mentalwelfare commission for scotland

GOOD PRACTICE GUIDE

Advance Statement Guidance: My Views, My Treatment

Reviewed June 2017

This guide has been updated to reflect key changes to the Mental Health Act implemented on 30 June 2017. This version replaces the previous 2013 version.

Contents

The Mental Welfare Commission for Scotland

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

Advance statement guidance

The Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Act') sets out how people can be treated if they are unwell and need treatment for mental disorder. Mental disorder, as defined by the Act means mental illness, learning disability or personality disorder.

The Act allows an individual to make a written statement, when they are well, which sets out how they would prefer to be treated (or not treated) if they were to become unwell in the future and their ability to make decisions about their treatment is significantly impaired. This is called an advance statement and is relevant only to treatment for mental disorder as defined by the Act.

It is not known how many people have made advance statements since the Act came into effect in 2005. From June 2017 NHS boards will have a duty to promote advance statements and notify the Commission when one has been made. Some people have found them to be very helpful. However, it would appear that fewer people than expected have made advance statements. There may be a number of reasons for this. Anecdotally, the Commission is aware that some individuals think that it is not worth it as they will be overridden anyway; others have said that they do not wish to contemplate the possibility that they may become unwell again in the future. Some professionals and service users have found them difficult to understand.

Our website[1] has a section with short film clips about advance statements and advice on how to make one.

This guidance has been produced with the hope that it may increase the number of advance statements that are made. They are an important contributor to the collaboration between the clinical team and the patient in promoting a therapeutic relationship and aiding recovery.

1 www.mwcscot.org.uk/get-help/getting-treatment/advance-statements/

Introduction

'In mental health care, advance statements would permit a person, during a period of mental well-being, to plan for the types of interventions he or she would wish or be prepared to receive in the event of a relapse into mental illness. Should the person then relapse and his or her judgement become seriously impaired as a result of illness, there is a record of his or her wishes while he or she had decision-making capacity.'

Millan Committee 2001

In recent years there have been great advances in person-centred care within mental health and learning disability services. Person-centred care focuses on the needs and wishes of the individual in relation to the ways in which they would like to be treated and what they need to maintain good mental health. This involves a collaborative partnership between the individual, their doctor and their care team.

The Act and the principles in it underpin person-centred care for individuals. By including provision for individuals to make advance statements it has strengthened participation in treatment and recovery. Individuals who may be required to accept treatment on a compulsory basis now have a means of ensuring that their wishes are taken into account.

The term 'advance statement' only refers to written statements, made under the Act, regarding treatment for mental disorder as defined in the Act. It does not equate to 'living wills' or 'advance directives' neither of which have any formal legislative basis in Scotland and which are more often used in respect of treatment for physical conditions or end of life care. This is an area which can cause confusion for individuals and it is therefore important to be clear about the nature and scope of an 'advance statement'.

The Act sets out the criteria under which an advance statement can be made, how it should be witnessed and what should happen when it is overridden. The relevant parts of the Act are Sections 275 and 276, and there are accompanying regulations.

As with the Millan Committee, the Code of Practice for the Act also makes the presumption that an individual who writes an advance statement will already have experience of treatment.

'Section 274 and 276 of the Act enable a patient to make an advance statement. This is a written statement setting out how they would wish to be treated, or wish not to be treated, for mental disorder should their ability to make decisions about treatment for their mental disorder become significantly impaired as a result of their mental disorder.'

However, the Act enables anyone to make an advance statement, if they have the capacity to do so, whether or not they have experience of mental ill health.

The Act also requires that where an individual's advance statement is overridden the reasons for doing so are notified to them, and to their named person, in writing, and that the Commission is informed. The Commission have undertaken to make enquiries about such overrides in certain circumstances.

The advance statement provisions, and the safeguards regarding medical treatment in Part 16 of the Act, also apply to individuals receiving treatment under the authority of the Criminal Procedures (Scotland) Act, 1995. This guidance applies equally to these individuals, although we do not specifically refer to the 1995 Act further.

Advance statements – What the Act says

Section 275 – advance statements: making and withdrawal

Section 275 defines what an advance statement is and how it has to be made.

Section 275 (1) says that an 'advance statement' is a statement specifying:

(a) the ways the person making it wishes to be treated for mental disorder;

(b) the ways the person wishes not to be so treated,

in the event of the person's becoming mentally disordered and the person's ability to make decisions about the matters referred to in paragraphs (a) and (b) above being, because of that, significantly impaired.

Section 275 (2) details the criteria that have to be met for it to be regarded as an 'advance statement'.

