Named persons

What is a named person?

01 In addition to their own rights to have their views heard, and to support and assistance, a patient's spouse or partner, relatives and carers may have an important role in mental health legislation in protecting the interests of a patient subject to compulsory measures, if they are chosen by the patient to be their named person under the Act.

02 The named person has particular powers and rights in relation to patients who become subject to compulsory powers, whether under the 1995 Act or the 2003 Act.

03 Broadly speaking, the named person has similar rights to the patient to apply to the Tribunal, to appear and be represented at Tribunal hearings (for example, concerning compulsory treatment orders, appeals against short term detention, review of compulsion orders etc.), and to appeal. The named person is also entitled to be given information concerning many compulsory measures which have been taken or are being sought, where this is provided for in the Act.

04 Generally, the role of the named person is to represent and safeguard the interests of the patient. The named person may be able to help the patient claim their rights by helping set out the patient's past and present wishes and feelings and by helping the patient be involved in, and understand, decision about their care and treatment.

05 However, the named person does not take the place of the patient in the way that, for example, a welfare guardian appointed under the Adults with Incapacity (Scotland) Act 2000 may be able to do so (depending on their powers). The named person and the patient are entitled to act independently of each other. For example, a named person can apply to the Tribunal for a review of the patient's compulsory treatment order with or without the patient's approval. Similarly, the named person is not the same as, nor does he or she replace, an independent advocate. The named person has the right to put his or her own view forward, even when the patient has a different view.

06 The principles of the Act require any person exercising functions under the Act (other than the patient and the parties referred to at section 1(7)(b) to (h) who might represent the patient) to take account of the views of the named person when making a decision or considering a course of action, where it is reasonable and practicable to do so. What is reasonable and practicable will depend on the individual circumstances of the case.

07 Where a patient has chosen to have a named person, at times when they come under the 1995 Act or the 2003 Act, the named person will be kept informed of the patient's status and can undertake certain functions for the patient. An exception is where the patient becomes subject to emergency detention. Their nearest relative must be

informed and, if the nearest relative does not reside with the patient, any person who resides with them must also be informed. The patient's named person must also be informed but only where the identity of the named person is known.

08 MHOs have certain duties in relation to identifying who the named person is. An MHO has a duty under sections 45 and 61 of the Act respectively to interview a patient when short-term detention or an application for a compulsory treatment order is being considered, unless it is impracticable to do so. Section 45(1)(b) of the Act states that the MHO must, where practicable, ascertain the name and address of the patient's named person before deciding whether to consent to the granting of a short-term detention certificate. Identifying the patient's named person may necessitate discussion with the medical practitioner who is considering granting the detention certificate and/or other relevant professionals as to whether the patient already has a named person, or where this is not the case, whether the patient has the capacity to nominate a named person.

09 Section 255 places a duty on a mental health officer, 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 1995 Act, in relation to the patient and it is necessary for that purpose to establish whether the patient has a named person.

10 Section 61(2)(c)(i) of the Act states that the MHO must inform the patient of their rights in relation to the application for a compulsory treatment order. It would be best practice for the MHO, when undertaking either of these duties, to provide the patient with such information on the role of the named person as suits the patient's needs to support them in making a decision in relation to having a named person. It would be best practice for the MHO to discuss with the patient the process and effect of nominating and revoking a named person under section 250 of the Act as well as the implications of not having a named person. The MHO might do this by explaining these issues to the patient orally and with a follow-up leaflet. The MHO should make use of any resources available to help patients understand the role of the named person, including those suitable to the patient's individual circumstances. The MHO (and others in the care team) may need to discuss the named person role with the patient on more than one occasion, over a period of time. Where the patient initially chooses not to have a named person or does not have capacity to make such a decision early on, then it would be best practice to discuss this with the patient at suitable future opportunities.

