prior to the 2007 amendments¹⁴ were mainly from three studies offering rich data that featured heavily in the synthesis.^{31,45,49} These studies represented the views of 57 carers, 34 service users and 43 mental health professionals through the analysis of interview data (Pinfold *et al.*⁴⁹ 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, although 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 1983¹ and MHCT, the samples drawn on were predominantly from England and Scotland, and most evidence predated the 2007 MHA amendments;¹⁴ therefore, they may not be completely representative of the wider population experiencing or providing such care in the UK in 2018. Nevertheless, although 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 1983¹ in Northern Ireland were investigated in just one study³⁸ included in the synthesis. The evidence from Scotland focused on experiences of implementation of the MHCT, without direct comparison with 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 1983¹ was amended in 2007.¹⁴ At best, the evidence can be considered indicative of issues with the MHA 1983¹ and MHCT¹¹ 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 time frame (6 weeks) and the following limitations resulting directly from this approach should be acknowledged:

- A pragmatic decision was made to prioritise studies that 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 (1–2 weeks) did not lend itself to the preferred method of synthesis, which would have used an iterative, inductive approach. For this reason, the findings of this review are largely descriptive in nature, and are not able to reflect on 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 undertaken only on those studies prioritised for inclusion in the synthesis. With more time, all eligible studies would have been searched.
- Critical appraisal was undertaken 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.²² The findings of our synthesis should be considered in the light of these restrictions, and the stated limitations of the evidence base.

Chapter 5 Conclusions

This rapid review synthesised qualitative evidence regarding experiences of service users, carers and other stakeholders regarding the NR provisions of the MHA 1983¹ in England and the NP provisions of the MHCT in Scotland. A number of common themes were identified across a small number of included studies. Given the paucity of evidence available, the outcomes that 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 1983¹ is important and can carry a heavy responsibility. It is important that the most suitable person is identified for the role, whenever 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
 - confirming that the potential NR is both willing and able to support the service user within the NR role
 - ensuring that the potential NR is aware of the service user's wishes regarding future treatment and is willing to act on them when appropriate
 - ensuring that the potential NR has an adequate understanding of both the parts of the MHA 1983¹ relevant to the circumstances of the service user and their role as the NR
 - confirming 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.
- 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.
- When possible, a flexible and positive approach to communication between professionals involved with care, service users and NRs/NPs may help to achieve agreed suitable levels of information-sharing.
- Although 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 and much of it was over 10 years old and comprised samples of individuals from a limited range of localities and services. Studies also suffered from a lack of evidence of rigour when collecting or analysing qualitative data. Despite the general consistency of experiences that 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.

For this reason, the main implications of this review are that the topic of the NR provisions of the MHA 1983¹ is complex, of significant importance to individuals detained under the MHA 1983¹ 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 1983¹ in England and Wales. There is no population group that 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 1983.¹ Although all areas and topics related to the NR provisions of the MHA 1983¹ warrant further investigation, some of the specific directions for primary research include:

- Examination of experiences of the NR/NP in the 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, although the studies based in Scotland were of good quality, they were few in number and all commissioned by the 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 2007.¹⁴
- 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.
- A dearth of evidence was uncovered 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 1983.¹ However, reporting of methodological considerations could be improved.

Acknowledgements

We are grateful for insightful feedback on the draft report from an individual with experience of the NR provision.

We would like to thank Sue Whiffin and Jenny Lowe for administrative support and Hannah Jones for proofreading.

Contributions of authors

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

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

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

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

Jo Thompson Coon was involved in guiding the direction of the review, advised on all stages of conducting the review and critically read and edited all sections of the report. She is also the guarantor of the report.

Data-sharing statement

All data requests should be submitted to the corresponding author for consideration. Access to anonymised data may be granted following review.

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Appendix 1 Literature search strategies

Bibliographic databases

MEDLINE and MEDLINE In-Process & Other Non-Indexed Citations

Host: Ovid.

Data parameters: 1946 to January week 2 2018 and 22 January 2018.

Date searched: 23 January 2018.

Searcher: Simon Briscoe.

Hits: 596.

Search 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.
19. "mental health tribunal*".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

PsycINFO

Host: Ovid.

Data parameters: 1806 to January week 3 2018.