These are:

- At the time of making it, the person has the capacity of properly intending the wishes specified in it; *In other words, the person must not be unwell to the extent that they cannot make reasonable decisions about their treatment. However, capacity has to be judged in relation to particular decisions, and is not an 'all or nothing' concept. The individual may be capable of including some wishes about treatment in an advance statement but not others;*
- It is in writing;
- It is subscribed by the person making it;
- That the person's subscription of it is witnessed by a person (the 'witness') who is within the class of persons prescribed by regulations;[2]
- The witness certifies in writing on the document that the person has, in the opinion of the witness, the capacity of properly intending the wishes specified in it. *The witness has to therefore make a judgement about the person's capacity to make the decisions referred to in the advance statement at the time of writing it.*

We discuss the matters of capacity to make an advance statement and witnessing an advance statement in more detail below.

Unfortunately, the Act does not say that the advance statement has to be dated. Clearly, if it is not, this can cause confusion. It should be standard practice for both the person making the advance statement and the witness to write the date on the advance statement when they sign it.

Section 275 (3) allows an advance statement to be withdrawn by the person who made it. The criteria for withdrawal are the same as for making an advance statement.

2 'The Mental Health (Advance Statements) (Prescribed Class of Persons) (Scotland) (No. 2) Regulations 2004' http://www.legislation.gov.uk/ssi/2004/429/contents/made

Section 276 – advance statements: effect

Section 276 covers what the Tribunal and others must do if there is an advance statement.

The Tribunal must have regard to the wishes specified in the advance statement, i.e. take account of what it says, if:

- Because of mental disorder, the ability of the person who made the advance statement to make decisions about how they would or would not wish to be treated is significantly impaired;
  This means that the person has become unwell and no longer has the ability to make the decision(s) they previously made and included in their advance statement. This should include whether the individual's ability to make the decisions referred to in their advance statement has now become significantly impaired.
- That the statement complies with the criteria listed in section 275 (2);
- Any measures or treatment that will be authorised or no longer authorised by any decision of the Tribunal correspond to those stated in the advance statement;
- Since the person made the statement there has been no change which would lead them not to make a statement or to make a substantially different one.

Section 276 also covers what certain other people must do when they are making decisions about an individual's treatment under the Act, and the individual has made an advance statement. These people are:

- A *'person giving medical treatment'*.

Medical treatment is defined in the Act as 'treatment for mental disorder'; and for this purpose 'treatment' includes-

a) nursing
b) care
c) psychological interventions
d) habilitation
e) rehabilitation

Therefore the advance statement is of relevance to all staff involved in providing care and treatment.

- A designated medical practitioner (DMP) who is deciding whether or not to authorise treatment under Part 16 of the Mental Health Act where the patient is not able or willing to consent to the treatment themselves (i.e. whether to issue a T3 form).

Everyone who is making decisions about an individual's care and treatment in these circumstances has to make their own decision about whether the advance statement complies with the criteria laid out in section 275 and to act accordingly. Even where there is a statement that does not meet the criteria, the principles of the Act should be borne in mind and therefore the wishes expressed in it should be considered.

Although, as noted above, medical treatment is defined widely, in practice, the emphasis of the advance statement should be on aspects of medical treatment over which the individual would normally have some choice.

Who can make an advance statement and when should they make it?

The provision to make an advance statement applies to everyone. There is no upper or lower age limit. There is no provision for parents to make an advance statement on behalf of their child (if the child does not have capacity to consent) or for welfare guardians, named persons or others to do so for adults who do not have capacity.

As noted in the introduction, the Millan Committee's recommendation was that an advance statement would be written at a time when the individual was well and recognising that their capacity to make decisions about treatment in the future may be impaired. The importance of the individual being able to record wishes about such treatment in the event of future illness was recognised.

The Act did not intend people to make advance statements when they were acutely unwell. However, people with severe and enduring mental illness and those with impaired capacity due, for example, to learning disability or dementia, may be able to make a valid advance statement. Their ability to do this will depend on the extent of their impairment in relation to decisions about their treatment. They may be able to make decisions and specify wishes about some aspects of their care and treatment and not others.

There is, therefore, not a 'right time' to make an advance statement. Some services have included discussion about advance statements in their discharge planning meetings with individuals; others have it as part of regular care programme approach (CPA) meetings. The role of advocacy in promoting and facilitating individuals to make advance statements at an appropriate time is very important and should be part of their remit, accepting that when they are first involved the person may be very unwell and not able to make one.

Capacity to make an advance statement

The Act says that, for the advance statement to be valid, the person making it has to have the 'capacity of properly intending' the wishes specified in it. A witness, who must be from the list of 'prescribed persons' permitted in regulations, is required to certify on the advance statement that, in their opinion, the person making it has this capacity.

'Capacity of properly intending' is not defined in the Act. The Code of Practice says that the witness has to certify that the person has capacity to understand and intend the statement about the treatments mentioned.

