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Beyond the call of duty: A Qualitative study into the experiences of family members acting as a Nearest Relative in Mental Health Act assessments

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Abstract

Research shows that tensions between family carers and professionals become acute where the issue of compulsory admission to hospital is at stake. In England and Wales, a specific family member is appointed to safeguard the interests of a person assessed under the Mental Health Act 1983. This currently occurs through the Nearest Relative (NR) role. The Government is proposing to replace this with a Nominated Person role, chosen by the service user. Drawing on the concept of carer burden, this study reports on the views of nineteen NRs in England to discover their experiences of being involved in a Mental Health Act assessment. Participants identified that they undertook the role due to a sense of duty. Their experiences were mixed with participants highlighting both feelings of distress during the assessment and feelings of relief once their relative had been detained. Participants reported feeling conflicted when their relative was detained and feelings of frustration towards mental health services. The findings have implications for proposals to reform the Mental Health Act 1983. They show that education and support programmes should be created for NRs/Nominated Persons and that research is needed to assess whether such support is effective at reducing carer burden.

Keywords: carers, mental health, Mental Health Act, nearest relative, nominated person, social work, AMHP

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Introduction

Carer involvement for people who experience mental health problems varies in policy and practice across jurisdictions (WHO, 2005). In the UK, where this study is set, it is estimated that 8.8 million adults are carers (Carers UK, 2020). The contribution made by carers in the UK was last valued at £132 billion per year (Buckner, 2015) indicating that there are clear benefits to state economies in families or friends adopting such responsibilities. Nonetheless, the physical and emotional burdens placed on carers can be huge. The concept of carer burden can help us to understand the issues which carers may experience and what Approved Mental Health Professionals (AMHPs) might do to support them. AMHPs are mental health professionals who have been approved by Local Authorities (LAs) to carry out a range of functions under the Mental Health Act 1983 (as amended by the Mental Health Act 2007) (MHA) (Mental Health Act 2007, 1983). These professionals' coordinate MHA assessments and have the power, when the legal criteria are met, to apply for a person to be detained in hospital against their will. Currently, 95 percent of AMHPs are social workers (Skills for Care, 2021). In this article, we draw on the concept of carer burden to consider the experiences of relatives acting for a person with a mental health problem during an assessment for compulsory hospital admission. We refer to people being assessed under the Mental Health Act 1983 as 'service users' in this article, although the Act refers to them as 'patients'.

Authors focussing on carer burden have argued that burdens may be objective or subjective (Malhotra, 2016). Objective burdens refer to the practical problems that carers may experience. For example, disruption to household routines, relationship problems within the family or financial difficulties. Subjective burdens relate to distress experienced by the carer such as feelings of anger, guilt, ambivalence or loss. Whilst concepts of carer burden are valuable some limitations should be noted. Most studies adopting this perspective focus on burden or strain, which has the potential to give an overly pessimistic picture of caring (Brown and Brown, 2014). Attempts to measure the scale of carer burden have also led researchers to favour quantitative designs. However, qualitative studies on the issue of carer burden are starting to emerge. A systematic meta-synthesis by Wirsén *et al.* (2020) identified nine papers with findings focussing on both experiences of burden by carers and personal perspectives of their needs. Whilst this research is valuable, none of these studies focussed specifically on carers' experiences of a relative's compulsory hospital admission, which our article will address.

A review of the literature on detention under mental health law suggests that carers face significant difficulties in this regard. Many of these

difficulties can be characterised as objective burdens, in that they relate to practical problems, which carers experience. Research shows that carers often make multiple appeals before their concerns are heard (Hallam, 2007) and experience professional response times as overly long; particularly where their relative is experiencing psychosis or a manic episode (Smyth *et al.*, 2017). Carers of people admitted under compulsion are also more likely to report ‘having problems with services’ (Boydell *et al.*, 2014). They also report feeling excluded from decision making during admission (Hickman *et al.*, 2016) and feel that caring responsibilities are transferred to them too quickly once the person is ready to be discharged from hospital (Jankovic *et al.*, 2011). Research also suggests that carers experience subjective burdens when a relative is detained, with carers reporting conflicting emotions such as anger, disappointment, frustration and relief (Stuart *et al.*, 2020).