Date searched: 23 January 2018.

Searcher: Simon Briscoe.

Hits: 578.

Search 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 hospial*)).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

Social Policy and Practice

Host: Ovid.

Data parameters: 201710

Date searched: 23 January 2018.

Searcher: Simon Briscoe.

Hits: 179.

Search 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 hospital*)).tw.
10. "mental health act".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: Health Management Information Consortium

Host: Ovid.

Data parameters: 1979 to November 2017.

Date searched: 23 January 2018.

Searcher: Simon Briscoe.

Hits: 139.

Search strategy

See *Social Policy and Practice* search strategy above.

Cumulative Index to Nursing and Allied Health Literature

Host: EBSCOhost.

Data parameters: not applicable.

Date searched: 23 January 2018.

Searcher: Simon Briscoe.

Hits: 362.

Search 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

Note: limited to English-language studies.

Applied Social Sciences Index and Abstracts

Host: ProQuest.

Data parameters: not applicable.

Date searched: 23 January 2018.

Searcher: SB.

Hits: 585.

Search 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 hospitali?ation* OR care)) OR ((sectioned OR sectioning OR detain* OR detention) N13 (mental* OR psychiatr* 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

Note: limited to English-language studies.

TABLE 6 Total number of hits per database and unique hits

Database	Number of hits
MEDLINE and MEDLINE In-Process & Other Non-Indexed Citations	596
PsycINFO	578
Social Policy and Practice	179
Health Management Information Consortium	139
CINAHL	362
ASSIA	585
Total number of hits	2439
Duplicate number of hits	696
Total number of unique hits	1743

Website searches

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

Website	URL	Search strategy	Limits	Date	Number of hits
Centre for Mental Health	www.centreformentalhealth.org.uk/	Searched for 'Nearest Relative' using website search function	None	24 January 2018	16
Mental Health Alliance	www.mentalhealthalliance.org.uk/news/index.html	Scanned the News and Publications pages	None	24 January 2018	N/A
Mental Health Foundation	www.mentalhealth.org.uk/publications/listing	Searched for (1) 'Nearest Relative' and (2) 'mental health act' using Publications page search function	None	24 January 2018	8
Mind	www.mind.org.uk/	Searched for 'Nearest Relative' in website search box	None	24 January 2018	54
Rethink Mental Illness	www.rethink.org/resources/a	Browsed the website library for relevant studies	None	24 January 2018	N/A
Royal College of Psychiatrists	www.rcpsych.ac.uk/usefulresources/publications.aspx	Searched for 'Nearest Relative' using website search function and browsed the Publications page for relevant studies	None	24 January 2018	86
SANE	www.sane.org.uk/resources/publications/	Scanned the Publications page for relevant studies	None	31 January 2018	N/A
Time to Change	www.time-to-change.org.uk/resources/research-reports-publications	Scanned the Research and Reports page for relevant studies	None	1 February 2018	N/A
Young Minds	https://youngminds.org.uk/	Searched for (1) 'Nearest Relative' and (2) 'mental health act' using search function	Search limited to publications	1 February 2018	15

N/A, not applicable.

Forward citation-chasing

Date searched: 2 February 2018.

Databases: Web of Science Core Collection, Scopus, Google Scholar.

Hosts: Clarivate Analytics (Web of Science) and Elsevier (Scopus).

Searcher: Simon Briscoe.

Search strategy

Citations of each study were searched for using Web of Science. If a study was not indexed in Web of Science then we searched using Scopus, and if study was not indexed in Scopus then we searched using Google Scholar.

TABLE 8 Number of studies retrieved by citation-chasing

First author and year of publication	Number of citations	Database
Banks 2016 ³⁴	2	WoS
Berzins 2009 ³²	0	GS
Berzins 2009 ³⁷	7	GS
Campbell 2008 ³⁸	4	Scopus
Jankovic 2011 ⁴⁶	17	WoS
Marriott 2001 ⁴⁸	9	Scopus
Rapaport 2004 ⁴	13	GS
Rapaport 2012 ⁵³	3	GS
Ridley 2010 ⁵⁵	10	WoS
Ridley 2009 ⁵⁶	NK ^a	WoS/Scopus/GS
Rugkåsa 2017 ⁵⁷	0	Scopus
Smith 2015 ⁵⁸	0	WoS/Scopus
Stroud 2013 ⁶⁰	6	GS
Stroud 2015 ⁵⁹	7	WoS
Total number of citations	78	
Duplicate number of citations	18	
Unique number of results	60	

GS, Google Scholar; NK, not known; WoS, Web of Science.

a Record could not be identified in citation indexes.

