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Treading a tightrope: Professional perspectives on balancing the rights of patients and relatives under the Mental Health Act in England.

Abstract

Involuntary detention is used internationally to detain and treat people who are deemed to have a mental disorder. In England and Wales, Approved Mental Health Professionals (AMHPs) co-ordinate Mental Health Act assessments which allow for patients to be detained. AMHPs have legal duties to identify, inform, and consult with a patient's Nearest Relative (NR), who are, in turn, given powers to initiate or challenge detention.

Our study takes an original approach through examining how AMHPs interpret their duties towards Nearest Relatives.

We adopted a two-stage design, which involved an online questionnaire with 55 AMHPs and focus group discussions with 33 AMHPs. The research was conducted in England between 2017 and 2018.

Our questionnaire found that a high proportion of AMHPs reported that they had spoken to NRs for background information when assessing patients under the Mental Health Act. However, AMHPs were less likely to ask patients about their views of involving the NR prior to assessment.

Focus group findings showed that AMHPs saw the NR role as offering an important 'safeguard' on the basis that NRs could provide information about the patient and advocate on their behalf. AMHPs identified practical difficulties in balancing their legal obligation towards NRs and patients; particularly where issues of potential abuse were raised or where patients had identified that they did not want NR involvement. Whilst AMHPs stated that they sought to prioritise patient wishes regarding confidentiality, their accounts identified that patient consent about information sharing was sometimes implied rather than explicitly sought.

Our findings reinforce conclusions by the recent Independent Review of the MHA, which states that current NR provisions are 'outdated, variable and insufficient'. We identify that current practice could be improved using Advanced Choice Documents and outline implications for AMHP practice.

Keywords: carers; decision-making; focus groups; mental health, Mental Health Act; social work and health care, AMHP

WHAT IS KNOWN ABOUT THIS TOPIC

- Mental health professionals have identified that the effectiveness of the Nearest Relative (NR) role is dependent on the quality of the relationship between patient and NRs.

WHAT THIS PAPER ADDS

- A survey and focus groups were used to examine how Approved Mental Health Professionals (AMHPs) interpret their legal duties towards NRs.
- AMHPs reported high levels of consultations with NRs during mental health assessments. AMHPs were less likely to ask patients whether they wanted their NR to be consulted.

- AMHPs found balancing the rights of patients and NRs challenging; specifically deciding when to consult and managing patient confidentiality.

Introduction

Involuntary detention is used internationally to treat people who are deemed to have a mental disorder. The World Health Organisation (WHO) (2005) recommends that countries should protect the rights of detained persons through mental health laws which provide objective criteria for detention; provide a right of appeal and ensure that detention is used as a last resort. The WHO also suggests that the rights of detained individuals might be protected through giving family members legal rights to advocate on their behalf. However, tensions may exist between those being assessed for detention and family members. For this reason, the WHO recommends that countries seek to balance the rights of both parties in law, according to cultural norms.

In England and Wales, family members have been given legal rights in the compulsory detention process through the 'Nearest Relative' (NR) role. This role stemmed from 'The Percy Report' (Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, 1957), which saw relatives as key to upholding patient welfare for treatment in the community based on their knowledge of the person (Rapaport & Manthorpe, 2009). Accordingly, the report recommended that powers should be given to relatives to apply for, and appeal against detention. These recommendations were enacted in the Mental Health Act 1959, with the NR being maintained in the subsequent amendments to the Mental Health Act (MHA) in 1983 and 2007.

NRs have three key areas of responsibility under the MHA 1983, as amended by the MHA 2007 (see Laing, Dixon, Stone & Wilkinson-Tough, 2018). First, they have a right to 'object' to an admission for treatment by the AMHP, thus preventing it. Second, they are given powers to request that an AMHP (who is responsible for coordinating MHA assessments) considers a request for a MHA assessment, and can order their relative to be discharged from hospital, or request an appeal against detention if that order is blocked. Thirdly, they may apply themselves to have their relative detained in hospital or be made subject to guardianship although the Code of Practice recommends that an AMHP should be the preferred applicant in most cases (DOH, 2015, 14.30). The number of applications by NRs are not recorded by the National Health Service (NHS Digital, 2018), although anecdotal accounts by AMHPs suggest that they are extremely rare (The Masked AMHP, 2013).

