mental welfare commission for scotland

Advance statement overrides monitoring report 2021-2022

Statistical monitoring

January 2023

Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Contents

Summary

1. Advance statements about mental health treatment are powerful ways of allowing the voice of a service user or patient to be heard at times when they may be so unwell that, despite support, they cannot do this. Advance statements may contain views about what a person wants or does not want in their mental health treatment. However sometimes Advance Statements are overridden. We call these advance statements overrides (ASOs).

2. The Commission should be notified when a patient is being treated under the Mental Health Act, and their advance statement is overridden. We receive notifications from responsible medical officers (RMOs - treating psychiatrists), designated medical practitioners (DMPs - Mental Health Act second opinion doctors) and Tribunals.

3. The Commission monitors advance statement overrides (ASOs). We implemented changes to our ASO monitoring processes from 1 November 2021. The aim is to focus resources on more robust, timeous monitoring of ASOs that have not been subject to any external scrutiny by a designated medical practitioner[1], and on follow up that is more beneficial to patients.

4. In this report we present the data on:
   - the number of ASOs the Commission was informed about between 1 November 2021 – 31 March 2022;
   - ASO situations where a patient did not have their treatment authorised under a T2 form with their consent, or a T3 form issued by a DMP with an ASO notification;
   - and the actions the Commission took in some of these cases.

5. The Commission received 72 advance statement override (ASO) notifications between 1 November 2021 – 31 March 2022. Some patients had several ASO notifications made to us. The Commission's policy is to undertake ASO monitoring of overrides of AS wishes relating to medication, ECT and artificial nutrition ('core treatment' ASOs). 44 individuals had a core treatment ASO.

6. The most common ASO related to an AS wish not to receive medication(s) (39 people).

7. A Commission medical officer checks the ASO notification. We undertake full ASO monitoring for ASO notifications that are: made by RMOs or the Tribunal; relate to artificial nutrition, ECT or medication, and the patient does not have a valid T2 or T3 with an ASO notification that authorises that treatment type. For these case we determine whether we are satisfied that the treatment decision in conflict with the patient's advance statement was clinically justified. We undertake follow-up action that we determine appropriate in order to arrive at a view.

[1] A DMP is a psychiatrist appointed by the Commission who checks that particular safeguarded treatments are appropriate and lawful.

8. We undertook full ASO monitoring for 17 patients. We were satisfied that the treatment decision(s) that had been made that were in conflict with the patients' advance statements were justified in all but one case[2].

9. As in our previous reports, most of our follow up from ASO monitoring in this period was in relation to issues with advance statement management e.g. advance statements being overlooked and not being seen by Tribunals or DMPs, or missed ASOs. We are concerned that such situations continue to arise, where the patient does not benefit from legal safeguards of the advance statement provisions. We found that three people had received medication without a T2B or T3B in place to authorise it i.e. outwith the authority of the Mental Health Act. We have followed up these cases.

10. The Commission has informed the Scottish Mental Health Law Review that published its final report at the end of September on work on advance statements (prevalence) and the reasons for overrides and our views on what needs to change in order to ensure that the safeguard works better. Our views and recommendations on how to make advance statements work better can be found in our reports on the prevalence of advance statements[3], a specific report on advance statements in forensic settings[4] and in our consultation response on advance decisions to the Scottish Mental Health Law Review.[5]

[2] (That situation involved the frequency of administration of the treatment rather than the choice of treatment. The patient wrote a new advance statement without the wish that was overridden and there was no longer an ASO.)
[3] T3-AdvanceStatements_2021.pdf (mwcscot.org.uk),
[4] (PDF) Advance statements in forensic mental health services in Scotland (researchgate.net)
[5] https://www.mwcscot.org.uk/node/1773

Chapter 1 - Introduction

The Mental Health (Care and Treatment) (Scotland) Act 2003[6] ('the Act') allows an individual to make a written statement when they are well saying how they wish to be treated (or not treated) if they become unwell in the future, and their ability to make decisions about their treatment becomes impaired.

This document is called an 'advance statement' (AS). This is an important way for individuals to be able to increase their participation in their care and treatment, and make their wishes known, if they need compulsory mental health treatment in the future and have reduced capacity to make decisions about medical treatment at that time despite appropriate support.

The Act requires a doctor, or Mental Health Tribunal, to have regard for a patient's advance statement if they are making decisions about their treatment under the Act. If they decide that they need to authorise a treatment that conflicts with the patient's advance statement, this is commonly known as an 'advance statement override' (ASO).

When an ASO decision is made, the doctor or Tribunal is required to notify the patient, any named person, and the Commission of the reasons for this.