In the UK, specific individuals are entrusted to safeguard the interests of the person being detained. This occurs through the Nearest Relative (NR) role in England, Wales and Northern Ireland under section 26 of the MHA in England, and section 32 of the [Mental Health \(Northern Ireland\) Order 1986](#) (Mental Health (Northern Ireland) Order 1986, 1986) respectively; and by virtue of the Named Person (NP) role in Scotland under Part 17 of the [Mental Health \(Scotland\) Act 2015](#) (Mental Health (Scotland) Act, 2015). Whilst the legal status of these roles should, in principle, increase information-sharing between these individuals and services, research shows a mixed picture. NRs in England have reported being unaware of their role and not receiving information from professionals (Rapaport, 2004). In contrast, NPs in Scotland reported better access to information since taking on the role (Ridley, 2009). Studies have shown that NRs have felt ignored by services and felt the need to be ‘pushy’ to obtain information or to be included in decision making (Rapaport, 2004). AMHPs have been described as ‘vague and evasive’ by some NRs, although some participants in the same study experienced AHMPs as calm and reassuring (Smith, 2015, p. 348).

Currently, NRs are identified through a hierarchical list of family members under section 26 of the MHA; a process which does not currently enable service users to choose their NR. Those appointed are given three key areas of responsibility; first, powers to ‘object’ to an admission by an AMHP for treatment, thereby preventing it; secondly, to request that an AMHP undertakes a Mental Health Act assessment; and thirdly, to act as the applicant for detention themselves (Laing *et al.*, 2018). The Government’s white paper on *Reforming the Mental Health Act* proposes that the law should be changed so that service users are able to choose who should represent them through a new Nominated Person role (DHSC, 2021). An implicit assumption within these proposals is that service user choice will resolve tensions between service

users and carers where the issue of detention is at stake. If the proposals are accepted, Nominated Persons will have the same rights and powers as NRs, plus additional powers. These may include the right to be consulted about care and treatment plans, hospital transfers, renewals or extensions to detention and the right to appeal treatments decisions at Tribunals where the person lacks capacity (DHSC, 2021). The white paper indicates that training will be provided to Nominated Persons to assist them to fulfil the role, although is silent on the issue of emotional support. Consequently, it is important to understand how individuals acting on behalf of a person detained under the MHA experience that role and what kind of supports may be needed to help them to exercise it appropriately. The purpose of this article is to identify NRs' perspectives on undertaking their role. Our research is novel as we identify whether the role is viewed as empowering or burdensome and what support was received by NRs in fulfilling the role. This is important, as qualitative carer burden research is yet to focus on this issue. Equally the study was undertaken in the context of anticipated reforms to the Mental Health Act 1983 arising from the 'wide opposition to the current concept of the "nearest relative"' (DHSC, 2018, p. 23). We begin by identifying our methods for the empirical research and then explain our key findings.

Methods

This article is based on a qualitative study of nineteen NRs located within four LAs across England. NRs were purposively sampled through LA gatekeepers, as it was possible that not all NRs would have been aware that they held the role. To ensure potential participants did not feel pressured to join the study, AMHPs were asked to approach NRs and to pass on an information sheet about the study, explaining the risks and benefits of taking part. Details of NRs who consented to be contacted were passed to Author 2.

Participants were included in the study if they had been identified as a NR by an AMHP in the preceding six months. This time scale was adopted to aid accurate recall of experiences. NRs were excluded if the assessing AMHP considered that they were vulnerable or posed a risk to the researcher. The total sample comprised twelve women and seven men, ranging between thirty-four to seventy-two years old. Eighty per cent self-identified as being from a white UK background, and 20 per cent from black and minority ethnic groups. Nine of the NRs lived with the person and ten did not (see [Table 1](#)).