When the Millan Committee made their recommendations about advance statements for inclusion in the Act, they said that the person should be able to understand the nature and effect of the advance statement and to make decisions regarding it.[3]

Capacity to consent to treatment is an integral part of healthcare and most people will be familiar with the necessity for signed consent forms for operations, etc. To have capacity to consent to medical treatment, the individual must be able to understand the nature, purpose and likely effects of the treatment. An individual is presumed to have capacity unless they seem not to understand what is proposed. If there are doubts about the individual's capacity to consent, this should be assessed. The General Medical Council (GMC) has issued guidance on capacity and consent which all medical staff should be aware of and which may be of use to other professionals.[4]

3 New Directions Report on the Review of the Mental Health (Scotland) Act 1984 2001

4 Consent Guidance: patients and doctors making decisions together. www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp

Capacity, however, is not an 'all or nothing' concept, and has to be judged in relation to particular decisions. An individual can be capable of making a decision about one thing but, at the same time, not be capable of making a decision about something else that is more complicated and difficult to understand. Someone may retain capacity to make decisions about aspects of their medical treatment even when their decision-making ability is significantly impaired, for example being willing to take medication but being completely unable to see that they also need to be in hospital.

The Commission has previously published guidance on the assessment of an individual's capacity to consent to medical treatment for mental disorder. This is contained in our good practice guidance *'Consent to treatment: A guide for mental health practitioners'*, (2010).

If an individual does not have full capacity to consent (or refuse consent) there may still be some decisions and choices they can make about their treatment.

The following case study illustrates this point;

> *Ms A has a diagnosis of schizophrenia. Three months ago she needed to be admitted to hospital under a short-term detention certificate and later became subject to a compulsory treatment order (CTO). Her symptoms included persecutory delusions that gangsters from London were following her and planning to harm her. She had no insight into the fact that she was unwell, and did not think that she needed any treatment for schizophrenia. She accepted that her registered medical officer (RMO) had the authority to treat her under the Mental Health Act, and agreed to take oral antipsychotic medication because of this. However, she did not understand that there was any purpose in taking this treatment, and was not capable of giving informed consent to the treatment. There was a particular antipsychotic medication that she did not want to take, as it has caused her to have a painful muscle spasm in her neck in the past. She discussed this, and the potential side effects of other medications, with her doctor. They decided together which medication they thought would suit her best.*

Who can witness an advance statement?

The regulations for the Act say that an advance statement, written by an individual, has to be witnessed by a person of the 'prescribed class'. The list of 'prescribed persons' who can witness an advance statement includes:

- Clinical psychologists entered on the British Psychological Society's register of chartered psychologists;
- Medical practitioners;
- Occupational therapists registered with the Health Professions Council;
- Persons employed in the provision of (or in managing the provision of) a care service;
- Registered nurses;
- Social workers;
- Solicitors.

The list does not include independent advocates. However, advocates have a crucial role to play in promoting advance statements and providing information and support to individuals who wish to write one.

With regard to those 'persons employed in the provision of a care service', the Commission believes that the intention of the Act was to limit the authority to witness an advance statement to managers or senior managers of such services, and not staff. By 'the intention of the Act', we mean what the Scottish Government intended the Act to mean in practice when they wrote it. This would clearly be in line with the other individuals who are listed as being suitable persons to be witnesses. However, the regulations are not clear in respect of this and we accept that others may have a different view. There are no 'conflict of interest' regulations as far as witnesses are concerned. Some medical practitioners and others may feel concerned about witnessing an advance statement that they may have to override in the future, however, there is no reason why they should not witness an advance statement. They are confirming that the individual had the capacity to state the wishes in it and not the appropriateness of them.

The role of the witness

When an individual wishes to make an advance statement, the proposed witness should have a discussion with them about what they wish to include, and their reasons for this. They should ask the individual about:

- The situation they think may occur in the future when regard would be given to their advance statement;
- Whether they think they would have mental disorder at that time, and whether they think they would need treatment for this;
- Their reasons for their wishes regarding future treatment that they wish to include in their advance statement.

During this discussion, the witness will want to consider the following things:

- The person's understanding about what the treatment is, its purpose, and why it might be considered for them;
- The person's understanding about the principal benefits, risks and alternatives, and how they are using this information to make a choice;
- Their understanding of what the consequences would be of receiving or not receiving the treatment in question.

The person witnessing the advance statement will need to consider whether the individual's decision-making regarding the wishes in their proposed advance statement is reasonable, and whether they thus have capacity to make it.

The necessary level of understanding about the treatment, and insight into potential future illness and need for treatment, will vary depending on the wishes the individual wants to include in their advance statement. Whether they have capacity to make the advance statement is a therefore a judgement call that the witness needs to make.