At the Commission, we undertake monitoring of ASO notifications that we receive to check that ASO treatment decisions are necessary, and that adequate reasons are given for these (the Commission determines the process for monitoring notifications within the organisation's resources. This is not one of our statutory duties however in keeping with our mission of protecting rights and in order to be able to monitor legislation and influence reform we undertake this process).

We implemented changes to our ASO monitoring processes on 1 November 2021 in order to provide more timeous review of overrides wherever possible. We provide more information about this in this report.

Advance statements and how they are made

Section 275 of the Act sets out what an advance statement is, and how to write a valid advance statement.

An advance statement is a written statement in which the individual can include wishes about how they want to be treated if they become unwell in the future, and/or ways in which they do not wish to be treated. An advance statement can only include wishes about mental health treatment.

Section 275 says that an advance statement specifies wishes about treatment in the event that the person becomes "mentally disordered" and their ability to make decisions about those treatment matters becomes significantly impaired.

The writer must be capable of making these wishes at the time they write their advance statement. The Act requires that the statement is signed by a witness who confirms this.

The legal requirement for professionals to have regard for the advance statement applies if the individual is being treated under the Act (section 276 contains these provisions).

[6] https://www.legislation.gov.uk/asp/2003/13/contents

The Commission has published advance statement guidance for individuals (*Advance statement guidance; My views my treatment*[7]) and professionals[8]. This, and other useful information about advance statements, is available on our advance statement webpage[9].

In our guidance, we recommend that an advance statement can contain the individual's views about:

- Whether or not they wish to be treated in a hospital or in the community
- Which forms of medication they do or do not want to receive and why
- Which other forms of therapeutic intervention they do or do not want to receive and why
- An individual may wish to record other preferences they have for aspects of their care plan in a personal statement that can accompany an advance statement.
- If a person wishes to withdraw an advance statement, they need to do so in writing and a witness must certify that they are capable of deciding to do this.

The advance statement register

When an individual writes an advance statement, they should give a copy to their doctor. The doctor should ensure that health board procedures are followed to place the advance statement with the individual's medical records.

The Act requires the health board then to send information to the Commission about the existence of the advance statement, and where it is kept. They should do this by sending the Commission an ADV1 form[10].

The Commission then adds the advance statement information to the advance statement register. We should also be informed when an individual withdraws their advance statement. We then update the register.

People can access the register to see if a patient has an advance statement, including: the patient themselves; a person acting on their behalf (e.g. a solicitor or named person); their mental health officer (MHO); their responsible medical officer (RMO); or the health board responsible for their treatment.

ASO decisions and notifications of these

Sections 276(7) and 276(8) set out requirements that must be complied with in circumstances where a decision is made to provide a patient with treatment under the Act that is in conflict with wishes specified in their advance statement.

[7] https://www.mwcscot.org.uk/sites/default/files/2019-06/advance_statement_guidance.pdf
[8] https://www.mwcscot.org.uk/sites/default/files/2019-06/advance_statement_guidancesep2018revision.pdf
[9] https://www.mwcscot.org.uk/law-and-rights/advance-statements
[10] https://www.gov.scot/publications/mental-health-law-forms/

Circumstances in which an advance statement might be overridden, and those responsible for making the decision to override, are:

- The Tribunal, if it makes a decision to authorise measures which conflict with the wishes specified in the advance statement.
- *A 'person giving medical treatment'*, if they make a decision to give, or not give, treatment and this is in conflict with the wishes specified in the advance statement. (This would usually be the RMO.)
- A designated medical practitioner (DMP)[11], if they make a decision regarding treatment that is in conflict with wishes in the advance statement. This may be: a decision to issue a certificate authorising treatment that the patient stated in their advance statement that they did not wish to receive; or a decision not to authorise treatment that the patient stated in their advance statement that they wanted to receive.
- The Tribunal, or person, who is considering whether an ASO is necessary, must have full regard for the advance statement and the principles of the Act. Particularly, if they decide that this is required, the measures or treatment must provide maximum benefit for the patient and be the least restrictive option for them.

Where an advance statement is overridden, the Tribunal or person who made the ASO decision must justify this, and record in writing the circumstances and the reasons for their decision. They must send a copy of that record to the patient, their named-person (if they have one), the Commission, and any welfare attorney or guardian. A copy of the written reasons must be placed in the patient's medical records.

We call the records of reasons, and this being sent to the people who must receive it, "making notifications".

Where the Tribunal records that the person is receiving treatment, or measures are authorised, in conflict with their advance statement, the Commission receives notification of this on the Mental Health Act forms that the Tribunal completes, and in their full record of the Hearing (the "Full Findings and Reasons").

When we receive notifications from a Tribunal that a patient is receiving medication in conflict with an advance statement, we review this as if it was an ASO notification. We include this in our ASO monitoring figures if we feel that the treatment in question represents a true ASO situation for the patient.