AMHPs have a key role in co-ordinating MHA assessments and in deciding whether an application should be made. They are required to "assert a social perspective and to make properly informed independent decisions" informed by law and the views of patients, professionals and families (The Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008 (3(2(5(a))))). The MHA requires AMHPs to inform NRs of an application for admission under section 2 of the MHA (section 11(3)) and to consult the NR when considering an application to hospital under section 3, or guardianship under section 7 of the MHA (section 11(4) MHA). However, tensions between these duties and patient confidentiality exist. The case law position is complex (see Laing et al, 2018), although current tensions are summarised within the Code of Practice. It states,

"there will be cases where these duties [to the NR] do not apply because disclosing information about the patient to the nearest relative cannot be considered practicable, on the grounds that it would have a detrimental impact that is disproportionate to any advantage to be gained from informing the nearest relative" (DH 2015, 4.36).

AMHPs therefore need to consider both the risks and benefits of consulting with the NR when conducting MHA assessments. The NR role was previously viewed as a safeguard by Governments, on the basis that NRs could advocate for and protect patient rights (DH, 2000, p. 47). However, the effectiveness of the safeguard has now been questioned. The identity of the NR is currently established by the AMHP through a hierarchical list under section 26 of the MHA, affording patients no choice. This could lead to an AMHP identifying a NR who has little knowledge or involvement with the patient, or whose involvement may be harmful. It has also been argued that the list reflects outdated family structures (Laing et al, 2018). Powers to displace (i.e. remove) NRs under the MHA 1983 have been viewed as complex and difficult to navigate (DH, 2018a). Following the Independent Review of the Mental Health Act (DH, 2018b), the Government has pledged to replace the NR role with that of the Nominated Person (Gov UK, 2018). If the proposals are implemented, patients will be able to choose who they would wish to act on their behalf; with nominated persons being given extra powers to be consulted on care plans, renewal of detention and to challenge treatment plans within Tribunals. It is therefore timely to consider how AMHPs have managed consultation with NRs since the MHA 1983 was amended by the MHA 2007 and how this might be improved within future legislation.

Previous qualitative research on the NR role has identified several limitations. Whilst patients, carers and Approved Social Workers (who conducted a similar role to AMHPs prior to the MHA 2007) agreed that the role might act as a patient safeguard, they felt that this was dependent on a positive relationship between patient and NR (Rapaport, 2004). Where the relationship was strong, the safeguard was seen to act well. Where relationships were poor, the role was seen to threaten patient rights. NRs and patients also highlighted that they had been unaware of the role, whilst Approved Social Workers said that they sometimes failed to consult, due to poor hospital records or workload pressures.

Whilst recent research has focussed on AMHPs' understanding of their role (Buckland, 2014; Fistein, Clare, Redley & Holland, 2016; Morris, 2015; Vicary, Young and Hicks, 2019), there are no studies which address AMHP interactions with NRs. Much of the available research is limited in scope, with a recent rapid systematic review concluding that, "the topic of the NR provisions of the MHA 1983 is complex, of significant importance to individuals detained under the MHA 1983 and insufficiently studied to date" (Shaw, Nunns, Briscoe, Anderson, Thompson Coon, 2018, p. 47).

The purpose of this paper is to examine how AMHPs have interpreted their duties towards NRs and patients under the MHA, and how they balanced the rights of both parties in the compulsory admission process.

Methods

We adopted a two-stage design consisting of an online survey, complemented by focus groups.

