mentalwelfare commission for scotland

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VISIT AND MONITORING REPORT

Experience of Named Persons

Experience of Named Persons

An exploratory study into the views of named persons under the Mental Health (Care and Treatment) (Scotland) Act 2003

Note: For clarity and to avoid confusion we refer to the individual subject to compulsory powers under the 2003 Act as the 'service user' throughout this report. Where directly quoting the 2003 Act we use the term 'patient'.

This study was conducted for the Mental Welfare Commission for Scotland by Anne Birch, Researcher at the Commission. Paula John, Mental Health Officer seconded to the Commission, provided advisory support.

Our aim

We aim to ensure that care, treatment and support are lawful and respect the rights and promote the welfare of individuals with mental illness, learning disability and related conditions. We do this by empowering individuals and their carers and influencing and challenging service providers and policy makers.

Why we do this

Individuals may be vulnerable because they are less able at times to safeguard their own interests. They can have restrictions placed on them in order to receive care and treatment. When this happens, we make sure it is legal and ethical.

Who we are

We are an independent organisation set up by Parliament with a range of duties under mental health and incapacity law. We draw on our experience as health and social care staff, service users and carers.

Our values

We believe individuals with mental illness, learning disability and related conditions should be treated with the same respect for their equality and human rights as all other citizens. They have the right to:

- be treated with dignity and respect
- ethical and lawful treatment and to live free from abuse, neglect or discrimination
- care and treatment that best suit their needs
- recovery from mental illness
- lead as fulfilling a life as possible.

What we do

Much of our work is at the complex interface between the individual's rights, the law and ethics and the care the person is receiving. We work across the continuum of health and social care.

- We find out whether individual care and treatment is in line with the law and good practice
- We challenge service providers to deliver best practice in mental health and learning disability care
- We follow up on individual cases where we have concerns and may investigate further
- We provide information, advice and guidance to individuals, carers and service providers
- We have a strong and influential voice in service policy and development
- We promote best practice in applying mental health and incapacity law to individuals' care and treatment.

Introduction

The Mental Welfare Commission for Scotland (The Commission) has a duty to report on the operation of the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act"). We also monitor the application of the Principles of the Act and promote best practice in their use. The Act introduced new measures to improve the rights and representation for patients: among them named persons, advance statements, independent advocacy and the Mental Health Tribunal for Scotland.

The purpose of this study was to explore the experiences of individuals undertaking the named person role[1] and their views in relation to the named person's rights under the Act concerning compulsory treatment orders[2] (CTO).

The key questions concerned the named persons' understanding, experience and views on:

- the named person role
- being consulted by professionals in relation to compulsory treatment orders
- notifications and information received;
- the impact of the named person role on the service user and named person.

Our study was the first to contact named persons direct via information held on the Commission's database. Since commencing the study, which explored named persons' understanding and experience under the 2003 Act, there have been continued policy and legislative developments. The study findings are discussed in relation to the continuing provisions of the 2003 Act and the amendments proposed under the Mental Health (Scotland) Bill.

[1] Mental health (care and treatment) (Scotland) Act 2003: Code of Practice. Volume 2. Civil compulsory powers. Chapters 3, 4, 5, 6.
[2] Mental health (care and treatment)(Scotland) Act 2003 : Code of Practice. Volume 1. Chapter 6. Patient representation: named person

Key findings and recommendations

In one quarter of records examined the individual subject to compulsory powers did not have a named person (43, 25%); most of these did not want a named person (28, 16%), for others a potential family member was not suitable, capable, available or eligible to take on that role (10, 6%).

There was a lack of clarity in named persons' understanding of their current named person status (nominated, default, or appointed) and an absence of signed nomination forms. Very few received written information about the role and understandings of the role varied widely. We found that named persons could be better informed about the limits to the named person authority concerning decisions they can make and also about the nature and implications of the compulsory powers applicable to the detained individual.

The practice of involving named persons and notifying them of changes in legal status and circumstances appeared highly variable across practitioners and services. For a significant minority the first they heard about being the named person was when they received something through the post or had contact from a lawyer prior to the tribunal. Named persons were not always kept informed of significant problems or incidents; this is especially important when they can have input that would be helpful.

Named persons understanding of what information they were entitled to receive varied from 'no idea at all' to 'all the information that's going'. Half those interviewed raised issues about paperwork including: late paperwork; volume and complexity to absorb at a time of crisis; needing assistance to read and understand documents.

Three quarters of named persons interviewed had attended at least one tribunal, they largely found tribunals as anticipated and the less confident appreciated panel members' efforts to put them 'at ease'.

Named persons were generally not well informed about the roles of welfare guardian and welfare power of attorney, or independent advocate. The majority were unaware of or unclear about the purpose of advance statements.

The Commission supports the Mental Health Scotland Bill's provisions for named person status to be made clearer, for an individual to only have a named person if they choose to have one, and that named persons should give written and witnessed consent to the role. This will enable the named person to discuss matters with the individual and obtain information about the role and responsibilities of a named person prior to their accepting the nomination.