Appendix 2 Identification of initial themes for framework synthesis

Themes (and subthemes)									
Study	Research objective 1	Research objective 2	Research objective 3	Research objective 4	Research objective 5				
Berzins 2009 ³²	Perceptions of the introduction of the NP	Autonomy and choice	Reasons for nominating someone as a NP: 1. nominating relatives 2. nominating friends and partners 3. nominating a professional as a NP and social isolation	Advantage for service users and carers		Autonomy: understanding and information: 1. service users' and carers' understanding of the NP provisions 2. sources of information about the NP provisions 3. autonomy and choice, whom service users want to nominate as a NP	Low uptake	Power imbalances: 1. the relationship between service users and carers 2. the relationship between service users and professionals 3. the relationship between carers and professionals	The NP provisions and human rights: 1. the default NP and human rights – lack of choice 2. information-sharing and human rights
Dawson 2009 ³³	The appointment of the NP: 1. who are NPs 2. receiving and processing information, timing of nominating a NP, hoping not to be ill again same result 3. risks associated with appointments – an unsuitable NP 4. compulsion or choice – the requirement to have a NP	Interaction and overlap, NP and other forms of representation: 1. legal representation 2. independent advocacy workers 3. the use of advance statements		Definitions of the role of the NP and its perceived impact: 1. the role of the NP 2. the value and effectiveness of the role 3. NPs within the tribunal process 4. impact of the NP and their relationship 5. factors that support or hinder the NP role	Definitions of the role of the NP and its perceived impact: 1. the role of the NP 2. the value and effectiveness of the role 3. NP within the tribunal process 4. impact of the NP and their relationship 5. factors that support or hinder the NP role				
Rapaport 2002 ³¹	Bias and abuse	Recognition of patients without relatives: 1. proactive practice 2. policy deficits	Inflexible identification: 1. discrimination 2. real life 3. cultural contrasts and complications	NR and ASW: 1. powers and duties – assessment and detentions 2. other powers and duties	Safeguards and relative relevance	Under statute: 1. enduring effects 2. relative recognition 3. accessing services and assessments 4. meeting relatives' needs	Build-up to crisis and assessment: relatives' perspectives: 1. ASW duties to the NR 2. determining identity 3. coping with inflexibility – strategies and compromise 4. informing NR	NR recognition	

Green shading: selected themes used to revise stage 1 framework.

Appendix 3 List of excluded studies coded as 'forensic' during title and abstract and full-text screening

Aalsma MC, Brown JR, Holloway ED, Ott MA. Connection to mental health care upon community reentry for detained youth: a qualitative study. *BMC Public Health* 2014;**14**:117. <https://doi.org/10.1186/1471-2458-14-117>

Bamford K, Benton C. Gathering meaningful service user feedback regarding a community forensic service. *J Intellect Disabil Offending Behav* 2015;**6**:81–93.

Buchanan A, Gunn J. What psychiatrists think about Part III of the Mental Health Act 1983. *Psychiatr Bull* 1999;**23**:721–5.

Chandley M, Cromar-Hayes M, Mercer D, Clancy B, Wilkie I, Thorpe G. The development of recovery based nursing in a high-security hospital: nurturance and safe spaces in a dangerous world? *Ment Health Soc Inklus* 2014;**18**:203–14.

Cooke K, Bailey D. Women's experience of forensic mental health services: implications for practice. *J Ment Health Train, Educ Pract* 2011;**6**:186–94.

Cummins I. Mental health and custody: a follow on study. *J Adult Prot* 2012;**14**:73–81.

Department of Health and Social Care (DHSC), Home Office, Green D, Lamb N. *Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983: Review Report and Recommendations*. London: DHSC; 2014.

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Docking M. Safe haven (custody for people with mental illness). *Police Rev* 2008;**116**:36–7.