However, we recognise that, while a Tribunal's decision to authorise measures may have the consequence that that there is a conflict with the patient's advance statement medication wishes, the Tribunal's decision to authorise treatment does not authorise a specific medication or other treatment. The choice of medication/ treatment is a matter for the RMO to decide (and a DMP, where required).

If the responsible medical officer (RMO) or a DMP is making a notification of an ASO, we advise that it is good practice for them to do this in the form of a letter of explanation to the patient, copied to other people who need to receive it, including the Commission. We consider

[11] A designated medical practitioner (DMP) is commonly known as a Mental Health Act second opinion doctor. A DMP is an independent psychiatrist. A patient who is subject to the Act may require to be visited by a DMP to decide whether to authorise treatment that the patient is incapable of consenting to, or refuses to consent to. (NB a patient who is capable of making a decision to refuse ECT cannot have ECT authorised under the Act).

that this is a good, person-centred way to do this. The letter should be individualised and written in the most appropriate way for the patient's information. A DMP also records the reasons for the ASO on the T3 form[12] that they complete to authorise treatment (and the Commission receives a copy of that too).

Review of advance statement overrides by the Commission

The Commission independently reviews notifications of ASOs that we receive in respect of wishes regarding:

- Medication
- ECT and;
- Artificial nutrition.

We refer to these as "core treatment ASOs".

This monitoring is undertaken by a Commission medical officer.

The Commission previously aimed to review all core treatment ASO notifications that we received. ASO monitoring by the Commission is not a statutory duty and we do not have specific resources for this. Due to increasing numbers of ASOs and resource issues, a lot of the ASO monitoring work that we undertook in the past was quite retrospective – this meant that we were sometimes reviewing advance statement overrides for patients who were no longer in hospital or being treated under the Act, or who had regained capacity to determine their choices. For some years we were behind with the ASO monitoring that we aspired to do. This situation continued due to other pressures on Commission medical staff time, including our response to COVID-19.

We previously published a detailed report of our ASO monitoring for 2017-18 and 2018-19[13]. Where we sought more information about ASO decisions, we were satisfied from our enquiries that the actual treatment decisions made were justified.

Where we had concerns, these were often about advance statement management issues, other events we saw in the patient's detention history where their advance statement was overlooked and not regarded (e.g. Tribunals, DMP visits), or issues with authority for their treatment.

In 2021 we reviewed our ASO monitoring procedures. The aim is to focus resources on more robust, timeous monitoring of ASOs that have not been subject to external scrutiny by a DMP, and on follow up that is more beneficial to patients. We wish to move to real-time ASO monitoring.

[12] A T3 form is a statutory form that a DMP completes as their certificate to authorise treatment under the Act that the patient is incapable of consenting to receive, or does not consent to receive. A T3A is for ECT (NB ECT can only be without the patient's consent if they are incapable of consenting). A T3B is for medication after 2 months of treatment or, (needed from the outset), medication to reduce sex drive or artificial nutrition.

[13] https://www.mwcscot.org.uk/sites/default/files/2021-02/ASO_report_Feb2021.pdf

We implemented a more targeted process focussing on:

- ASO notifications from RMOs.
- Other ASO notifications from which we identify that the patient may be being treated without a DMP having had regard for an advance statement (that was in place when they issued a T3A or T3B form).
- Situations where treatment may not be properly authorised (if a T2[14] or T3 form would be required to authorise the treatment and we do not have a form).

We now undertake full ASO monitoring for core treatment ASO notifications that are:

- RMO notifications.
- Medication or ECT ASOs recorded by the Tribunal where we do not have: a valid T3 form for the treatment type with an ASO notification; or a T2 form authorising that treatment type.
- Artificial nutrition ASOs.

We take no further action where:

- The ASO notification has been made by a DMP on a T3A form for ECT or a T3B form for medication.
- The ASO has been recorded by the Tribunal for ECT or medication and we have: a valid T3 form for the treatment type with an ASO notification; or a T2 form authorising that treatment type. (A current T2 or T3 at the time of ASO monitoring, issued before or since the Tribunal.)
- A medication ASO is an override of a request for a treatment, not a refusal.
- The ASO notification is in respect of non-core treatment wishes ("other treatment wishes").

When we undertake full ASO monitoring:

- We obtain a copy of the advance statement, review the content, and check that it is properly completed, witnessed and valid.
- For RMO ASO notifications or artificial nutrition ASOs, we determine whether we are satisfied from the explanation that the ASO was clinically justified. If we need more information about the treatment and the ASO to help us make this decision, we ask for this (usually from the patient's RMO or a DMP who has issued a T3B).

[14] A T2 is a statutory form that the RMO completes as their certificate to authorise treatment with medication under the Act that the patient is capable of consenting to receive, and has given written consent to receive. A T2A is for ECT. A T2B is for medication after 2 months of treatment or, (needed from the outset) or medication to reduce sex drive. A T2C is for artificial nutrition (this is a non-statutory form).