Recommendations

In light of the proposed changes set out in the Mental Health (Scotland) Bill we recommend that the Scottish Government revise both the Mental Health (Care and Treatment) (Scotland) Act 2003: Code of Practice and the guide *Are you a Named Person* (2008).

We recommend that the Scottish Government should review the Code of Practice to clarify:

- The role of the MHO in providing verbal and written information to the named person

- The role of others in the multidisciplinary mental health team in consulting with and informing the named person

We recommend that the Scottish Government review and rewrite the guide *Are you a Named Person* for use by the named person, the MHO, the named nurse and others in the multidisciplinary team. Specifically we would like to see the revised guide address:

- The functions and limits of the role
- The range of documents and notifications that named persons might potentially receive, when and from where
- The balance between the rights of the service user to confidentiality with the 2003 Act's intention to inform and involve the named person
- The functions and limits of the roles of welfare power of attorney, welfare guardianship and independent advocacy
- The function and value of advance statements

The revised guide should also signpost other agencies, relevant information and good practice guides, including the Commission and the Office of the Public Guardian.

We recommend that all MHO training and related continuing professional development training should emphasise the importance of adhering to the Code of Practice, Volume 1, Chapter 6, paragraphs 7 and 10) re informing the patient and the proposed named person about the role of named person. Local authorities should consider any additional training needs for individual MHOs in respect of this.

NHS Education Scotland (NES) should consider the implications of this report for future development of information and training.

The Mental Welfare Commission for Scotland should continue to seek involvement of carers and named persons via visits and other routes; to monitor how the named person role is operating in practice and to ensure named persons are informed about the Commission's role and services.

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Legislation and policy context

Overview of the named person role under the 2003 Act

The named person concept was created as a direct response to concerns about the powers vested in nearest relatives under the Mental Health (Scotland) Act 1984. It allows for the appointment of a person who will gain a number of powers and rights should the appointer become subject to compulsory powers under the 2003 Act.

Currently, under the provisions of the Act, if an individual needs treatment under the 2003 Act then the person can choose someone to help protect their interests. This person is called a named person and anyone aged 16 or over can chose a named person.

The Act gives service users the right to nominate a named person. This may be a relative or carer but need not be. If a service user does not nominate anyone, the primary carer becomes the default named person, and if there is no primary carer, the nearest relative is assigned the role. Individuals taking on this role may come from any background but should not be a professional member of the mental health care team for the service user. All named persons will be persons of capacity able to take on the role.

The named person role is set out in the 2003 Act, Code of Practice and *A guide to Named Persons* (2005)[3] for the service user. There is also a guide aimed at the named person *Are You a Named Person?* (2008)[4].

A Named Person is someone who will look after the person's interests if he or she has to be treated under the Act.

The Act is based on a set of guiding principles that can be used as a guide to what a service user can expect in their care and treatment, and which most people performing functions under the Act have to consider. These include:

- taking into account the present and past wishes and feelings of the service user;
- taking into account the views of the service user's named person, carer, guardian or welfare attorney;
- the importance of the service user participating as fully as possible;
- the importance of providing the maximum benefit to the service user;
- the importance of providing appropriate services to the service user; and
- the needs and circumstances of the service user's carer.

Policy developments and The Mental Health (Scotland) Bill

The statutory framework for a named person is set out at sections 250-258 of the 2003 Act. These sections deal with appointing or identifying a named person to support and represent the interests of a patient subject to proceedings under the 2003 Act.

[3] Scottish Executive (2005) A Guide to Named Persons http://www.mwcscot.org.uk/media/73341/a_guide_to_named_persons.pdf

[4] The Scottish Government (2008) Are you a Named Person http://www.scotland.gov.uk/Publications/2008/04/04114446/0

In recent years there have been calls for amendment to the 2003 Act named person provisions.

The McManus Report (Limited Review in the Mental Health (Scotland) (Care and Treatment) Act 2003 (2009))[5] included a review of the new named person role introduced in the 2003 Act. It took into account the views of individual service users and carers and supporting organisations. It also took account of the research into the named person role carried out during the early years of the Act.[6] This research had obtained views on the role of named person from carers, via carer or mental health networks, and also views from professionals. The review noted problems and issues identified since implementation. It discussed possible solutions and set out some nineteen recommendations in relation to the role.

In December 2013 The Scottish Government issued A Consultation on proposals for a Mental Health (Scotland) Bill[7]. Chapter two of this consultation set out the proposed amendments to provisions for named persons under the Act. The Scottish Government analysis of responseswas published July 2014. The Mental Welfare Commission response to the consultation supported most of the named person proposals and highlighted the importance of being consistent about named person provision.

The Mental Health Scotland Bill[8] was introduced to the Scottish Parliament on 19 June 2. In Part 1 the Bill makes provision in relation to: *Representation by named person*.