Face to Face interviews were conducted by Author 2 in locations selected by participants. Semi-structured interviews were used to elicit responses about the experience of fulfilling the NR role. Participants were asked what led up to their relative being detained under the

Table 1. Participant information

Participant number	Relationship to detained person and ethnicity
1	Participant—Mother (White) Detained person—Son (White)
2	Participant—Mother (White) Detained person—Son (White)
3	Participant—Son (White) Detained person—Mother (White)
4	Participant—Father (White) Detained person—Adult Daughter (White)
5	Participant—Brother (White) Detained person—Sister (White)
6	Participant—Mother (White) Detained person—Son (White)
7	Participant—Son (White) Detained person—Mother (White—German)
8	Participant—Daughter (White) Detained person—Father (White)
9	Participant—Mother (White) Detained person—Son (White)
10	Participant—Mother (White) Detained person—Daughter (white)
11	Participant—Husband (White) Detained person—Wife (White)
12	Participant—Wife (White) Detained person—Husband (White)
13	Participant—Mother (White) Detained person—Adult daughter (White)
14	Participant—Husband (White) Detained person—Wife (White)
15	Participant—Wife (White) Detained person—Husband (White)
16	Participant—Husband (White) Detained person—Wife (White)
17	Participant—Mother (White) Detained person—Son (Dual-heritage)
18	Participant—Father (White) Detained person—Son (White)
19	Participant—Mother (White) Detained person—Son (White)

MHA; whether they were aware of any concerns about the person's mental health before the MHA assessment took place; whether they remembered being contacted by the person carrying out the MHA assessment and how they felt about being identified as NR. They were also asked how they understood the NR role; whether they felt able to challenge the professionals involved; and what their relationship was like with the person who had been assessed.

Interviews were recorded and professionally transcribed. Transcripts were coded using thematic analysis (Braun and Clarke, 2006). In using this method, we adopted what Braun and Clarke refer to as a

‘contextualist’ method, which sits between the poles of essentialism and constructionism and is akin to critical realism. In other words, we adopted the view that individuals make meaning from experience, and that whilst their social context influences the way they interpret the world, they retain agency to comment on their ‘reality’. Coding was agreed through team consensus. Three transcripts were coded by each author to develop an initial coding frame. These transcripts were rotated between the authors who identified emerging codes not identified within the original frame. All codes were discussed before a final coding frame was agreed. The transcripts were distributed equally among the authors for final recoding, and there was a further cross-check of transcripts before the final thematic analysis took place. Coded material from transcripts was cut and pasted by authors into individual Word documents. These codes were then collated into themes by the research team, with illustrative extracts from the interviews selected by Authors 1 and 2 and subsequently reviewed by all authors.

Ethics

Ethical approval was gained through the University of the West of England ethics committee, as well as from each LA site. The participant information sheet identified the benefits and risks of the study and individuals were given the opportunity to ask questions before taking part. All participants gave written informed consent. As the interview contained potentially distressing questions, each session ended with a debriefing session and participants were given information about support services. No remuneration was given for taking part. All research data were saved on a secure drive at the University of the West of England.

Results

Although the intention of the study had been to explore the NR role primarily from a legal and rights perspective, participants invariably responded to the questions by highlighting their feelings towards their relative’s detention. For most NRs, discussing the assessment was an emotional experience, and this manifested itself in different ways in their narratives, resulting in the themes in our analysis.

Most experiences expressed by NRs were negative. Whilst participants sometimes highlighted the emotional aspects of acting as a carer more generally, we focus specifically in this paper on their views towards compulsory detention and the NR role.

A sense of duty

Most participants highlighted a sense of duty or obligation towards their relative, which had existed prior to them being made aware of the NR role. Several referred to the legal powers they had been given under the MHA as an extension of this duty. For example, when asked how they felt about being identified as the NR, one participant said:

[I was] perfectly happy to that and I couldn't do otherwise. Yes, it's your duty, it's not an extreme thing to be asked to do. (Participant 5)

In some instances, NRs identified that a close relationship with the person was not important. For example, when Participant 5 was asked whether the NR role had affected his relationship with his sister, he responded:

There isn't one...I'll do anything I need to do to help her, but to say there is a relationship - my relationship is with the person she was... (Participant 5).