11 It would also be best practice for the MHO to explain to the patient what will happen if they do not nominate a named person. This would include explaining the abilities of the listed initiator (see below) should the patient not have capacity to make applications or appeals to the Tribunal on their own behalf. The MHO will consequently also need to explain the difference between the roles of the named person and the independent

advocate. An independent advocate would enable a patient to have his or her voice heard and views taken into account, provide support and information to allow the patient to make informed choices, and assist the patient to put these views forward.

Who can be a named person?

12 The named person must have attained at least 16 years of age. While the Act does not prevent it, it is expected that the named person will not be someone with a professional relationship with the patient, such as a doctor/patient relationship, or anyone who works to deliver care or treatment to the patient, as it could create a conflict of interest. However, a person working in a related role but not responsible for the patient's care or treatment, for example a residential housing worker might be approached to act as named person and may feel reluctant to decline where the patient has not chosen a carer, relative or friend. A person working in such circumstances may feel that he or she has a duty of care and may wish to accept the named person role, to ensure the patient has a named person, but may also feel that a conflict of interest arises. For example, if an application for a community-based CTO were to be made specifying the service as part of the care plan, then the support worker acting as named person could feel that a conflict of interest had arisen between their work role and their role as named person. It may be that the patient would benefit from the assistance of an independent advocate, and this should be explored before agreeing to act as named person where a perceived conflict of interest may arise. It would be best practice for anyone working in a support role who wishes to undertake the named person role in circumstances like these to discuss the nomination with the patient's MHO with a view to identifying and preventing any potential difficulties. It would be best practice for a person in circumstances such as these to seek guidance and support from their employer before agreeing to act in the named person role.

When a named person should be given information

13 Once someone has been nominated to be a named person, they must agree to taking on the role in writing. It would be best practice for the MHO, or any other practitioner discussing this with the potential named person, to ensure that they are provided with information about the role in a form which is helpful to them. This is likely to be presented both orally and in written form. It would be best practice to provide information to the named person about their rights and the patient's rights. It would also be best practice to explain the role the named person can play in supporting the patient to make and be involved in decision and in helping the patient claim their rights.

14 On all occasions where a named person is being nominated, the MHO should consider the impact on the nearest relative/primary carer where they are not nominated as the named person. This could be achieved by explaining to them the role of the named person and the rights of any relatives or carers who are not nominated as the patient's

named person. It would be best practice to explain the section 1 principles about the views and involvement of carers and any rights under carers legislation.

The named person's role and powers

15 The Act confers on the named person certain powers and rights which will come into effect usually when the patient becomes subject to a short term detention order, a compulsory treatment order or a compulsion order under the Act. The named person also has rights under the Act to receive information where a patient has been made subject to an emergency detention certificate or detained by way of the nurse's holding power at section 299. In addition, section 1(3) provides that a person who is discharging functions under the Act should take into account the views of the named person where this is relevant to the discharge of those functions.

16 The MHO will need to be very familiar with the procedures regarding the nomination process of the named person and should make sure that the named person is fully aware that they have been nominated as named person and the process for agreeing to take on the role. It would also 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 the named person of certain events, including the Tribunal.

17 The MHO is required under the principles of the Act to take into account the views of the named person, any carer, any guardian and any welfare attorney. However, when ascertaining the identity of the named person, the primary carer or the nearest relative, the MHO should be careful to respect the patient's rights with respect to confidentiality.

18 Under section 255 of the Act, the MHO is under a duty to make an application to the Tribunal where a named person has been identified but, in the opinion of the MHO, that person is unsuitable to act as the patient's named person. The application will be for an order to remove 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 be inappropriate to act for example if he/she bullies the patient or lacks capacity. If the MHO has concerns for the patient's safety and welfare if they share information with the named person because they have concerns that the named person is inappropriate, then the MHO may wish to make an application under section 255. A named person who is or has been a mental health services user is not to be automatically deemed inappropriate to act.

19 The expectation is that the patient's right to choose whom they wish to have as a named person would be respected. The MHO has no power to veto the patient's choice at the time of nomination, nor should they apply undue influence on the patient. The MHO should intervene using the powers at section 255 only where there are clear and significant reasons for doing so. It would be best practice, if appropriate, to seek the patient's views and the views of the carer before such application. Under section 256, a

range of other people may also apply to the Tribunal for an order under section 257, if they consider that the named person is inappropriate. The Tribunal will not appoint a replacement named person and the patient will only continue to have a named person if the patient chooses another person to act in the role.