Douglas N, Plugge E. The health needs of imprisoned female juvenile offenders: the views of the young women prisoners and youth justice professionals. *Int J Prison Health* 2008;**4**:66–76. <https://doi.org/10.1080/17449200802038256>

Ford K, Sweeney J, Farrington A. User views of a regional secure unit – findings from a patient satisfaction survey. *Int J Psychiatr Nurs Res* 1999;**5**:526–41.

Gorsuch N. Disturbed female offenders: helping the 'untreatable'. *J Forensic Psychiatry* 1999;**10**:98–118.

Haddock A, Snowden P, Dolan M, Parker J, Rees H. Managing dangerous people with severe personality disorder: a survey of forensic psychiatrists' opinions. *Psychiatr Bull* 2001;**25**:293–6.

Hartford K, Carey R, Mendonca J. Pre-arrest diversion of people with mental illness: Literature review and international survey. *Behav Sci Law* 2006;**24**:845–56. <https://doi.org/10.1002/bsl.738>

Hewitt D. The Nearest Relative: losing the right to concur? *J Adult Prot* 2010;**12**:35–9. <https://doi.org/10.5042/jap.2010.0413>

HM Inspectorate of Constabulary, HM Inspectorate of Prisons, Care Quality Commission, Health Care Inspectorate Wales. *A Criminal Use of Police Cells? The Use of Police Custody as a Place of Safety for People with Mental Health Needs*. London: HM Inspectorate of Constabulary; 2013.

Hörberg U, Sjögren R, Dahlberg K. To be strategically struggling against resignation: the lived experience of being cared for in forensic psychiatric care. *Issues Ment Health Nurs* 2012;**33**:743–51. <https://doi.org/10.3109/01612840.2012.704623>

Irvine A, Allen L, Webber M. *Evaluation of the Scarborough, Whitby and Ryedale Street Triage Service*. York: Department for Social Policy and Social Work, University of York; 2016.

Jones SL, Mason T. Quality of treatment following police detention of mentally disordered offenders. *J Psychiatr Ment Health Nurs* 2002;**9**:73–80.

Kravitz HM, Cavanaugh JL, Rigsbee SS. A cross-sectional study of psychosocial and criminal factors associated with arrest in mentally ill female detainees. *J Am Acad Psychiatry Law* 2002;**30**:380–90.

Lea S, Callaghan L, Eick S, Heslin M, Morgan J, Bolt M, et al. 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 Serv Deliv Res* 2015;**3**(15).

Leese M, Russell S. Mental health, vulnerability and risk in police custody. *J Adult Prot* 2017;**19**:274–83.

MacInnes D. Interventions in forensic psychiatry: the caregiver's perspective. *Br J Nurs* 2000;**9**:992–8. <https://doi.org/10.12968/bjon.2000.9.15.5494>

Marks L, Grey A, Pearce S. General practice in prisons in England: views from the field. *Int J Prison Health* 2006;**2**:49–62.

McGilloway S, Donnelly M. Mental illness in the UK criminal justice system: a police liaison scheme for mentally disordered offenders in Belfast. *J Ment Health* 2004;**13**:263–75.

McKinnon IG, Thomas SD, Noga HL, Senior J. Police custody health care: a review of health morbidity, models of care and innovations within police custody in the UK, with international comparisons. *Risk Manag Healthc Policy* 2016;**9**:213–26.

Menkes DB, Bendelow G. Diagnosing vulnerability and 'dangerousness': police use of Section 136 in England and Wales. *J Public Ment Health* 2014;**13**:70–82.

Mental Welfare Commission for Scotland. *Mental Health of Women Detained by the Criminal Courts: Visit and Monitoring Report*. Mental Welfare Commission for Scotland. 2014. URL: www.mwscot.org.uk/media/190441/women_offenders_final_report.pdf (accessed 4 March 2018).

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Völlm B, Edworthy R, Holley J, Talbot E, Majid S, Duggan C, *et al*. A mixed-methods study exploring the characteristics and needs of long stay service users in high and medium secure settings in England: implications for service organisation. *Health Serv Deliv Res* 2017;**5**(11).

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A decorative graphic consisting of numerous thin, parallel green lines that curve from the left side of the page towards the right, creating a sense of movement and depth.

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