The Scottish Government[9] wishes to:

[5]Professor Jim Mcmanus (Chair) (March 2009) Limited Review of the Mental Health (Scotland)(Care and Treatment) Act 2003: Report http://www.scotland.gov.uk/Resource/Doc/281409/0084966.pdf

[6] Dawson A, Ferguson I, Mackay K, Maxwell M (2009). *An Assessment of the Operation of the Named Person Role and its Interaction with other Forms of Patient Representation.* Scottish Government Social Research. http://www.scotland.gov.uk/Resource/Doc/263258/0078745.pdf

Ridley J., Rosengard A., Hunter S. et al (2009) *Experiences of the early implementation of the Mental health (Care and Treatment) (Scotland) Act 2003: A Cohort Study.* Scottish Government Social Research, Edinburgh (Web only) http://www.scotland.gov.uk/Resource/Doc/271836/0081033.pdf

Ridley J., Hunter S. and Rosengard A. (2010) *Partners in care?: views and experiences of carers from a cohort study of the early implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003.* Health and Social Care in the Community (2010) 18(5), 474–482

Berzins KM and Atkinson JM (2009) *Service users' and carer's views of the Named Person provisions under the Mental Health (Care and Treatment) (Scotland) Act 2003.* Journal of Mental Health, June 2009; 18(3): 207-215

Berzins KM and Atkinson JM (2010) *The views of policy influencers and mental health officers concerning the named Person provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003.* Journal of Mental Health, October 2010; 19(5): 452-460

[7] A Consultation on proposals for a Mental Health (Scotland) Bill (December 23, 2013) http://www.scotland.gov.uk/Publications/2013/12/1962

[8] The Mental Health Scotland Bill

[9] The Mental Health Scotland Bill accompanying documents http://www.scottish.parliament.uk/parliamentarybusiness/Bills/78451.aspx

Mental Health Scotland Bill: Policy Memorandum (20 June 2014) http://www.scottish.parliament.uk/S4_Bills/Mental%20Health%20(Scotland)%20Bill/b53s4-introd-pm-bookmarked.pdf

Mental health Scotland Bill: Explanatory notes. http://www.scottish.parliament.uk/S4_Bills/Mental%20Health%20(Scotland)%20Bill/b53s4-introd-en-bookmarked.pdf

- ensure that a person can be reassured that their named person is an individual that they are content to have protect their interests, and that a named person will take on that role only if they are content to do so.

The proposed changed provisions incorporated into the Bill, post consultation are:

- An individual should only have a named person if they chose to have one (Section 18: Opt-out from having named person.
- An individual should give their written and witnessed consent to acting as a named person (Section 19: Consent to being named person). The rationale for this is that this will enable the named person to discuss matters with the individual and obtain information about the role and responsibilities of a named person prior to their accepting the nomination.
- The repeal of the Tribunal's power upon application to appoint a named person where no such person exists. (Section 20: Appointment of named person). The Tribunal retains the power on application to remove a named person where that person is considered to be inappropriate, and where, in such a case the patient is under 16, the Tribunal will be able to appoint another person as the named person.

Stage 1 of the parliamentary process has begun, the Health and Sport Committee as the lead committee for the Bill issued a "call for evidence" inviting views on the Bill from stakeholders (Friday June 27, 2014)[10].

How we carried out the study

We aimed to interview 20-30 named persons for service users currently on an extant Compulsory Treatment Order (CTO) or Community Compulsory Treatment Order (CCTO). We wished to interview persons from health boards with a range of high and low rates of compulsory orders and from a range of urban and rural population bases.

We took a download of all extant CTOs and CCTOs from the Commission's database of Mental Health Act forms (2036 records) at the end of January 2013. We extracted cases up to 14 months post the start date of the first compulsory treatment order (677) in order to capture persons in the first year of a compulsory order. We examined records across five health board areas. Across three large health boards we used random stratified sampling to identify records (270), and then examined a batch of 30 records at a time, extracting named person details where available and issuing invitations. We examined further batches over a six week period February to March 2013. As there were very few replies from the first rural board we included in addition all relevant cases for two additional rural boards.

In total we examined a sample of 174 records in detail. In 47 cases there was no named person contact details (43 no named person identified and 4 no recorded named person address). We wrote direct to 127 named persons for whom we had an address. We interviewed 22 people who agreed to take part.

[10] Mental health Scotland Bill – Call for written evidence.
http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/78995.aspx

Health Board	Sample	Invited	Interviewed	Sample	Invited	Interviewed
Large urban board	89	68	12	51%	54%	55%
Mixed urban rural	40	29	5	23%	23%	23%
Three rural boards	45	30	5	26%	24%	23%
Total*	174	127	22	100%	100%	100%

- May appear to sum to more than 100% due to rounding effects

	Sample		CCTO		CTO	
Number of records examined	174	100%	53	100%	121	100%
Named Person not identified or no recorded address	47	27%	15	28%	32	26%

Prior to the interview, we sent a courtesy letter to the service user concerned to inform them of the study.