Survey

A practice survey of AMHP involvement with the NR was designed. Participants were AMHPs who reported undertaking MHA assessments in the last month. They were recruited by advertising the survey to AMHP regional and national email networks. Additionally, adverts for the survey were cascaded by team and service managers in the local authorities where recruitment occurred for the second stage of the study, under the same approvals. The survey was piloted with two participants before being distributed. Data were collected between April 2017 and July 2017. Data were imported

from the online survey tool (Bristol Online Surveys) directly into IBM SPSS version 23. Descriptive statistics were calculated using this statistical package.

Participants were asked to give their age; gender; how long they had been qualified as an AMHP; which team they were based in; and the average amount of days spent on AMHP duty per month. Respondents were asked to report on their practice for the preceding month, as this timeframe could be recalled with sufficient accuracy, supported by diary reference, to provide a representative picture of practice. Participants were also asked to report the number of section 2 MHA applications (allowing a patient to be detained for assessment and treatment for up to 28 days) and section 3 MHA applications (allowing a patient to be detained for treatment for up to 6 months) that they had made within that time. In line with their legal duties in the MHA, AMHPs were asked to self-report how often they had spoken to the NR to gain background information; how often they had informed or consulted with NRs; how often they had spoken to the person being assessed about their view of involving the NR; and the proportion of NRs who had objected to admission.

Focus Group Research

Seven focus groups were conducted with AMHPs in five local authorities in England. We conducted focus groups with AMHPs who worked together, as this allowed us to tap into fragments of interactions approximating 'naturally occurring data' occurring in the workplace (Kitzinger, 1994). In other words, participants were able to discuss incidents that they had experienced using their own terms, and were able to challenge one another about discrepancies between practice ideals and reality.

AMHPs were recruited to focus groups through service or team managers. Potential participants were sent an information sheet explaining the purpose of the study, stating that participation was voluntary and offering the opportunity to receive further information by phone. Dates for each focus group were given to those consenting by managers of the team. All participants gave signed consent. No remuneration was given for taking part.

Six of the focus groups were made up of AMHPs operating within day time hours in five Local Authorities and one focus group was made up of members from an Emergency Duty Team, offering an out of hours service across four Authorities. The number of participants in each focus group ranged between two and ten, with 33 participants taking part in total. Twenty-two participants were female and 11 were male. Data were collected between March 2017 and January 2018.

Two researchers attended each focus group with one researcher taking the lead, and the second making notes and asking supplementary questions. A semi-structured interview schedule was used. Participants were asked a range of questions including how they identified the NR; what they viewed the main function of the NR role to be; at what point they sought to contact the NR; and dilemmas faced in practice. Participants were also asked to reflect on the strengths and limitations of current law, policy and guidance relating to the NR role.

Focus groups were recorded, and then transcribed by a professional transcription company. Transcripts were coded using thematic analysis (Braun and Clarke, 2006). Codes were agreed through

team consensus. One transcript was coded by Author 1 and Author 3 to generate an initial coding frame. Author 1, Author 3 and Author 4 then coded two to three transcripts each using this frame, with each researcher making notes of emerging codes not included in the original frame. Codes were then re-reviewed by to produce a final coding frame. Each coder re-coded their transcripts using the revised frame. Finally, each coder cross-checked the transcript of one other coder to ensure consistency across the team. We adopted a social constructionist approach to the analysis; in that we viewed focus groups as a site in which tacit knowledge about the NR role could be shared and developed collectively (Ryan, Gandha, Culbertson & Carlson, 2014). Coded material was cut and pasted into separate word documents by code. These codes were then collated into themes by Author 1 and Author 3, who then ordered the themes, chose illustrative extracts from focus groups and wrote the first draft of the qualitative data section. This section was subsequently reviewed by all authors.

Favourable ethical opinion for the study was sought and granted by [University ethics committee]. Approval for both the quantitative and qualitative components of the study was also sought and received from the Executive Council of the Directors of Adult Social Services (ADASS).

Results

Survey results

Fifty-five AMHPs consented to participate and all completed the survey. Their characteristics are described in Table 1.