Nomination of named person

20 Section 250 of the Act sets out the process for nominating a named person. A patient aged 16 or over may choose an individual to be their named person. The nomination may be made whether or not the patient is, at the time, the subject of compulsory measures under the 1995 Act or the 2003 Act. The patient must have the capacity to understand the decision they are making and its effects, and have not been subject to any undue influence. Practitioners involved with the patient's care should take all reasonable steps and provide as much appropriate information as possible to support the patient in exercising their capacity to make and understand this decision.

21 To be valid, a nomination must be signed by the patient making it and witnessed by a prescribed person. As the named person must agree to take on the role, it would be advisable for the patient to check whether their desired named person is willing to act in that role, prior to making the nomination. The prescribed person must witness the patient's signature of the nomination and must certify that the patient making the nomination understands its effect and has not been subject to any undue influence. The Act does not define undue influence. However, helping a patient to understand the choices they have in relation to nominating their named person would be likely to be reasonable, whereas persuading a patient to nominate a particular person is unlikely to be so. A nomination remains valid if the patient who made it subsequently becomes incapable.

22 Under section 250(4) of the Act, a nomination may be revoked by the patient who made it provided that the revocation is signed, and witnessed by a prescribed person who certifies that the patient revoking the nomination understands its effect and has not been subject to any undue influence. Where the prescribed person cannot certify that the patient understands the effect of their nomination or revocation, and/or has not been subject to any undue influence, the prescribed person may decline to act as witness. It would be best practice then for the witness, if the patient so requests, to assist the patient to identify another prescribed person to act as witness.

23 The nominated named person must agree in writing to act as the named person. This agreement must also be witnessed by a prescribed person. It would be best practice for the prescribed person witnessing the agreement to confirm that the named person understands what the role entails.

24 It will be important that the patient's named person is identified, wherever practical, in a patient's case notes and on correspondence between general practitioners and hospital managers. Such case notes could include the patient's primary care notes held by his or her general practitioner, by secondary care services such as a community mental health team, or by hospital managers. The named person should be made aware of this and of the purpose of this record by the healthcare professional who includes the information into the patient's case notes. If the patient has not chosen to have a named person, this should be noted instead. Where a named person is not identified in the case notes, and other care colleagues have indicated that they have no such record, the MHO should be contacted to ascertain whether they know who the patient's named person is or whether any further action to identify the named person is necessary. It would be best practice to notify the Tribunal of any change to the named person, including where a named person chooses to no longer act or the patient revokes a nomination.

25 It is important that the information in the nomination is clear and reflects the patient's wishes, whatever language or form of communication is used. It would be best practice for any person discharging functions under the Act to offer assistance in contacting the relevant service where the patient appears to require interpretation and translation assistance.

Witnessing a nomination and agreement

26 The nomination by any patient of their named person must be witnessed by a prescribed person. The prescribed person must be able to assess and declare that in their opinion the patient making the nomination understands the effect of nominating a named person and has not been subjected to any undue influence in making the nomination. This is important to ensure the nomination is recognised as valid.

27 The named person must also agree to take on the role in writing and this must also be witnessed by a prescribed person. Regulations made under section 250 and 253 of the Act (The Mental Health (Patient Representation) (Prescribed Persons) (Scotland) Regulations 2017) provide that any of the following persons may act as a witness:

- persons providing independent advocacy services;
- medical practitioners;
- arts therapists, dieticians, occupational therapists, physiotherapists, practitioner psychologists and speech and language therapists (if registered with the Health and Care Professions Council);
- persons employed in the provision of, or managing the provision of, a care service;
- registered nurses;
- social workers; and
- solicitors.

28 The role of the witness is to certify that the patient can make a valid statement, not to scrutinise, veto or endorse the nomination.