The short semi-structured telephone interviews were conducted by the Commission's researcher and a mental health officer seconded to the Commission.

Who we interviewed

Number of persons	Sample		CCTO		CTO	
Records examined	174	100%	53	30%	121	70%
Invitations issued	127	100%	38	30%	89	70%
Interviews	22	100%	3	14%	19	86%

Location at interview	All	CCTO	CTO
Community	10	2	8
Hospital	12	1	11

A smaller proportion of those on Community CTOs (14%) accepted the invitation to interview than were in the original sample and invitations (30%). However, on receiving the returned questionnaires, we found some of the people originally based in hospitals were now in the community and with this 'community' representation in place we decided not to issue further invitations.

Three quarters of the interviewed sample were named persons for service users mainly of the middle age groups, 25-44 and 45-64. All but one of the service users had a mental illness, and in addition two had a learning disability and three had a personality disorder.

Our sample included a larger proportion of women (68%) than men (32%) and two thirds of interviewees were named person for a man and a third for a woman. All but one of the respondents were a family member for the individual on compulsory treatment (spouse, child, parent, sibling, grandparent, nephew/niece).

Appointment of named person and understanding of the role

Why this is important

The appointment of the named person is a multifaceted process. The Mental Health Officer (MHO) has a duty to identify the named person and it would be good practice for the MHO to ensure that the potential named person is both willing to undertake the role and understands what it might involve.

Currently Section 255 places a duty on the MHO, in certain circumstances, to take steps to find out whether a patient has a named person and if so, who it is. The circumstances are where the officer is discharging a function under the 2003 Act, or the Criminal Procedures Scotland Act (1995), in relation to the patient and it is necessary for that purpose to establish whether the patient has a named person.

The Act says the MHO should take reasonable steps to identify the named person, and where the individual does not have a named person or the MHO is not able to establish there is no named person, the MHO should record the steps taken to identify the named person and give a copy to the Tribunal and the Commission as soon as is practicable.

Under the current provisions of the Act (Part 17 Chapter 1) a named person may be:

- Nominated - chosen by the service user (section 250)
- Default - primary carer (section 251) or nearest relative (section 254)
- Appointed - by the Mental Health Tribunal (section 257)

Anyone, aged 16 or over, may choose / nominate a spouse or partner, a relative or carer or other person to be their named person. If the individual is under 16 years of age then the named person will be a person with parental rights and responsibilities for the individual, the local authority (if the individual is looked after), or the individual's main carer.

A named person must be at least 16 years old. A nomination should be signed by the patient and witnessed by a prescribed person (section 250). It may be wise for the patient to check the desired named person is willing to act in that role.

It may be that the patient is content for their carer or nearest relative to act as their named person and in that case no nomination is required and the patient should not be put under pressure to nominate someone else. If the patient does not choose a named person, or the person chosen does not want to do it, the Act says that the main adult carer will automatically be the named person. If there is more than one adult carer then they can decide between them who it will be. If there is no adult carer then it will be the nearest relative, as set out by the Act (section 251).

An individual may make a 'declaration' to stop someone being their named person. Currently, if this then means the individual will be without a named person the MHO might, in certain circumstances have a duty to apply to the Mental Health Tribunal to get someone else appointed.

A nomination may be revoked by the patient who made it provided that the revocation is signed and witnessed by a prescribed person. The witness to nomination or revocation of a named person must certify that in their opinion the patient understands the effect of the nomination/revocation and that they have not been subject to undue influence. The patient may also make a declaration as to a person they do not want to be a named person. The individual can revoke a nomination or declaration at any time.

It is expected that a named person will not have a professional relationship with the patient (e.g. doctor, nurse, social worker) or deliver care / treatment as it could create a conflict of interest. There may also be potential conflicts of interest for someone in a less direct support role in taking up a named person role (e.g. housing support worker, advocate). Where the Mental Health Officer (MHO) considers a patient has identified a named person that the MHO considers unsuitable to act as a named person, the MHO is under a duty to apply for an order to remove and replace an 'apparent' named person' (i.e. a person whom the MHO has deemed to be inappropriate to act in that role).

A named person may decline to act at any time by notifying their refusal, in writing, to the patient and to the local authority area in which the patient lives.

A nomination/declaration stays in effect even if the patient later become's unable to make decisions or communicate either because of mental disorder or physical disability.

What we expect to see

We expected the name of the named person to be clearly identified or, where this was not available, a clear account of why there was no named person and steps taken by the MHO.

We would hope to find that named persons have a clear understanding of their named person status under the Act. Where an individual has been nominated as named person we would expect that the named person had been provided with and had signed a nomination form.

We would expect that the named person had been fully informed about the named person role at the point they were first nominated or at the point compulsory powers were first considered for the service user.

We would expect them to understand the range of rights and powers conferred by the role (see page 15) and also the limitations of the role.