Table 1: Participant characteristics

Gender	Male 18 (32.7%)	Female 36 (65.5%)	Non-binary 1 (1.8%)		
Age	25-34 2 (3.6%)	35-44 18 (32.7%)	45-54 21 (38.2%)	65+ 2 (3.6%)	
Professional Background	Social work 54 (98.2%)	Nursing 1 (1.8%)			
Team Organisation	Co-located with NHS 10 (18.2%)	Integrated with NHS 23 (41.8%)	In local authority 22 (40.0%)		
Years worked as AMHP	<5 18 (32.7%)	5-10 15 (27.3%)	11-15 11 (20.0%)	16-20 6 (10.9%)	21+ 4 (7.3%)

Days per month contracted for AMHP work	<5 34 (62%)	5-10 11 (20%)	11-15 3 (5%)	16-20 4 (7%)	21+ 3(5%)
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The number of MHA assessments and section applications reported by participants from their previous month of practice is shown in Table 2.

Table 2: Number of Mental Health Act assessments reported and section 2/3 applications made.

	Total number	Mean	Range
Number of MHA assessments reported	243	4.42	1-14
Number of section 2 Applications made	107	1.95	0-8
Number of section 3 Applications made	59	1.07	0-3

To aid understanding of involvement of the NR at various stages of section 2 and section 3 assessments, total frequencies for each item, as calculated by SPSS, were divided by the total number of section 2/section 3 applications made; percentages are shown in Table 3.

Table 3: Involvement of the Nearest Relative in section 2/3 assessments as a proportion of total section 2/3 applications.

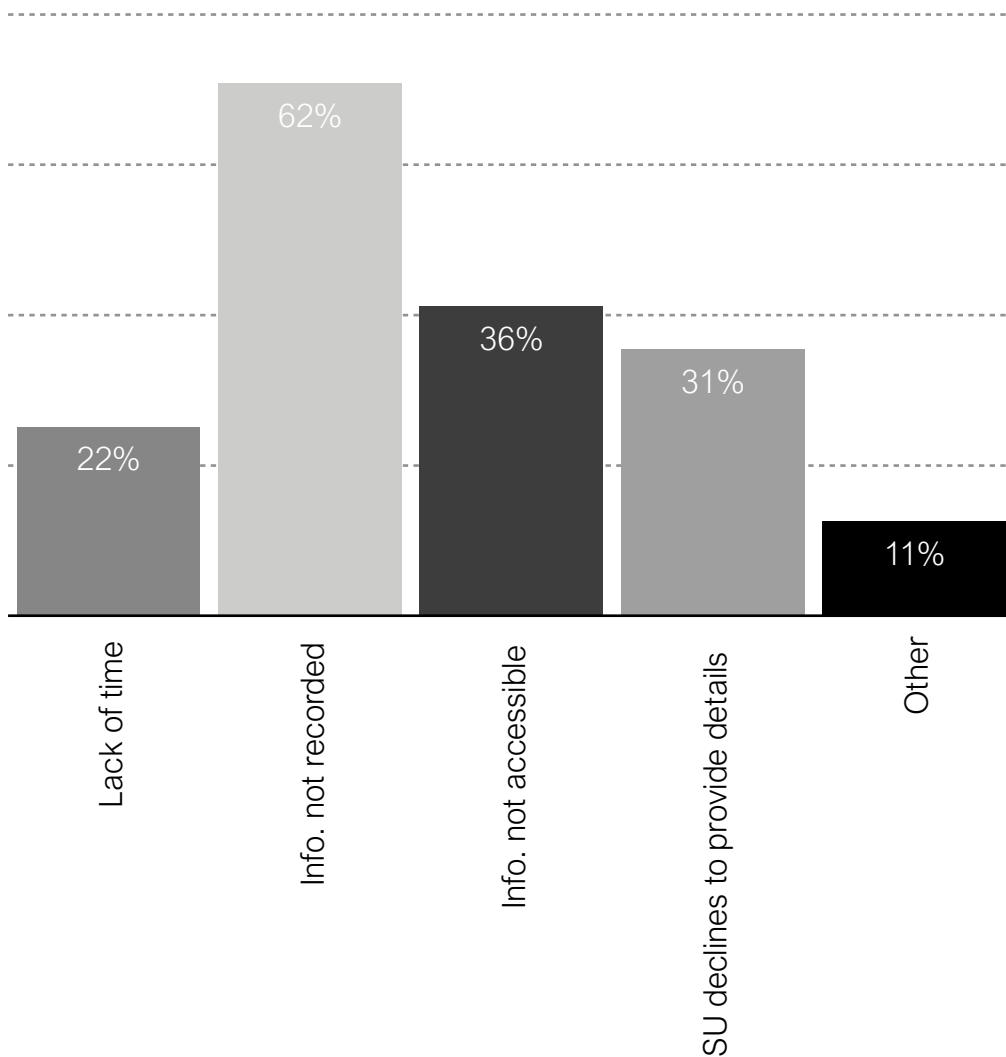
	Section 2 (% of 107 total applications)	Section 3 (% of 59 total applications)
Proportion of occasions that the NR was spoken to for background information	89%	100%
Proportion of occasions that the NR was 'Informed'/'Consulted' on the outcome of MHA	83%	97%
Proportion of occasions that the SU was asked their view on involving the NR	65%	73%