29 However, if the prescribed person has concerns about the person being nominated to be the named person, or has concerns about undue influence, then it would be best practice to discuss these concerns with the patient, if appropriate. The practitioner should approach this using the rights and principles in section 1 of the Act, and in a way that supports the patient to make a decision as far as possible, and gives the patient as much autonomy as possible. In such circumstances, best practice may involve providing as much information to the patient as possible, only raising concerns if it is of maximum benefit to the patient and seeking the views of any carer, welfare guardian or welfare attorney as appropriate.

30 It would be best practice to seek the agreement of the named person and for them to certify their agreement as soon as possible after nomination. The named person may not reside in the same local authority area or health board area as the patient. Local authorities and health boards may wish to consider protocols for mutual assistance where an MHO or health practitioner local to the nominated named person witnesses their agreement to take on the role instead of the patient's MHO or someone involved in their care travelling for this purpose.

The named person may decline to act

31 A person nominated to act as named person can decline to act at any time, either by declining to accept the nomination in writing or giving notice that they no longer wish to act as the named person to the nominator and local authority for the area in which the patient who nominated them resides. If they consider that there might be a conflict of interest in continuing in this role then the person should give serious consideration to declining to act as the named person. For example, if the independent advocate has been nominated as named person (without consultation), the independent advocate should decline to act, as there are differences between the two roles which could cause confusion were the same person to fulfil both roles.

32 It would be best practice for any professional who is informed that the patient's named person is no longer acting in that role, to ensure that the patient's MHO (or if the patient does not have a designated MHO, the local authority for the area in which the patient lives) is notified of this. Where the MHO, or other party such as the RMO, is notified that the named person will no longer act in this role, it would be best practice to ensure all those with any duty which involves the named person, including the Tribunal, are made aware that there has been a change and to ensure that updates are made to any records which list or identify the named person.

Revocation

33 The patient may revoke a nomination at any time. Any revocation must be signed by the patient and witnessed. The witness, as with the nomination process, must certify that in their opinion the patient understands the effect of the revocation and that they have not been subject to any undue influence. Where an MHO is made aware that the patient has revoked their named person nomination, they should discuss with the patient whether they wish to appoint another named person. Where they do not, the MHO should explain the implications of not having a named person.

The Tribunal's powers in relation to the named person

34 The Tribunal has powers under section 257 to make certain orders about named persons, where an application under section 255 or section 256 has been made. Where a patient is under the age of 16 and has no named person, the Tribunal has a power to make an order appointing a specified person to be the patient's named person. The Tribunal also has the power to make an order declaring that the acting named person is not the named person and, where the patient is under the age of 16 specifying someone else to be the named person in that person's place. The Tribunal may make such order as it thinks fit. However, it cannot appoint a child under 16 to be a patient's named person.

The listed initiator where there is no named person

35 A patient may choose not to have a named person or may not have the capacity to make such a decision. The Act makes provision in such circumstances to ensure that the patient does not lose their right of application or appeal to the Tribunal if they are incapable of instructing a solicitor.

36 Section 257A of the Act provides for the circumstances where the patient does not have a named person, and is incapable of making a decision to initiate an appeal or application in relation to their case. In such a case, a 'listed initiator' can make the application or appeal on behalf of the patient. The listed initiator is any relevant welfare guardian or welfare attorney, the patient's primary carer and the patient's nearest relative. The welfare guardian or welfare attorney can also be notified of certain events. If the patient chooses not to have a named person, it would be best practice to explain to the patient that the listed initiator may act in such a way. The patient may also choose to preclude their primary carer and/or nearest relative from acting in such a way by making a written declaration. If such a written declaration is made, it would be best practice to make the MHO aware of this and to inform the Tribunal so that they are aware that an application from these persons is not valid.