For Tribunal ASO notifications where a patient does not have their treatment authorised under a T2A or T2B form with their consent, or a T3A or T3B form issued by a DMP with an ASO notification:

- We review the information we have about the ASO.
- We determine whether we are satisfied from the explanation that the ASO treatment decision was clinically justified. If we need more information about the treatment and the ASO to help us make this decision, we ask for this.
- We review the circumstances of why a T3 that authorises the treatment has no ASO notification (e.g. if the DMP was not shown the advance statement).
- We take follow-up action that we determine appropriate. This may include arranging another DMP visit for the DMP to have regard for the advance statement.

If, following this, the Commission were to reach the view that the ASO was not justified, the Commission would consider what action to take and write to the patient and relevant others to inform them of our actions and the outcome

Chapter 2: Our findings from our ASO monitoring 1 November 2021 to 31 March 2022, and recommendations

Advance statement override notifications received

We received 72 notifications of ASOs.

Table 1 shows the numbers of these notifications that were made by RMOs, DMPs and Tribunals.

Table 1: ASO notifications made to the Commission, 1 November 2021 – 31 March 2022

ASO notifications made by	Overall number	Types of ASO notification
Mental Health Tribunal	56	40 - Medication (two also had ASOs of an "other treatment wish")
		1 - ECT
		2 - Wish to have a particular medication (one also had ASO of an "other treatment wish")
		13 - ASO of "other treatment wish" only
DMP	13	10 - T3B - medication
		3 - T3A - ECT
RMO	3	3 - medication
Total notifications	72	

The total numbers of ASO notifications mentioned above include more than one ASO notification for some individual patients.

We did not receive any ASO notifications regarding artificial nutrition.

Individuals with ASO notifications

We received one or more ASO notification for 54 people

Table 2: Types of ASOs for individuals, 1 November 2021 – 31 March 2022

ASO type	Number of people	
Medication ASO	39	(two also had ASO of an "other treatment wish")
Wish to have a particular medication	2	(one also had ASO of an "other treatment wish")
Wish not to have ECT	3	
ASO of an "other treatment wish" only	10	
Total	54	

Table 3: Medication ASO notifications from the Tribunal and DMPs for individuals, 1 November 2021 – 31 March 2022

ASO notification from:	Number of people
Tribunal notification(s) only	29
DMP (T3B) notification only	6
Tribunal notification(s) and DMP (T3B)	4
Total	54*

**Three of these individuals had a medication ASO notification made by their RMO as well.*

ASO monitoring and follow-up

ECT ASOs

The three patients for whom we received ASO notifications in respect of ECT all had their treatment authorised by a DMP under a T3A form with ASO notifications. Our ASO monitoring policy is not to undertake full ASO monitoring for these ASO notifications as external independent scrutiny has been undertaken by a Commission appointed DMP.[15]

Medication ASOs

ASO notifications made by DMPs on T3B forms

We received medication ASO notifications from DMPs on T3B forms for 10 people. Our ASO monitoring policy is not to undertake full ASO monitoring for these ASO notifications.

However, we noted matters that we followed up for two of these patients.

In one case the DMP saw and regarded an AS dated 2012, but there was a more recent AS dated 2016.

For the other patient we looked at the T3B in detail when we reviewed a Tribunal AS notification. We found that, while the DMP had notified one ASO decision, the T3B authorised another medication in conflict with the patient's AS. We have included more details of this case in our sections on follow-up for patients with Tribunal medication ASO notifications and a valid T3B with ASO. (For more details of this follow-up, see the Appendix, Table 8.)

In our report on advance statements in forensic settings (reference above) we raised concerns about the issues that can arise when more than one advance statement exists as has occurred in the first example above and we recommended that Scottish Mental Health Law Review introduce a statutory review period for advance statements.

Medication ASO notifications from the Tribunal

We received medication ASO notifications from the Tribunal for 33 people.

Six of these people had a T2B in place to authorise their treatment, and 12 had a valid T3B form authorising medication with an ASO notification. Our ASO monitoring policy is not to undertake full ASO monitoring for these ASO notifications.

[15] However, we did undertake follow-up for one of these patients. This was in relation to their advance statement not having been signed by the witness. (For more details of this follow-up, see the Appendix, Table 7.)

However, we noted matters that we followed up for three of these patients. (See Table 4. For more details of this follow-up, see the Appendix, Table 9.)