Proportion of occasions that the NR objected to the application	Not applicable for section 2	3.9%
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Inferential statistics were not calculated due to the non-standardised survey used and relatively small number of participants.

The frequency of participants reporting specified barriers to NR engagement in MHA assessment and application encountered in the last month were automatically calculated by the online survey tool used, and are shown in Figure 1. Other barriers reported in free-text responses were: dynamics within SU and NR relationship and concern about relationship breakdown; unavailability of NR (at night or when abroad); and a lack of clarity around who was the NR.

Figure 1: Proportion of AMHP's reporting encountering specific barriers to engaging the Nearest Relative in the previous month of practice (% of 55 respondents)



Qualitative findings

Our analysis found that AMHPs sought to balance the rights of patients and NRs throughout the assessment process. These practices drew on their opinions of the purpose of the NR, so we begin by setting out these assumptions.

AMHP perceptions of the purpose of the NR role

Throughout the focus groups, AMHPs commonly referred to the NR role as a 'safeguard'. AMHPs signaled two points about the nature of this. First, NRs were seen to provide a safeguard because they could provide a detailed picture of the patient. For example:

"...when we do assessments in the private hospital which is on our patch the information from the hospital can be inconsistent and you can't always get information from the place in authority, so the Nearest Relative is often most informative (AMHP 9, FG 3).

In some cases, as illustrated in the quote above, AMHPs did not draw a distinction between the type of information which might be given by professionals and NRs; with NRs being identified as a backstop when professionals were unavailable. In other instances, information offered by NRs was viewed as qualitatively different because, in contrast to professionals, they had observed the person over time or had a detailed knowledge of their social situation.

Second, the NR was seen to function as an advocate for the patient, making their views and wishes known:

"...they're [patients] not able to self-advocate or they've not got the capacity to make decisions about their care and the treatment. They need somebody else, to, to speak up for them you know, there's IMHAs [Independent Mental Health Advocates] obviously but, um, but IMHAs don't know the person very well. The Nearest Relative will have information about the background which will help, you know with the treatment, assessment, treatment plan (AMHP 1, FG5)".

AMHPs identified that NRs were able to represent a patient's wishes because they could view the person holistically; in contrast to 'medical' practitioners who were seen to focus on drug treatment. The NR's legal rights to be informed about admission, to object to an admission for treatment and to apply for the discharge were portrayed as safeguards, because they provided a counter-balance to this 'medical' view. However, AMHPs also indicated that the safeguard was undermined where NRs did not know the patient well. Notably, the NR's right to act as the applicant in a MHA assessment or to request a MHA assessment were not positioned as safeguards. For example:

"But with the right [of an NR] to request the assessment, I kind of- I don't know. I'm the opp [sic], on the opposite side of kind of Nearest Relative, I'm kind of always a bit sceptical of nearest relative requests to assess. Because I don't know. I always get a bit like, ooh, I don't know. It feels a bit uncomfortable a lot of the time (AMHP 1, FG 7)".