This suggests that some family members may feel compelled by societal expectations/obligations in relation to duty, i.e. that families should care for one another, even where the relationship is absent or has become strained.

In other instances, relatives made a connection between the emotional bonds between themselves and their family member, and a duty to act on their behalf. In taking this position, they argued that they were able to advocate effectively, *because* they were carers. For example:

I think that, yes, I mean – You know, because my son is very dependent on me anyway, so I feel like I am responsible for, you know, for his, for his health, you know. And because, I probably, you know, because he's been with me all his life...For him, family is family (Participant 9).

For this participant, the NR role appeared congruent with her role as a mother, due to her son's dependence on her. The phrase, 'family is family' was used to reflect the view that family members should have primacy in care decisions and to reflect her son's agreement with this position. Within the interview, the participant identified that this view was held by both parties, despite disagreements between them about the need for medical treatment.

No NRs in our study disagreed with the concept of the NR role, although it is possible that individuals who held such a view may have refused to act as a NR in the first place, and thus would not be captured in our sample. Notably, no NRs in our sample suggested that the NR function should be given to another person outside of the family unit.

Experiences of distress

Several participants in our research identified the experience of being involved in a MHA assessment as distressing. Several reasons were given for this. In some cases, NRs identified that they felt distressed because they had been unsupported by services during the assessment. For example:

The actual sectioning process was about as horrible as it ever could have been. It was possibly the worst experience of my life. . .one minute there were police cars and half a dozen doctors and lots of shouting and kind of stuff going on and then the next minute I was just here on my own and that was a bit kind of challenging, difficult (Participant 17).

In the above extract, reference to police cars, 'half a dozen doctors' and lots of shouting is used to convey a sense of chaos in the home. The participant also contrasts the chaos experienced 'one minute', to being on her own 'the next minute'. In doing so, she indicates that it was not just the degree of activity that was challenging but also the fact that she was left on her own immediately after the event. Notably, this participant was not wholly negative of services and remarked that she had received support from the AMHP later in the day. In other instances, participants attributed their distress primarily to feelings of uncertainty about the NR role. For example, one participant praised the AMHPs she had spoken to as being 'fair' and 'lovely' but said that she was unclear about the purpose of the NR role or how she should support her relative. She said:

The whole experience was pretty traumatic really I suppose. There should be more support actually for me or actually tell me what I need to do to support him. (Participant 1)

In other cases, NRs described feelings of distress due to their role as NR impacting negatively on their relationship with the service user. For example, one participant said:

And the fact that I, again, I'm an authority figure to his care, it completely unbalances the relationship. You know? . . .I mean, it brought tears to my eyes yesterday after he had to be held down. I made him a cup of tea and I handed it to him, and I had a moment of brief clarity for him. He looked up, smiled at me, looked me in the face, and said thank you, darling, and then it was gone. . .So changing roles, being the provider, it's very hard. You know? It's very hard doing that (Participant 8).

The NR's reference to the relationship being unbalanced referred to her relationship as a daughter to the service user. In line with NRs noted above, she identified feeling distressed by her relative being overpowered by others; in this case restrained. However, her experience of the service user being present and then 'gone' reflect feelings of

‘anticipatory grief’ described within the dementia literature, where carers may experience feelings akin to bereavement, due to changes in the person’s personality (Holley and Mast, 2009). These feelings were highlighted by the NR role here which caused a change in the power-dynamic between them. In other cases, NRs were distressed by the change in power dynamics that the NR brought about; but remained hopeful that these changes were temporary.