Table 4: Patients with Tribunal medication ASO notifications and a valid T3B with ASO or T2B – summary of main follow-up undertaken

Situation for patient	Follow-up undertaken
We noted some issues with the completion of the T2B in place. The copy of the patient's AS we saw was signed by the witness but not by the patient.	We raised these matters with the RMO. They arranged a DMP visit that provided an independent safeguard.
The patient had named two drugs in their AS that they did not want to receive. On two T3Bs for the patient these drugs were authorised and the DMPs had notified one ASO but not the other.	We informed both DMPs of these matters. We wrote to the RMO and the patient with our view that the current T3B should not be considered to authorise the medication in conflict with the ASO in the future (the medication had been stopped).
The Tribunal had regard for an older AS, not the patient's current AS.	We contacted the RMO and MHO about AS management. We checked that the DMP who issued the current T3B had seen the correct AS.

15 people for whom we received ASO notifications from the Tribunal did not have either a valid T3B for medication with an ASO notification or a T2B form for medication. (See Table 5)

Table 5: Patients with Tribunal medication ASO notifications and no valid T3B with ASO or T2B

T2B/T3B status	Number of patients
No extant T2B or T3B	2[1]
T3B with no ASO notification	10
Old T2 form	1
T2B or T3B not required	2
Total	15

[1] *These individuals had received treatment outwith the authority of the Mental Health Act. One was still receiving unauthorised treatment.*

We undertook full ASO monitoring for these patients.

Information about these 15 patients and the follow-up we undertook is contained in Table 6. (For more details of this follow-up, see the Appendix, Table 10.)

We were satisfied that the treatment decision(s) that had been made that were in conflict with the patient's advance statement were justified in all cases but one. (For one individual we thought that it might be appropriate to increase the interval between depot medication

administrations in keeping with their advance statement. However, the patient wrote a new advance statement without that treatment wish and there was no longer an ASO.)

Table 6: Patients with Tribunal medication ASO notifications and no valid T3B with ASO or T2B – summary of main follow-up undertaken

Situation for patient	MWC decisions / follow-up undertaken
No T2B or T3B in place to authorise medication.	We raised with the RMO that treatment was unauthorised. They informed the patient of this and their rights, and requested a DMP visit.
No T2B or T3B in place for medication during the MHA episode. The patient was now informal.	We raised with the RMO that treatment was unauthorised. They informed the patient of this and of their rights. A DMP visit request had been made to the Commission that was not actioned by us in error. We apologised to the RMO and asked them to include our apology in their letter to the patient. We are reviewing the MWC's administration of DMP visit requests.
DMP had issued the T3B apparently without seeing or regarding the AS, but there was an ASO.	This arose for six patients. We contacted two RMOs with advice about AS management. We advised one of them to discuss with the patient whether they wanted to review their AS (which had a particular wish that was out of date). We asked two other RMOs to request a DMP visit. We had discussion with one DMP about having missed the patient's AS.
DMP had seen the AS but missed an ASO.	This happened in two cases. For one patient we confirmed that they were still receiving depot antipsychotic in conflict with their AS. We asked the RMO to arrange a DMP visit. We wrote to the DMP about the missed ASO for their learning. For the other patient we decided that, in the individual circumstances, it would be disproportionate to arrange another DMP visit specifically to have regard for this particular ASO before the subsequent DMP visit was next requested.
The patient was receiving depot antipsychotic more frequently than they said in their AS that they wished to receive it.	The T3B authorised this. The DMP had seen the AS and indicated there was no ASO. We followed this up with the RMO. The patient had written a new AS and there was no longer an ASO. We wrote to the DMP for their learning.
The DMP indicated on T3B that there was no ASO.	We considered that the medication that the patient was receiving was actually in keeping with their advance statement and therefore took no further action.

Old T2 form in place for medication, dated 2014.	We wrote to the RMO asking them to review the patient's consent to treatment and arrange to issue a new T2B or request a DMP visit as appropriate. We suggested that they discuss with the patient whether they wish to review their AS and consider undertaking an audit of T2B and T3B forms.
T2B or T3B not required	Two patients.

Medication ASO notifications made by RMOs

We received medication ASO notifications from RMOs for three patients.

We undertook full ASO monitoring on these ASO notifications.

We also received a DMP and/or Tribunal medication ASO notification for each of these individuals.

We were satisfied that these three ASO decisions by RMOs were all justified and confirmed that the treatment was properly authorised. In two cases a T2B or T3B was not due. A T3B authorised the treatment for the other patient (a depot antipsychotic).

We conducted follow up for two of these cases:

- We e-mailed one RMO with good practice advice about ASO notifications for the future.
- For another patient we requested more information from the RMO about the patient's treatment and confirmed that they had no named person to notify.

ASOs of requests for a particular medication

We received ASO notifications for two patients regarding wishes to receive a particular medication. We checked and confirmed that both of these patients had a valid T3B form authorising treatment with medication.

Our policy is not to undertake further ASO monitoring for these ASOs.

ASOs of other treatment wishes

For ten patients we received ASO notifications for non-core treatment wishes only.