37 The listed initiator will need to demonstrate that they have the ability to act in this situation. The Mental Health Tribunal for Scotland (Practice and Procedure) (No. 2)

Amendment Rules 2017 set out that the application or appeal to the Tribunal must be accompanied by:

- A written statement from an AMP confirming that in the opinion of that practitioner the patient is incapable in relation to a decision as to whether to initiate an application or appeal;
- A written statement from the person making the appeal that the patient is 16 and has no named person; under which circumstance(s) they are able to act as the listed initiator (i.e. whether they are the welfare guardian, welfare attorney, primary carer or nearest relative); and that the patient has not made a written declaration stating that they are not to act in this role (if the primary carer or nearest relative).

38 It is expected that in most cases, the RMO will be the AMP who provides the written statement. However, the listed initiator is able to seek a statement from an AMP other than the RMO, including if the RMO disagrees and declines to provide the statement.

39 The listed initiator is not a role in the same way that the named person is. It is simply an ability to act in certain circumstances. Once the listed initiator has made the application or appeal, the Tribunal Rules set out that the Tribunal may appoint a curator ad litem to lead the case, and the listed initiator is not an automatic party to the Tribunal in the way that a named person is. There is no statutory requirement to notify or involve the listed initiator in the same way as the named person, with the exception of a small number of notification requirements for the welfare guardian and welfare attorney. However, any relevant function under the act should still be carried out in line with the section 1 principles around having regard to the views of the carer, the needs and circumstances of the carer and of providing such information to the carer as to allow them to care for the patient.

40 Where there is no named person, it would be best practice for the MHO or other practitioners to explain to any persons known to them who could take action as the listed initiator, in particular those closely involved with the patient's care, of this ability to act. It would also be best practice to set out how they can make use of this ability to help the patient claim their rights, for example by initiating an application when they feel that this would be in line with the patient's past and present wishes and feelings.

41 Interaction with those able to act as a listed initiator will depend on individual circumstances, having regard to the patient's right to confidentiality and to the section 1 principles. There is no requirement under the Act to search out a nearest relative where it is not evident or to involve someone where it might be harmful to the patient to do so, for example where the practitioner is aware that the patient does not want the individual to be involved in their case.

42 Any decision about contacting or involving a listed initiator should be made by considering how this will best realise the patient's rights in line with the section 1 principles. The practitioner should seek the patient's views if possible, and act in line with any past or present wishes or feelings expressed by the patient as far as possible. The practitioner should base such a decision in what they consider to be of maximum benefit to the patient and should also ensure that any action is comparable to the action they would take for a non-patient, unless necessary in the circumstances. Where notification is not mandated under the Act, and the listed initiator has a right to apply or appeal to the Tribunal, the practitioner should consider, in line with the principles above, making the listed initiator aware of the decision and of this right.

43 The table below sets out some of the differences between the named person and listed initiator. This is not comprehensive but is designed to show that the listed initiator is an ability to act, unlike the named person which is a role, with much wider rights under the Act. The listed initiator has that ability because they hold another role such as welfare guardian or carer. Any rights or duties under the Act that relate to their other role do not fall away because they also initiate an appeal.

Comparison between named person and listed initiator		
	Named person	Listed initiator
Section 1 principle to take into account views	Yes	No
Range of notification requirements	Yes	No
Consultation before treatment	Yes	No
Ability to make an application or appeal to the Tribunal	Yes	Yes
Party to Tribunal hearings (including attending and receiving papers)	Yes	No

Named persons for patients under 16 years of age

44 Where the patient is a child under 16, the child cannot nominate a named person. The Act makes provision at section 252 for the person with parental responsibilities in

relation to the child, or the local authority where the child is looked after by the authority, to be the named person. Where parental responsibility is shared, the relevant parties may decide between themselves who will act as the named person. If those parties do not agree, the named person will be the one of them who provides the most care and support for the child (or who did before a child was admitted to hospital). In any other case the child's primary carer (who must be 16 years or over) shall be the named person.

45 The MHO and certain other persons listed in the Act have a power to apply to the Tribunal for an order under section 256. This applies where the patient has no named person; the apparent named person appears to the applicant to be inappropriate to act in that role; or such other circumstances as may be prescribed in regulations made by the Scottish Ministers.