Experiences of relief

Whilst half of our participants identified the MHA assessment as being distressing, others spoke of a sense of relief following the MHA assessment. One participant described feelings of both distress and relief; however, all other participants who described experiencing relief were distinct from those in the ‘experiences of distress’ group. For example, one participant stated:

...being frank, but it’s a sense of relief when it [detention] happens almost, because, you know, she’s not going to end up doing something horrible to someone or herself. It’s literally that extreme I guess (Participant 5).

In the above example, this sense of relief was related to a belief that his relative was ‘out of control’ as evidenced by violent behaviours towards others. Similarly, Participant 4 gave a lengthy account of two MHA assessments, which occurred during a period where his daughter was experiencing a manic episode. He said:

To be perfectly honest, we were relieved that she was being sectioned and, you know, short of her being detained in a dungeon, we would probably have agreed to anything at that time...because we knew from past experience that’s what she needed. There wasn’t really anywhere – anywhere she could go. You know? It wasn’t a retrievable situation (Participant 4).

In the above interview, the statement that the family would have accepted any form of detention, ‘short of her being detained in a dungeon’ is used to signal the extent of that relief. This relief was linked both to concerns about his daughter’s safety and his own need, ‘just [to] come home and have a good night’s sleep’.

In exceptional cases, relief was experienced for other reasons, with one participant stating that they had been relieved to be named as NR (in preference to another family member) and others indicating a sense of relief due to the kindness shown to them by mental health professionals or employers.

Feeling conflicted

Several participants highlighted conflicting emotions when acting as NR. These feelings were expressed as being linked to their powers to act as a NR; specifically, the right to request a MHA assessment, the power to object to their relative been admitted for treatment under section 3 of the MHA, and the power to discharge their relative from section 2 or section 3 of the MHA.

NRs identified that their statutory powers affected their relationship with the service user. Relatives would tell NRs not to talk to mental health staff, to avoid them requesting an admission or would encourage them to exercise their powers of discharge. For example:

Oh yes, it's hard. It's really hard because he's obviously unwell, but he can't see that and he wants – he probably sees me as being disloyal to him, in the fact that I won't do something to get him out, because he doesn't want to be there...Because [he's] always telling me [that I can apply for his discharge] (Participant 2).

Such situations left NRs feeling conflicted because they felt that they had to communicate honestly with mental health professionals to fulfil the NR role effectively, but also understood the reasons for their relative's appeals. Whilst all NRs felt some degree of distress, feelings of conflict were mitigated where the NR believed that detention was justified. For example:

With my mum, because my mum's very paranoid...whenever I go to meetings and things, she says, don't say anything to the doctors to make me stay here longer...And I would say it [the NR role] puts me in an awkward position, because as much as I hate to see my Mum in hospital, equally I would not want her to come out before she was ready and then have to go in again (Participant 3).

However, in cases where NRs felt unsure about the need for treatment, they voiced acute feelings of guilt. For example:

The trouble is, being that close, maybe you don't always do the right thing, which is what you feel guilty about, because you're not too sure what the hell it is. But what is the right thing? I don't know. But whether he's- he has felt let down by me for allowing it [detention] to happen. You know? On a daily basis I get texts and emails. Please get me out, this is awful. You know? I can't bear it here. I'm going to be attacked by one of these loonies or whatever it is that, you know, he's texted. And I think I can't- I can't help you. There's nothing I can do. And that's horrendous (Participant 6).

In the above example, the participant's angst arose from her son's distress as well as her own uncertainty about what the right course of action was. Additionally, feelings of conflict could be compounded by

disagreement amongst family members after detention as to whether detention in hospital was the correct outcome.

Frustration with mental health services and staff

A dominant theme within the data was that of frustration with mental health services. Feelings of frustration arose for several reasons. First, participants felt frustration on the grounds that mental health staff had ignored or minimised concerns until the person was acutely unwell, at which point a MHA assessment was arranged. For example, one participant spoke of her son's paranoia being dismissed by a mental health service, despite him receiving treatment under a Community Treatment Order previously. She said:

And so, I was raising concerns continually with the mental health team saying, look he's not well and in the end, I said to the mental health team guy, I said, you need to stay with him for more than ten minutes, because you don't - he put's up - he's very guarded and he put's up that he's fine and doesn't need any help (Participant 2).