While our policy is not to undertake further ASO monitoring for these ASOs, we checked whether these patients had a valid T2B or T3B form authorising treatment with medication where required. A T2B or T3B was required for nine patients and was in place for eight (five had T3Bs, three had T2Bs).

One patient had had no T2B or T3B since their last T3B expired in 2020. They were receiving treatment outwith the authority of the MHA. We undertook follow-up for this individual and one other for whom a DMP had missed an ASO on a previous T3B (the patient had not actually received the medication). (For more details of this follow-up, see the Appendix, Table 11.)

Chapter 3: Further considerations

With our new ASO monitoring process we aimed to move to real-time ASO monitoring for ASOs that had not been subject to external scrutiny by a DMP. Pressures on Commission medical time have continued and we have not managed to monitor as many ASOs as promptly as we expected. However, we are clearly intervening more because the events we are monitoring are more recent. We hope the summary and details above provide an insight into the work of the Commission in the monitoring of advance statement overrides. We consider that the work that the Commission does provides assurance that decisions to override an advance statement (in the limited circumstances described) are scrutinised.

As in the past, most of our follow up from ASO monitoring in this period was in relation to issues with advance statement management e.g. advance statements being overlooked, not being seen by Tribunals or DMPs, or an older advance statement being seen rather than the patient's current one.

We followed up with RMOs three cases where the patient had been treated with medication without a T2B or T3B form in place to authorise it. The RMOs informed the patients about the unauthorised treatment and of their rights.

For seven patients we found that a DMP who had issued a T3B for medication had not seen their advance statement. For four we found that a DMP had seen their advance statement but had actually missed an ASO when they authorised treatment. We followed these cases up as we considered appropriate, including asking the RMO to request a new DMP visit on three occasions.

Following notifications, for several patients we made a decision that it would not be proportionate to arrange another DMP visit specifically to have regard to the patient's advance statement before a DMP visit was next requested as the Commission had undertaken the scrutiny of the individual circumstances. This included three cases where the DMP had not seen the AS, and one where the DMP had missed an ASO that we had then picked up. We are content that these decisions that we made were appropriate. However, we are concerned that such situations continue to arise, where safeguards of advance statements are missed, and that addressing them takes considerable time and resources. We observe that two of these advance statements were quite old (2014) and amounted to a blanket wish not to have any psychiatric medication. It is for these reasons that in previous reports and recommendations to the Scottish mental health law review we have called for more robust advance statement management processes.

We appreciate that an individual may choose not to review and update their advance statement, or they may not be capable of doing so. Everyone has the right to keep an advance statement in place. However, we think that the benefit of the RMO, Tribunals and DMPs continuously requiring to be shown and have regard for an advance statement that contains a blanket refusal of all psychiatric medication may not be a judicious use of resource. We have previously recommended the need to make a distinction between blanket refusals, requests and refusals for specific medications/treatments (that we consider should be subject to resourced scrutiny) to the attention of the Scottish Mental Health Law Review.

We appear to be receiving fewer ASO notifications from RMOs than we would expect. We appreciate that there are constraints with regards to workforce and the levels of acuity, however it is important that these safeguards are observed and are delivered at a quality that patients would expect.

In our report from 2021, *Advance Statements in Scotland*, we provided the first prevalence figure of advance statements for people who were treated under the mental health act and had been visited by a DMP. Based on this work, we were able to estimate that this was at 6.6% despite advance statements being in operation for over fifteen years. We reported that 36.9% of these advance statements are overridden. In this report, we have provided the details of the work that is undertaken at the Commission in the event of an override.

As we increase the proportion of ASOs that we monitor in real time through the changes we have made to our processes, we consider that it is likely that we will continue to contact more RMOs about reasons for ASO decisions and the need to make ASO notifications.

Appendix: ASO monitoring – more details of decisions and follow-up

ECT ASOs

Table 7: Follow-up undertaken for a patient with an ECT ASO

Situation for patient	Follow-up undertaken
The copy of the advance statement attached to the CTO1 form from the Tribunal was not signed by the named witness.	We followed this up with the RMO. They agreed to ensure that this is looked at and that the patient is given advice about reviewing their AS.

Medication ASOs

ASO notifications made by DMPs on T3B forms

Table 8: Follow-up undertaken for two patients with ASO notifications on T3B forms

Situation for patient	Follow-up undertaken
The DMP saw and regarded an AS dated 2012, but there was a more recent AS dated 2016. Tribunals and a previous DMP had also regarded the old AS.	We e-mailed the RMO about AS management and sent them a copy of the 2016 AS. The content about antipsychotic medication was much the same in the two advance statements. We decided that it would not be proportionate to arrange a DMP visit for the DMP to have regard for the later AS before a DMP visit was next requested. The patient has had a DMP visit since and the DMP regarded the 2016 AS.
We looked at the T3B when we were reviewing a later Tribunal ASO notification for the patient. We found that, while the DMP had notified one ASO decision, the T3B authorised another medication in conflict with the patient's AS.	We have included information about this case and follow-up in the section on Tribunal medication ASOs and follow-up below.