We would expect them to have an understanding of the nature of compulsory powers and implications for the individual service user.

What we found

Identification of named person by the MHO

On examining the sample 174 records (compulsory treatment orders, social circumstances reports and other associated paperwork) we found that three quarters of individual service users had a clearly identified named person. We also found evidence of a wide variety of and sometimes extensive actions taken by MHOs to identify potential named persons.

One quarter (43, 25%) did not have a named person. In the majority of cases (28, 16%) there was evidence that the individual had made a clear decision that they did **not** want a named person. Evidence included three ***declarations***[11], expressed choice (23) including that noted at a MHTS tribunal (2), no default available (4) or default not chosen (3), where a previous named person had been dropped (4). Key reasons given included: estrangement from family or breakdown of marriage /family relationships (7).

In other cases (7) there was an available family member but they were not suitable, capable or available to undertake the role e.g. parent or grandparent was older or infirm, parent also had learning disabilities, parent was in a nursing home, sibling already looking after an ill spouse, sibling at same address also has mental health problems, child not able and nominated in-law not willing to take on role.

In three cases the individual's nearest relatives lived abroad and were not eligible to be named person (section 254 (6) (c)).

Of the remaining five cases without a named person, two already had a welfare guardian and for three there was no clear information.

Understanding of status

Almost two thirds of participants said they felt clear about their named person *status.* In just under two thirds of cases the status understood by the named person matched the status recorded on 2003 Act paperwork. A third of interviewees did not feel clear about their status. The terms *default, nominated or appointed* were used interchangeably by some. One person spoke of nominating themselves at the time they became a Guardian. None of our interviewees had been appointed by the Tribunal.

Of the thirteen who mentioned *nomination,* only four thought they probably had signed a form, even if quite some time ago, and two were clear they did not, the rest were not clear.

We found the role named person was undertaken by a wide range of relatives and the majority did not live with the individual on the compulsory order; whilst a third identified as 'main carer' the rest called themselves 'next-of-kin'. 'Main carers' felt the role was automatic; others tied becoming named person to specific compulsory events. One named person was a 'nearest relative'.

The majority felt they had full choice about taking on the role and would not want to have it any other way. Where there was active choice between family members as to who should be the named person this had taken account of interest and availability to take on a lead role.

Whilst in two thirds of cases there had been discussion between the service user and the named person about the role, in a third of cases there had not.

Just one person felt professionals had not given them any choice about taking on the role and were not happy with this; they wanted to remain as informal next-of-kin only.

[11] The New Mental Health Act: A Guide to Named persons. (2005) contains a sample *Declaration with regard to named person form* which can be signed by an individual to declare that a particular person should **not** be their named person.

The single non-related named person had held a non-clinical role at the hospital where the individual was a forensic patient on a rehabilitation ward. The individual was on a CTO and was estranged from family but had a long-standing connection with the person nominated to be named person.

Understanding of role

Whilst it is the duty of the MHO to both locate the named person and explain to them the named person role, this did not always come through clearly from the interviews. Just half of our interviewees (11) had some recollection of a professional or professionals talking to them to some degree about the named person role and most of those (9) referred to direct contact with an MHO. A handful referred to the role being explained by other social workers, medical or specialist staff, the rest felt they had not been asked or had the role explained to them. At least three people thought the first they heard about being the named person was when they received something through the post or had contact from a lawyer prior to the Tribunal.

Understandings of the named person role varied widely across several dimensions: from informal 'just like next-of-kin', being a 'friend' to the more formal 'representative' or even in separate instances 'an appointee' or an 'advocate'. Named persons spoke of 'looking after the well-being of', 'looking after the interests of', having the 'welfare at heart of' the individual in a role which faced both towards the unwell individual and towards the supporting professionals.

Taking an active role meant speaking or acting on behalf of the individual, to accompany them or attend meetings on their behalf particularly if they were unwell or not able. Support included filling in forms or trying to explain things to the individual in language they could understand. Others spoke of a more passive role of being there 'to be informed' of changes in the service user's circumstances, particularly changes in treatment. More than a quarter expressed a sense of being able to make decisions ***for*** the individual when they were too unwell to be able to do so. A couple, erroneously, seemed to think they had a strong say in decisions or even ***veto*** against decision they did not agree with.

The majority of named persons felt able to carry out the role and a small number already had or were seeking greater responsibilities as POA or Guardian. There were a number of unanswered questions such as 'can there be two named persons?' There were also concerns about what arrangements would be made when changes in their own health or personal circumstances meant they could no longer undertake the role.

We did not find much evidence of named persons receiving written information about the named person role, there was little recognition of the *Guide to Named Persons.* The internet was not accessible for all and there was limited reference to interviewees looking up material on the internet for themselves.

There was a very wide variation in the level of understanding of the compulsory order currently applicable to the service user and its implications.