In line with others interviewed, this participant expressed frustration with the level of mental health support in the community, expressed by her exhortation that professionals needed to spend more time with her son to accurately assess him. Whilst participants reported that they were invariably told who they should contact in a crisis, it was often deemed to be tokenistic, with participants believing that staff had not adequately responded to or addressed their concerns. For example:

They just have their little platitudes that say, oh, you can call the crisis number, or you can call the police. They don't actually know what that means. They tell people to do things that aren't going to help. But because they think they've ticked the box (Participant 19).

Reference to 'platitudes' here indicates that this participant felt that staff lack empathy; a view also reflected by other respondents in the study. Those who believed that staff should be more proactive in using compulsory powers also felt that their relatives' mental health problems could have been 'nipped in the bud' (Participant 2) through detention at an earlier stage. In doing so, they expressed concerns that an undue focus on the service users' rights and wishes may have acted against their best interests in the long run.

Secondly, participants identified a lack of information sharing by professionals. For example, one participant noted that in the period leading up to detention:

I could tell them [information], but they weren't able to tell me, which I can understand with confidentiality and all that, but actually that's quite frustrating as a relative when you're shut out (Participant 4).

In the above case, the participant noted that information-sharing improved once her relative had been detained. However, in other cases participants stated that information-sharing remained poor. Whilst participants recognised that staff were constrained by confidentiality policies, NRs expressed frustration that they were given no sense of progress during the period of detention or were not informed of major decisions about care following compulsory hospital admission. For example, one participant noted that whilst ward staff would speak to them if he initiated contact, in his view, his daughter could ‘break a leg’ without the ward ringing him up to inform him (Participant 4). Similarly, others spoke about not being informed of major decisions such as their relative being moved to another unit. One participant said:

I just think that every unit needs to actually get their backsides in gear with regards to the nearest relative and they should be giving you all of the information. Every time a child moves unit or an adult moves unit, you should be given all that information again, you know and it shouldn't be photocopies of an original brochure that's ten years old, that's actually photocopied upside down and inside out and everything else (Participant 13).

Although the above participant noted that she had been given an information sheet about the NR role, this action was highlighted as problematic on the basis that the information received was out of date and poorly presented. Taken together, these actions caused her to conclude that the NR role was not taken seriously by mental health staff. In addition, participants were frustrated by a lack of effective planning after inpatient admission, during periods of hospital leave or discharge. In several cases, participants stated that they had not been informed that leave or discharge was due to be granted and had been given no information about support arrangements. This suggests that NRs are not routinely consulted or provided with information once the hospital admission takes place.

Thirdly, participants were clearly frustrated and disappointed by the lack of support offered to them. For example:

Yes, I think more support for that person [NR] would be good. And to be offered proactively because I'm sure if I went digging around maybe there is some support, but I haven't found anything that's of use to me (Participant 2).

In the above example, the participant identified that she had accessed some support through a mental health charity but had done so on her own initiative. In line with this experience, other participants also felt that they would like to be offered greater support to exercise the NR role. For example:

So, we don't feel that the hospital is particularly proactive in terms of saying we appreciate the pressure you're under, or the stress you must feel under and we've got this for you. You know?...They've told us about carer support but that tends to be, in our experience, more to do with practical day-to-day looking after someone after hospital...You know, rather than psychologically, how do you deal with the predicament you find yourself in (Participant 4).

In this, and other cases, NRs spoke about the need to be offered more information about the specifics of the NR role. This included information both about what the role entailed as well as emotional support both prior to and following the compulsory admission.