Medication ASO notifications from the Tribunal

Table 9: Follow-up undertaken for three patients with Tribunal medication ASO notifications and a valid T3B with ASO or T2B

Situation for patient	Follow-up undertaken
We noted some issues with the completion of the T2B in place. Also, the copy we received of the AS referred to by the Tribunal was signed by the witness but not the patient.	We raised the T2B completion issues with the RMO, gave them good practice advice and asked them to consider issuing a new T2B. We asked them to discuss with the patient the need for an AS to be signed and to suggest they review their AS. The RMO reviewed the patient, considered they were no longer consenting to treatment and requested a DMP visit. The patient had written a new AS with the same treatment wish that treatment conflicted with. The DMP regarded this and issued a T3B authorising the treatment with ASO notifications. There had been a delay before the new AS had been passed on from the CPN to medical records.
The Tribunal wrote that the patient was prescribed two medications in conflict with their AS. The patient had named both individual drugs in AS wishes not to receive them. The medications were authorised on a T3B. The DMP had given ASO reasons and made notifications for one (a regular mood stabiliser) but not for the other (a named antipsychotic prescribed "if required").	The T3B authorised any antipsychotic "if required", and therefore included the drug named in the AS. This T3B was superseded 13 days after the Tribunal by another T3B that specifically excluded that antipsychotic. If this had not been the case, we would have suggested to the RMO that they consider an alternative antipsychotic. We informed the first DMP about the missed ASO. There was also an issue with the second T3B. The DMP authorised the named mood stabiliser without an ASO explanation. The RMO had planned to stop this and did so. We wrote to the RMO with our view that the T3B should not be considered to authorise that mood stabiliser if it is proposed to re-prescribe it. This was agreed. We wrote a letter to the patient informing them of this and also informed the DMP.
We noted that the Tribunal had regard for older AS (2009), and we had a more recent AS (2013).	We e-mailed the RMO and MHO re AS management. We also suggested to the RMO that they arrange to suggest to patient that they might consider reviewing their AS. Medication was authorised by T3B with ASO, and the DMP had regarded the 2013 AS.

Table 10: Patients with Tribunal medication ASO notifications and no valid T3B with ASO or T2B – MWC decisions and follow-up (15 patients)

Situation for patient	Commission decisions/ follow-up undertaken
No T2B or T3B in place. We confirmed with medical records that there was no form since Dec 2019.	We raised this with the RMO. The RMO requested a DMP visit and informed the patient of the treatment they had received outwith the authority of the MHA and of their rights. The service undertook an audit of T2B and T3B forms.
No T2B or T3B in place during the MHA episode. The patient was now informal.	The patient had been treated with medication outwith the authority of the MHA for some time before they became informal. We followed this up with the RMO and advised that they should inform the patient of this and of their rights. It transpired that a DMP visit request had been made to the Commission three months after the T3B was due and this was not actioned by us. We apologised to the RMO for this and asked them to pass our apologies on to the patient. We are reviewing the Commission's administration of DMP visit requests.
Medication authorised by T3B. DMP issued T3B without seeing or regarding the AS. RMO had written in the DMP visit request that there was no AS (although they indicated on CTO renewal forms before and after then that there was an AS).	We reviewed the authorised treatment and the AS. We considered that the AS wish to have "no more tablets" amounted to a blanket wish to have no medication. We considered that it would not be proportionate to arrange a DMP visit specifically to have regard for this AS before a DMP visit was next requested. We e-mailed the RMO to inform them of this and with advice about AS management. We asked them to discuss again with the patient whether they wanted to review their AS (which was written in 2014 and included a wish to remain in a ward since closed).
Medication authorised by T3B from 2020. DMP had not seen or regarded the AS. We do not have a copy of the DMP visit request made by the RMO to know if this included information about the AS.	The patient's wishes in their AS (dated 2012) included a wish not to take antipsychotic medication that interfered with their blood sugars and a preference to have no medication at all. The patient was receiving an antipsychotic with low propensity to disturb blood sugars. We decided that it would not be proportionate to arrange a DMP visit specifically to have regard for this AS before a DMP visit was next requested.
Medication authorised by T3B from 2020. DMP issued this without seeing or regarding the AS, which was dated 2014.	We previously followed up this matter in 2020 and raised concerns about AS management with the RMO and the clinical director. The patient's wishes in their AS not to have injections or tablets amounted to a blanket wish to have no medication. We decided that it would not be proportionate to arrange a DMP visit specifically to