Implications

We recognise the efforts made by MHOs to identify named persons and ensure that status and contact details are recorded in 2003 Act paperwork. For almost a quarter of records examined there was clear evidence that the individual subject to compulsory powers did not want a named person or that a potential family member was not suitable, capable or available to take on that role. However named persons' understanding of the terms 'nominated, default, appointed' and their own status was not always clear or did not always match the status recorded on paperwork and there was little evidence of signed nomination forms. We also note the wide range of family members taking on the named person role, most not living with the individual and some at a great distance away. Whilst most had taken on the role willingly at least one person interviewed had not given clear consent and others had not been fully clear about the extent of what might be expected from them.

We consider it essential that the MHO has a clear discussion with the proposed named person and that no assumption is made that they will automatically take on the named person role. The MHO needs to have a discussion with the proposed named person about the role at or before the point of detention, and as it can be very difficult for named persons to take in information at a point of crisis, that this discussion be revisited soon afterwards at a calmer time. The named person needs to understand and accept the role otherwise they may find they have signed up to more than they bargained for and that they are involved more than they wish to be. We found named persons could be better informed about the limits to the named person authority concerning decisions they could make. Named persons could also be better informed about the nature of the compulsory powers the service user was subject to.

Our response to the consultation supported proposals put forward for the Bill. We feel that our examination of records and the views of named persons interviewed is in line with the proposals for named person status to be made clearer, for an individual to only have a named person if they choose to have one, and that named persons should give written and witnessed consent to the role, The rationale for this is that this will enable the named person to discuss matters with the individual and obtain information about the role and responsibilities of a named person prior to their accepting the nomination.

The MHO should revisit the role periodically with both the service user and the person undertaking the named person role, to clarify the current circumstances and wishes of both to ensure that there is still a good fit and that all are happy with the arrangement.

The McManus report found that named persons found it difficult to obtain information about the role and what is expected of them. Our study found that this was still the case. We would like to see all named persons having access to written information on the named person role; online information will not be accessible by all. This is primarily the responsibility of the MHO but other mental health services could usefully signpost such information. The Guide to named persons will need to be updated in light of the Bill's amendments.

Experience of involvement and notifications

Why is this important

The named person has various rights and responsibilities, aimed at providing safeguards for the service user if compulsory measures are used or contemplated. A named person only has rights if:

- There is an application being made, or
- A certificate has been issued, or
- An order has been made

If the individual is being treated as a voluntary patient and there is no application pending for them to be treated under the Act, then their named person has no rights or powers.

The named person rights or "powers" in representing a service user subject to compulsory measures, appear throughout the Act. There are six different kinds of rights, and an example of each is listed below.

- to be consulted when certain things happen – such as when an emergency detention, a short-term detention or an application for a compulsory treatment order (CTO) or detention pending review of CTO (s.114) is being considered;
- to be notified when the service user's circumstances change – for example, if their short-term detention is revoked, where a certificate suspending the individual's detention in hospital is granted or if the individual is to be transferred to another hospital – notification of applications[12] and outcomes from the Tribunal;
- to receive copies of certain records or information which are given to the service user, including the record made if treatment has been given which conflicts with the individual's Advance Statement (if they have made one);
- to make applications or appeals to the Mental Health Tribunal for Scotland, and to speak and give or lead evidence at a hearing;
- to consent to two medical examinations taking place at the same time, if the service user is not capable of giving their consent to this (two medical examinations are needed when an application is being made for a compulsory treatment order);
- to ask for an assessment of the individual's needs from the local authority and/or Health Board[13]. This does not relate to the use of compulsion.

If an individual has to be treated under the Act any person involved in their care must take account of the views of the named person, where this is relevant to the discharge of those functions[14]. It would be best practice for the MHO to ensure that the named person's identity is made known to all those who have functions under the Act which include a duty to notify

[12] Guidance to Tribunal Administration No. 2/2010 (Revised 18 June 2014) The provision of documents in tribunal applications http://www.mhtscotland.gov.uk/mhts/files/members_area_files/PGN_Admin_2_2010_Provision_of_Documents_revised_18June2014.pdf

[13] A Guide to Named Persons (2005)

[14] Code of Practice Volume 1: Section1 (3) 2003 Act.

the named person of certain events[15]. The identified named person and contact details (or lack of named person) should be clearly recorded on the service user's medical record and space is available for this on the relevant forms.

In making a CTO application the MHO has a duty to ascertain the name and address of the patient's named person (Section 59) as soon as possible after the duty to make the application arises and notify the named person that the application is to be made (subject to section 60 (2)). With regard to the principles of the Act the MHO should consult and include the named person's views in the MHO's report and care plan. Once a CTO is granted the named person should be consulted at most points and be notified of changes of status.

The named person can appeal against compulsory orders (except emergency certificates) and any extension or variation. The named person can also appeal against the patient's transfer to another hospital, including to the State hospital.

The named person will generally receive full copies of all papers presented to the tribunal and is entitled to their own legal representative at the tribunal hearing[16].

An individual and their named person can act independently of each other. For example a named person can decide to make an application to a Tribunal on the individual's behalf without waiting for the individual to do so.