Discussion

Several limitations should be noted. As a qualitative study, the findings are not representative but demonstrate the range of views held by participants. Recruitment was reliant on AMHP gatekeepers and therefore may be subject to selection bias. The study relied on oral histories of NRs and there was no opportunity to triangulate accounts with other professionals involved in the MHA assessment. Apart from one participant, who was identified by his NR as of dual heritage, all other participants were white. As rates of detention amongst black and minority ethnic (BAME) groups are higher than amongst white groups (Barnett *et al.*, 2019), it is likely that the experiences of BAME NRs are also different. Despite these limitations, the findings provide useful insights about the MHA compulsory admission process from the NR perspective and help us to understand the emotional burdens and practical challenges they face. This is important, as the government plans to reform the role and expand the responsibilities and powers that nominated persons have under the MHA, which is likely to compound these impacts.

The findings from this study contribute to existing material on carer burden. As noted in our introduction, whilst there is a growing qualitative literature on experiences of carer burden, no articles have focussed on carer experiences of compulsory hospitalisation. Previous research on carer burden has found that the parents and spouses of people with mental health problems accepted a caring role once their relative had been diagnosed with a mental health problem (Mizuno *et al.*, 2011; McAuliffe *et al.*, 2014). This was due to a belief that they were duty-bound to care for their relatives. In a similar vein, NRs in our study saw the NR role as fulfilling a natural duty to their relative, stemming from family ties or societal expectations.

Whilst all participants in our study felt duty-bound to assume the NR role, it was seen to lead to a range of burdens. The subjective burdens of NRs were dominant within our findings, namely their experiences of

distress, relief, of feeling conflicted and frustrated with mental health services and staff. Previous qualitative research on carer burden has found that distress was caused by a belief that their needs had been misunderstood or forgotten (Wirsén *et al.*, 2020). These themes were absent from our research. However, our findings were congruent with other MHA assessment research, which found that family members can experience emotions such as anger or disappointment, when a relative is detained under the MHA (Jankovic *et al.*, 2011). Previous research has highlighted the emotional impact on carers of discovering that a relative has been detained after the event (Stuart *et al.*, 2020). In contrast, NRs in our study spoke of being distressed due to feeling unsupported during the MHA assessment or because they felt unsure of how they should be supporting their relative as a NR. NRs were also distressed by changes to the order of family relationships and by the realisation that the role gave them power over a family member. In line with previous research (Hickman *et al.*, 2016), some NRs felt relief once their relative had been detained. These NRs valued hospitalisation because they felt it made their relative safe and provided them with a period of respite. However, our research also highlighted that detention in hospital may bring up other feelings. NRs in our study reported feelings of conflict which were linked to their powers to act as NR. These emerged where their relatives asked them not to act in a way which would prevent or end detention. Conflict also arose where NRs were ambivalent about detention. These feelings of conflict were broader than those identified in other carer burden research, which were focussed on relationships between carers and nursing staff (Pejlert, 2001).

Our findings also highlighted objective burdens experienced by NRs, as reflected in accounts that their concerns were ignored or minimised, that services failed to share information and did not offer adequate support. These feelings reflect previous findings in carer burden research in which carers have described having to fight the system to bring about hospital admission (Veltman *et al.*, 2002). Our findings also indicated that NRs felt that they were not provided with enough support to conduct the role. Some NRs in our study indicated that they felt ill-equipped, incapable and unsupported, echoing findings in earlier studies in England (Rapaport, 2004). For example, information sheets (where provided) were out of date and lacking in detail; information provided was minimal, nor openly shared with NRs about their relative's inpatient care and subsequent leave and discharge plans.

Whilst our study highlights a range of negative emotions that were experienced, it is important to emphasise that there were also some perceived benefits to carers expressed by our participants. The NR role was experienced by some in our study as positive and empowering, often coupled with a sense of gratitude and relief to be involved in making formal arrangements for a relative's mental health care. Many of the

NRs in our study expressed relief to be accessing professional help and support for their relative, and the MHA was viewed as a mechanism to achieve that. The NR role and direct involvement in the formal legal process was viewed by some participants as empowering, as it provided leverage to access professional support and services, and as a mechanism for easing their caring burden. Although it is obvious that the process was often accompanied by significant distress, particularly if it was a chaotic assessment, involving the use of restraint/force and the presence of the police.