In line with the above participant, AMHPs voiced unease about NRs who sought to initiate admission, as this was seen to undermine the perceived advocacy function of their role. Additionally, AMHPs raised the problem of some NRs acting against patient's interests; either for financial benefit or because they wished to separate from the person as a spouse.

Deciding when to consult

Several factors were identified by AMHPs which influenced *when* they should consult with NRs. In two of the focus groups AMHPs identified that it was necessary to consult with NRs before an

assessment had taken place. In these cases, AMHPs identified that the NR should be consulted so that they could advocate on behalf of the patient. This was seen as crucial, due to the NR's legal right to object to an admission under section 3 of the MHA. However, consultation was seen as desirable by some where NRs had no legal right to object (such as during a MHA for assessment and treatment under section 2 of the MHA).

Whilst consultation with NRs was viewed as important, participants in four groups stated that they would delay consulting with NRs in cases where an individual had been detained under section 136 of the MHA. This section gives the police the power to take someone appearing to be mentally disordered to a place of safety for a MHA assessment. It is distinct from the admission sections discussed earlier. These judgements were made on the basis that many patients detained under section 136 were intoxicated. For example:

"I call them frequent flyers, people who regularly turn up at the 136 suite and you know, this guy just gets utterly bladdered [drunk], rings the police, I'm going to kill myself, he's in there, don't tell my family. Okay, you know, well we know where this is going.... You know, there's no need to go blundering into his life when [you're] pretty clear you're not going to detain that man (AMHP 2, FG2)".

In line with the example above, many AMHPs identified a reluctance to share information with NRs until it could be established by a doctor that the patient was suffering from a 'mental disorder' (as required by law). This was not purely a legal issue, with AMHPs being sensitive to patients' feelings of embarrassment about being seen by mental health services. However, these considerations were voiced specifically in relation to s. 136 use, whereas potential embarrassment was not seen as an issue for patients involved in community assessments.

All focus groups acknowledged that there was a legal duty to consult or inform NRs of detention (which is required of the AMHPs under section 2 and 3 of the MHA respectively). However, AMHPs also highlighted the practical challenges to achieve this. For example:

"If we had all day it would be no problem. But we don't have all day. Or all week. Because sometimes it can be a week. Where's the person? Where are they? What if we have to actually find them? We have to go through the electoral register and blah, blah, blah (AMHP 4, FG4)".

In a similar vein, participants in another focus group spoke of the difficulty of not being able to contact the NR, where a person was detained in a place of safety under section 136 of the MHA. In these examples, the duty to consult was weighed against the interests of the patient themselves. Here, AMHPs indicated that they had made a professional judgement not to consult with the NR, as a delay might cause the patient unreasonable distress.

Confidentiality

In cases where patients and NRs were seen to have a positive relationship, the process of consultation was viewed as valuable. AMHPs identified difficulties where the patient had stated that they did not want information shared with the NR, or where the patient's view was uncertain. When discussing how to respond to such cases, AMHPs frequently referred to legal principles under the Human Rights

Act 1998; namely a person's right to liberty under Article 5 of the Act and their right to respect for private and family life, under Article 8. Article 5 rights were seen to be protected through consulting with the NR who might act as a safeguard against unjustified detention. Article 8 rights were seen to protect a patient's right to confidentiality where they did not wish information to be shared. For example:

"But it's those situations where they [patient] say don't consult or tell my father, brother, whatever because they did x, y, z they've been abusive do you know what I'm saying? (AMHP 3)

Sure, and then you've got the Article Eight stuff to bring in and balance that (AMHP 7, FG3)".