What we expect to see?

We would expect named persons to feel that they had been consulted by the MHO and other professionals, that their views had been noted and taken into account.

We would expect that named persons had been notified of any changes in the individual's status under the Act.

What we found

Practice of involving named persons appeared highly variable across practitioners and services. Around half of the named persons we spoke to felt positively involved and that their views were taken into account but for the rest experiences were mixed. Whilst the 'individual' availability and involvement of the MHO was appreciated by most a significant minority (7) suffered from lack of or inconsistency in MHO availability.

We found that most of the named persons felt clear about how to contact members of the mental health services if they needed to and that in turn they felt that services knew they were the named person and would contact them if needed. The few concerns expressed concerned delay in getting through to staff or delay in calls returned.

Around half the sample spoke positively about being invited to reviews. Efforts to involve people who could not attend by telephone were appreciated. However, on some occasions, named persons felt they were not party to important meetings.

[15] Code of practice, Volume 1 (p86)

[16] This is paid for on a free, non-means tested basis under the Assistance by way of Representation (ABWOR) scheme.

Practice of notifying named persons of changes in legal status and circumstances also appeared variable. Half the named persons we spoke to felt well notified about changes. Others felt less well informed, including at points of patient transfer, from one hospital to another or from hospital to a care home, or in one case where a person had been transferred to a nursing home updates from hospital had stopped. Late notification of specific incidents was also an issue.

We found a very wide range of understanding about what information a named person was entitled to receive, from no idea at all to 'all the information that's going'. About half those interviewed were fairly positive about paperwork received, finding it to be as expected and to arrive on time. Around half raised some issues concerning paperwork. The amount of paperwork received at a time of crisis could be a problem; it could be difficult to read, understand and take in so much, sometimes repetitive information. Occasional factual errors (e.g. wrong address, wrong initial) led to late arrival of paperwork. A sense that the named person's words had been misinterpreted and recorded in the written report could lead to upset.

Literacy was a key issue. Getting timely copies of paperwork meant named persons could go through it with individuals where needed. However in one example a named person asked another relative to go over the papers and so both became aware of sensitive information they previously did not know about. This was potentially information that the named person (and other relative) may not need to know and that may breach the individual's right to privacy.

Getting copies of documents meant there was a lot of 'paperwork' that the named person had to store in connection with the role.

Three quarters of named persons interviewed had attended one or more tribunals and for the most part practical reasons prevented others attending, including difficulties re travel, ill-health or work commitments. Whilst three quarters of named persons felt well-prepared for tribunals there was room for improvement in communication from MHOs prior to tribunals; there was some evidence of lack of understanding of the patient's solicitor's role. Tribunal paperwork largely arrived on time but late paperwork could lead to named persons feeling 'rushed'. There was more than one instance of named persons having sight of paperwork for the first time on the day of the tribunal and having to take time just before the tribunal to read it. Named persons interviewed largely found tribunals as anticipated and the less confident appreciated panel members' efforts to put them 'at ease'. Generally they felt well able to represent themselves, they put forward their views and felt they were listened to; use of legal representation for themselves was little thought of or used.

There was little discussion of the impacts of the named person role specifically. However living with a mentally ill person as a main carer could at times be stressful. Three named persons who were also primary carers reminded us of the importance of seeing them as an individual and taking account of how the situation was affecting them.

Implications

Named persons were not always kept informed of significant problems or incidents; this is especially important when they can have input that would be helpful. MHOs, and other

professionals, need to be well informed about their responsibilities for involving and notifying named persons at all stages and changes of compulsory measures.

Information and support for the named person can be an issue where the named person is different from the primary carer. Practitioners can be in a difficult situation knowing whether either or both should be informed or consulted in specific situations.

Information given to named persons can be overwhelming. Many need a lot of help to understand it. There is information going to the named person that may be unnecessary and may breach the individual's right to privacy under article 8 of ECHR. The McManus report recommended that the Scottish Government should draw up a Code of Practice for named persons, covering matters such as confidentiality. Such guidance covering the kind of notifications and content that named persons are entitled to would help all to understand the limits of the named person role.

More attention to preparation for tribunals, and the roles of all participants, would be helpful. MHOs should prepare service users for tribunals but attention to preparing named persons for tribunals needs to be proportionate and realistic; other members of the mental health team, particularly doctors and nurses have a role to play here.

Named persons who are also carers should be informed about Carer's Assessment[17] and locally available support for carers. Assessment may need to be revisited over time as the named person/carer's own circumstances change.

[17] The Community Care and Health (Scotland) Act 2002: Carers have a right to a separate Carer's Assessment of their needs for support in continuing to provide care

The named person role, other roles and forms of patient representation

Why is this important

We wanted to find out whether any named persons also held the roles of Welfare Power of Attorney or Welfare guardianship and if so how they perceived the interaction of the named person role with these other roles.