The frustration and conflicted emotional responses experienced by many NRs in the study tie in closely with the tensions inherent in the NR role itself, that is to actively enable the compulsory admissions process, yet at the same time have the power to challenge decisions taken by mental health professionals to compulsorily admit a relative to hospital. The final report of the Independent Review of the MHA made several recommendations to reform the NR role, primarily to replace it with a Nominated Person who 'should be given improved support, which could include courses provided by recovery colleges, support lines or on-line materials' (DHSC, 2018). The government white paper has accepted these recommendations and stated its intention to develop clear and detailed guidance on the role of the Nominated Person. But this does not go far enough, given some of the difficulties recounted by the NRs in our study. There is nothing in the white paper (DHSC, 2021) about providing training, or practical and emotional support at any stage of the process. Our study findings indicate that it is crucial to provide both, particularly if the NR responsibilities will be expanded to include wider powers to object to Community Treatment Orders, appeal clinical treatments at the tribunal and be consulted about statutory care and treatment plans, as the white paper proposes. It is also essential to ensure that the support is timely, accessible, enduring and provided comprehensively throughout the compulsory admission and detention process. The law in this area is currently anomalous as the NR does not benefit from any independent support. For example, a relative can be a Relevant Person's Representative (RPR) in the [Mental Capacity Act 2005](#) (Mental Capacity Act 2005, 2005), providing support to a person who is subject to the Deprivation of Liberty safeguards. The RPR is a similar role to that of the NR in supporting the service user, yet s/he is entitled to distinct support from an Independent Mental Capacity Advocate.

Previous studies have suggested that there is a need to provide better training to health and social care staff to enable them to support NRs/NPs more effectively (Marriott, 2001; Ridley, 2009). There is also evidence that providing psychoeducation to mental health carers may lessen levels of carer burden (Chiocchi *et al.*, 2019). However, it is unclear whether such programmes will be effective for those carers undertaking

a legal advocacy role, as NRs/NPs are expected to do. Our findings show the need for awareness raising, better quality information and enhanced support for NRs/NPs to help them to understand the expectations of the role and to discharge it with confidence. Future research might usefully assess whether psychoeducation programmes can be adapted to support the emotional needs of NRs/NPs and whether such programmes are effective at reducing carer burdens.

The study findings suggest that it is also incumbent on AMHPs and other professionals involved in the process to recognise the expectations and challenges faced by NRs/NPs and consider how performing the role can impact adversely on the family dynamics and relationships with the service user. AMHPs should also ensure that targeted information and ongoing support is offered to family members who have been actively involved in the assessment and admission process in this way. This should be reflected in future training programmes in line with the AMHP Workforce plan, which provides that ‘AMHP services should identify ways in which patients and carers are able to engage and influence the development of AMHP services and AMHP practice’ (DHSC, 2019, para 6.2).

Conclusion

Our findings shed light on the experiences of NRs, and the extent to which the role is perceived as beneficial, burdensome, or both. Notably, the NRs in our sample reported a range of mixed emotions in shouldering their statutory responsibilities. There is a sense of obligation (social/familial) involved with performing the NR role, and, in line with the carer burden literature, that it brings significant emotional burdens that go above and beyond the call of duty in many cases. The government has committed to reforming the NR role in the MHA white paper. The demands of the NR role should not be underestimated as the new legislation is fleshed out in the months ahead. Provisions for effective practical and emotional supports for NPs should be introduced, akin to the additional support provided to the RPR, to ensure that the NP will be a more positive, supported and supportive experience. Future AMHP workforce and training plans should be configured to recognise these additional burdens imposed on carers/relatives in the compulsory admission process, to ensure AMHPs can proactively provide more information and support to them prior to, during and after the formal assessment process. It is encouraging that recent government proposals recognise and respond at a basic level to the needs of this largely invisible caring workforce. However, far more robust systems of support are needed for the reforms to lead to any marked or meaningful improvements for service users and their families.

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