The above example is illustrative of the discussion in several groups, in that participants identified the need to balance competing human rights considerations. The issue of abuse was seen to be important, in the case where NRs may have sexually, physically or financially abused their relative. Three of the groups stated that there was a need to consider the patient's view about information sharing before a MHA assessment had taken place. However, problems with substantiating abuse were highlighted.

There were differences of opinion amongst AMHPs as to how information-sharing with NRs should be managed where patients objected to this. On the one hand, AMHPs in two focus groups argued that the emphasis within a consultation was on receiving information from the NR. For example:

"The services, I think, often doesn't have an awful lot, in my experience, a lot to do with Nearest Relative decision-making, actually. You might do. You might say, actually, you know, kind of who do you live with, who's the eldest of your parents? Who's your oldest sibling? But, kind of that's where it's about them giving you information about to help you make a decision rather than anything, them being actively involved, I think (AMHP 1, FG7)".

In this excerpt, the problem of information sharing was downplayed, with the AMHP listing questions which would be used to identify who the NR was under section 26 of the MHA. In this instance, confidentiality was not seen as an issue, on the basis that NRs would primarily be providing information. However, AMHPs in two groups identified that NRs needed a certain amount of information about the patient's mental health and treatment to exercise their duties effectively. Whilst one AMHP identified that the NR role gave her licence to share confidential information with NRs, a more common view was that only limited information should be provided. For example:

"Sometimes you literally have to say look, I'm really sorry I can't share some of the things with you because we've been asked not to but I'm here and whatever you tell me I'll listen so you're not actually giving information out, you're on that tightrope sometimes (AMHP 3, FG 3)".

The above reference to confidentiality being a 'tightrope' was illustrative of discussions amongst AMHPs. Whilst some uncertainty was expressed as to how to achieve this balance, most AMHPs gave preference to the patient's view. However, AMHPs also signalled that they had shifted their position

over time in response to recent case law, meaning they were now more cautious about giving information to relatives.

Whilst AMHPs stated that they sought to prioritise patient wishes regarding confidentiality, several practice examples painted a contrary picture. For example:

“...[if] the Intensive Team is working with somebody and they’ve been talking to the Nearest Relative [or a] person [who looks like it] I would be more inclined just to kind of, well I’m taking that, that’s implicit consent. Let’s go with that, you know, like unless you start to find something that you think oh my God, this is really iffy... (AMHP 2, FG 2)”.

In the above example, involvement between relatives and mental health services was used as a measure to imply patient consent. Participants in other groups also gave examples which would encourage them to contact the NR more readily; notably cases where patients were under 18 or had a diagnosis of dementia. Whilst some noted that patient wishes should be considered; comments indicated that consent might be implied rather than explicitly sought.

Discussion

The survey is the first of its kind to quantify the involvement of NRs in MHA assessments and applications. Several limitations should be noted. The survey was likely to have attracted participants for whom the NR role was of interest and, as it was based on self-report, is likely to be subject to memory and reporting biases. Further research could use case note scrutiny with a larger sample of AMHPs to provide a more accurate picture of practice. Focus groups were subject to the normal limitations of qualitative research, in that the findings identify a range of positions held by participants which are not necessarily representative. Two of the groups were limited by having a sample size of two.

It is clear from our findings that NRs are perceived by AMHPs to be a valuable source of information. We were encouraged to find that AMHPs self-reported a high frequency of information gathering from NRs during MHA assessment, and of ‘Informing’/‘Consulting’ the NR about the outcome of the assessment, irrespective of whether this was for a section 2 or section 3 application. However, the survey data highlights that NR involvement by AMHPs varies between use of section 2 and section 3 MHA assessments. This suggests that the protective safeguard established within section 26 is not realised in each assessment, and the provision is utilised in a manner that legislators may not have intended. This variation may be explained using the focus group data, as it is evident that the participants grappled with the legal and ethical dilemmas associated with applying relevant human rights standards to the MHA in practice; explaining in part the lack of absoluteness as to when the NR is engaged by the AMHP.