The 2003 Act introduced two other forms of patient representation alongside the role of named person: advance statements and independent advocacy. We were interested to find out how the named person role interacted with these other forms of representation.

Welfare Power of Attorney or Welfare Guardianship

Under the Adults with Incapacity (Scotland) Act 2000, if an adult is unable to make a decision to safeguard his or her own welfare, a court can appoint someone else to make decisions for them. This person is known as a welfare guardian. Guardians can be partners, carers, relatives or the chief social work officer (CSWO) for a local authority. Guardians can make decisions that can have a big impact on a person's life; for example, about where they live and how they should be cared for[18].

Whilst an individual retains the capacity to do so, he or she can appoint a power of attorney. Power of attorney gives a trusted person, often a family member or a solicitor, the power to make certain decisions or take certain actions on behalf of an individual, should that individual eventually lose their ability to make decisions for him or herself [19].

Any welfare guardian should take account of the named person's views and vice versa. The role of named person does not give power to make decisions on another's behalf but power of attorney does.

Advance statements

An advance statement is a written statement, drawn up and signed when the person is well, which sets out how s/he would prefer to be treated (or not treated) if s/he were to become ill in the future. It must be witnessed and dated. The Tribunal, any medical practitioner treating the person or a designated/delegated medical practitioner advising/reviewing a person's treatment, must have regard to an advance statement. If the wishes set out in an advance statement have not been followed the medical practitioner or the Tribunal must send to the patient, the patient's named person and the Mental Welfare Commission a written record giving the reasons for this.[20]

[18] Welfare guardianship (2013) Mental Welfare Commission for Scotland
http://www.mwcscot.org.uk/media/125133/guardianship_2014_update.pdf
[19] Working with the Adults with Incapacity Act (2007)
http://www.mwcscot.org.uk/media/51918/Working%20with%20the%20Adults%20with%20Incapacity%20Act.pdf
[20] A Guide to Advance Statements (2005) Scottish Government
http://www.mwcscot.org.uk/media/73229/a_guide_to_advance_statements.pdf

Once the advance statement has been witnessed the patient should give a copy to those who need to know about it, including the named person. The guidance suggests reviewing the statement each six months and certainly once a year.

Independent advocacy

Under the Act anyone with a mental disorder has the right to access an independent advocate. An independent advocate is able to give support and help to enable a person to express their own views about their care and treatment. [21]

An individual can have both an independent advocate and a named person but because their roles are different they cannot be the same person.

An independent advocate can give support and help the individual to express their views about care and treatment but cannot make decisions on the individual's behalf in the way that a named person can. An independent advocate can attend in a supporting role at a Tribunal but does not have the same rights as a named person to be consulted, informed or to make applications and representations to the Tribunal.

What we found

We found evidence of confusion or lack of clarity concerning the roles of advocate, named person, welfare guardian and welfare power of attorney. 'Financial' issues were mentioned in this context more than 'welfare' issues. The majority of named persons interviewed were unaware of the term 'advance statement', unclear or misunderstood what it might be. Understanding of the roles independent advocacy and legal representation varied widely

Implications

It was clear from our interviews that communication about the nature of these roles to named persons could be better. It is important that named persons have clarity over the extent and limits of powers and functions of each role.

The Commission already makes available guidance on the roles of Power of Attorney and Welfare Guardianship, independent advocacy, and advance statements. When named person guidance is revised in light of changes in the Bill we recommend that it makes reference to this and other relevant guidance.

The Mental Health (Scotland) Bill amendments (Section 21) provide for Health Boards to ensure that where they receive an advance statement this must be placed in the person's medical records and a copy must be sent to the Commission which will be required to keep a central register of advance statements which will be accessible by certain persons authorised by, or acting in connection with, the person who made the statement. This includes the individual to whom the advance statement relates and *"with respect to treatment of the person for mental disorder, by any individual acting on the person's behalf"* (Section 276C (2)b). The 2003 Act and guidance already makes provision for the named person to be given a copy of the advance statement and to be informed of any treatment authorised which conflicts with the wishes specified in the advance statement (Section 276(8)).

[21] A guide to independent advocacy (2005) Scottish Executive http://www.mwcscot.org.uk/media/73333/a_guide_to_independent_advocacy.pdf

Named persons' awareness of the Mental Welfare Commission

Why is this important

We wanted to know whether named persons were aware of, or had ever sought advice or guidance from the Mental Welfare Commission for Scotland, in relation to either their own named person role or concerning the individual they were named person for.

What we found

More than half the named persons had no awareness of the Commission. Others confused the Commission's name and function with that of other agencies, including 'complaints', the Mental Health Tribunal Service or other government or inspection agencies. One had contacted the Commission for advice.

Implications

The Commission should review the nature and accessibility of information available to named persons on the Commission's role and services.

The Commission should continue to seek involvement of carers and named persons during its visits to individual service users. It should also seek other routes to engage with named persons to ensure they are informed about their role and to monitor how the named person role is operating in practice.

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