	have regard for this AS before a DMP visit was next requested. We reviewed and held that decision.
Medication authorised by T3B from 2021. DMP issued T3B without seeing or regarding AS. RMO had written in the DMP visit request that there was no AS.	We confirmed that the individual was still receiving depot antipsychotic under the authority of the T3B in conflict with AS (which was dated 2016). We wrote to current RMO to ask them to request another DMP visit for DMP to have regard for the AS.
T3B had authorised the treatment (depot antipsychotic). DMP issued T3B without seeing or regarding AS. RMO had written in the DMP visit request that there was no AS.	The patient had become informal. We wrote to the RMO about AS management and they put in place measures to be more easily aware when a patient has an advance statement and shared this practice with colleagues. (The AS was dated 2017).
T3B authorised treatment. DMP issued T3B indicating that there was no AS. The RMO had written in the DMP visit request that there was an AS.	The DMP had written a letter to the RMO in which it was clear that the patient had responded well to risperidone previously and on re-admission (risperidone was the ASO). However, the DMP missed the AS. We discussed what had happened with the DMP. We wrote to RMO to arrange another DMP visit for DMP to have regard for the AS.
Medication authorised by T3B. The RMO had written in the DMP visit request that there was an AS, and the DMP had indicated on the T3B that there was an AS but no ASO.	Depot antipsychotic was authorised under the T3B in conflict with the AS. We contacted the ward and confirmed the patient was still receiving the depot. We wrote to RMO to arrange another DMP visit for DMP to have regard for the AS. We wrote to the DMP about the missed ASO for their learning.
T3B authorised antipsychotic medication. The DMP had indicated that there was an AS but no ASO. However, the patient wrote in their AS "In general I would not like to be treated with antipsychotics".	The DMP had specified on the T3B that no medications were to be given that were among those named on the patient's AS that they did not wish to receive. This is good practice. However, they had not given reasons or made notifications for the ASO of the general wish not to have antipsychotics (AS dated 2018). We considered that it was clear that the patient needed treatment with an antipsychotic, and in depot form because of history of non-concordance with treatment. We considered that it would not be proportionate to arrange a DMP visit specifically to have regard for this AS wish before a DMP visit is next requested.
The patient was receiving depot antipsychotic more frequently than they said in their AS that they wished to receive it. The T3B authorised this. The DMP had	We followed this up with the RMO. We asked for more information and whether they could give the depot in accordance with the AS. However, this ceased to be an issue when it transpired that the patient had written a

seen the AS and indicated there was no ASO.	new AS after the DMP visit and Tribunal that did not include any wishes about medication. We wrote to the DMP about the missed ASO for their learning.
T3B authorised antidepressant medication. The DMP indicated that there was an AS and treatment authorised was not in conflict with it.	We considered that the medication that the patient was receiving was actually in keeping with their advance statement and took NFA.
Old T2 form in place for medication, dated 2014.	Expiry dates on T2B and T3B forms were introduced with the current forms in 2017. Earlier T2 and T3 forms do not carry an expiry date. However, it was always recommended good practice to renew T2 and T3 forms at least every three years. This should have been done. We wrote to the RMO asking them to review the patient's consent to treatment and arrange to issue a new T2B or request a DMP visit as appropriate. We suggested that they discuss with the patient whether they wish to review their AS (which was dated 2008 and included a blanket wish not to have any psychiatric medication). We suggested that they consider whether an audit of T2B and T3B forms for their patients might be helpful.
T2B or T3B not required	There was no T2B or T3B. We followed this up with the RMO who confirmed that the patient was no longer receiving the medication and said they were considering revoking the CTO.
T2B or T3B not required	T2/T3B was not due before detention episode ended. RMO had made ASO notification in respect of the treatment in conflict with the AS, which we considered was justified.

ASOs of other treatment wishes

Table 11: Follow-up undertaken for two patients with ASOs of other treatment wishes

Situation for patient	Follow-up undertaken
No T2B or T3B in place since 2020. We confirmed with medical records that this was the case.	We raised this with the RMO. The RMO requested a DMP visit and informed the patient of the treatment they had received outwith the authority of the MHA and of their rights. The service undertook an audit of T2B and T3B forms.
On a T3B issued 6 months earlier the DMP indicated that there was no AS and made no ASO notification. However, the RMO had written in the DMP visit request that there was an AS. Depot antipsychotic had been included on the T3B. This was an ASO.	That T3B had been superseded and the patient had not actually received depot antipsychotic. The same DMP had recently visited again. On this occasion they had careful regard for the patient's AS and wrote a detailed letter to the RMO about their decision not to authorise depot antipsychotic in conflict with it. This is good practice. We discussed with the DMP how they missed the AS and ASO on the earlier occasion.

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