Our survey data indicates that patients were only consulted about their views on involving the NR on average in two-thirds to three-quarters of section applications. Those not consulted might remain unaware of the involvement of a NR, affecting the potential for them to apply to displace a NR whom they judged to be inappropriate. This is out of step with the empowerment and involvement guiding principles in the MHA Code of Practice, which state that patients should be fully involved in decisions about their care, support and treatment (Department of Health, 2015, p. 22). The reasons for the reportedly lower level of consultation with patients compared to NRs are unclear, although the mental

state of the individual is likely to play a role. However, it does suggest a potential imbalance of views when making decisions about compulsory mental health assessment and treatment. Formal objection by the NR to a section 3 application was reportedly very rare (in less than 4% of applications) which could either suggest that early consultation with NR is effective and prevents inappropriate applications, or that the NR powers to challenge detention are not being fully utilised.

Our focus group data indicates that whilst AMHPs see the NR as proving an advocacy role, they are suspicious of NRs who seek to instigate MHA assessments. Furthermore, AMHPs are influenced by the context of the assessment and this then affects how they choose to engage with NRs. The location of the MHA assessment clearly mattered, as signalled by some of the participants that they were not necessarily engaging in a 'true' mental health crisis when assessing s. 136 cases. In these instances, AMHPs in our focus groups felt that additional caution was called for before communicating with a NR. In addition, participants highlighted how they were required to evaluate the complexities of relationships between patients and NRs; making judgements about whether involvement of the NR would cause disproportionate harm. These included incidents when the NR might experience undue influence from the patient to use their powers, challenging their ability to act proportionally. Whilst AMHPs identified the need to exercise caution in this regard, several practice examples given painted a contrary picture. In these cases, patient consent to information sharing was assumed, rather than sought, particularly where the patient was a child or older adult.

Our study reinforces some of the conclusions of the recent Independent Review of the Mental Health Act which found the current model of family and carer involvement, "outdated, variable and insufficient" (2018b, p. 85). As our study has shown, AMHPs regard the NR role as providing an important safeguard, but often fail to speak to patients about their view on involving NRs in their care. The system proposed by the Independent Review would ensure that patients are afforded greater choice with all aspects of the role being 'upgraded', to strengthen the safeguard for detained mental health patients. The proposals might also resolve some of the dilemmas that AMHPs currently face in sharing information as patients would be given greater ability to specify this through Advanced Choice Documents. However, it should be noted that AMHPs identified that many of the tensions they faced in consulting with NRs were exacerbated by time and resource pressures. Proposals for a nominated person role may also falter, if enough resources are not put in place to facilitate them.

Our findings have several implications for AMHP practice. First, AMHP services should lobby for greater use of Advanced Choice Documents so that the views of patients towards information sharing can be more accurately established. Furthermore, they need to ensure that patient consent is explicitly sought, in line with legal expectations and human rights principles, rather than being assumed or implied. Second, AMHPs need to ensure that they do not discount the advocacy role of the NR in cases where NRs are lobbying for a MHA assessment. Whilst AMHPs are required to assert a social perspective by MHA Regulations, they are also required to consider carer perspectives on the nature of mental disorder and treatment (Approved Mental Health Professionals) (Approval) (England) Regulations 2008). Finally, AMHPs need to ensure that they do not make a false distinction between assessments conducted following detention of the patient under section 136 and other mechanisms for detention.

Conclusion

Our findings suggest that the NR is, in principle, still regarded by AMHPs as an important safeguard. It can be effective, when it works well. Although there are clear indications from the study that the

safeguard is not always working as well as the legislature intended. The AMHPs that we surveyed and spoke to currently perceive this aspect of their role to be complex and difficult, in particular, the identification of the most suitable NR, as well as the consultation process itself and how to balance competing interests and rights in that process. This is especially marked in the context of information sharing and the duty to maintain patient confidentiality, and considering at what point in the assessment process the consultation with a NR should take place.

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