The continuation of the case study from above illustrates this.

> *Ms A, returned home from hospital six weeks ago on suspension of detention. She is still subject to the CTO. She has been taking regular oral antipsychotic medication (Drug Y) and receiving care from the community mental health team. She is quite settled, enjoying life, and does not think that anyone is trying to harm her at the moment. She is not experiencing any troublesome side effects from Drug Y. However, she still does not have insight into the fact she has been unwell or the need for antipsychotic*

treatment. She thinks the gangsters have returned to London and lost interest in her just now. She takes her medication because she is required to under the CTO.

She decides to make an advance statement saying:

- *I do not want to be given Drug X because it caused me to have a painful muscle spasm in my neck in the past;*
- *If I have to take regular antipsychotic medication I would wish to take Drug Y as I have not experienced any major side effects from this.*

Ms A still does not have insight into her mental illness or understand that there is any purpose in taking treatment for this. She is not really giving informed consent to her current treatment. Therefore, there may be some wishes about future treatment that she would not be capable of including in an advance statement. However, as before, her wish not to receive a particular medication that has caused unacceptable side effects seems reasonable. So does her reasoning for stating that, if she has to take regular antipsychotic medication, she would wish to take Drug Y. She is capable of including these wishes in her advance statement.

A further case example is given below:

Mr B had an episode of hypomania six months ago. When he was unwell he was elated and disinhibited. He bought things he could not afford and did not need, including a new car, expensive clothes and three new laptops. He needed treatment in hospital under a short-term detention certificate (STDC). He found he responded well to treatment with Drug X, and became informal before he left hospital.

Mr B is currently well and has good insight into his previous episode of hypomania. He is not on any mood stabilising medication. He and his psychiatrist have decided together that he will now reduce and stop taking Drug X.

Mr B wants to do all he can to try to make sure that, if he starts to become hypomanic again, people realise that he is unwell and that he receives early, effective, care and treatment. He has made a Personal Recovery Plan and a personal statement.

Mr B also wants to make an advance statement expressing wishes about medical treatment. He plans to include the following:

- *If I have an episode of hypomania in the future, I want to be treated with Drug X. This was very effective treatment for me when I had hypomania in 2012.*

Mr B has a good understanding of his previous illness, and of the fact that he may develop another episode of hypomania in the future. He demonstrates a good understanding of the nature, purpose and likely effects of Drug X as treatment for hypomania, should he develop this again in the future. He is capable of properly intending the wishes he has specified in his advance statement.

Concerns about capacity

Where an individual has lack of capacity due to a permanent condition such as significant degree of cognitive impairment as a result of a learning disability or advanced dementia, the individual may not have the capacity of properly intending their wishes in an advance statement. What is more difficult is where, due to the effects of the mental illness, capacity to consent to treatment or to make an advance statement fluctuates or the decision-making process is influenced by abnormal beliefs e.g. persecutory delusions. An individual with fixed delusional beliefs about certain treatments is not going to have the capacity to make a valid advance statement in respect of them.

During their discussion with the individual, the potential witness may feel that the person would benefit from further information about treatment they are considering including in their advance statement. In that case, it would be good practice to assist them to access this information before witnessing the advance statement.

In some cases it will be difficult to assess whether the individual has the capacity to make the advance statement. In such circumstances, it is important to seek any further information that would be helpful and not to feel under pressure to reach a decision.

In many cases the proposed witness will be a mental health professional who is involved in the person's care. If it would be helpful, and the individual agrees, they may have discussion regarding the advance statement and the person's capacity with other involved professionals and relevant others.

If the proposed witness does not consider that the individual has capacity to intend the wishes in the advance statement, or they cannot reach a decision regarding this, they should not witness the advance statement. If the individual wishes, they can assist them to identify another person to give their view and consider witnessing their advance statement.

Whilst there is currently no sanction for people who witness a signature in circumstances where the capacity of the individual to properly intend is impaired, such action is not likely to be in keeping with adherence to their respective professional codes of conduct. Similarly, there is no mention in the Act of what action should be taken if an RMO/DMP is concerned that an advance statement is not valid. In circumstances where such a statement is overridden then we recommend that the appropriate notifications should be made with a covering letter to the Commission detailing the concerns.

Unwise decisions

Sometimes people make decisions that may be regarded by others as unwise. This in itself does not mean they lack capacity to make the decision. An individual may make a decision to make an advance statement on an emotional basis. This may be based on their past experience of illness or treatment and influenced by, for example, fear. Information and education may help if this is the case. On other occasions individuals may make a decision based on what you might think was inadequate information, and choose not to hear or consider further information that might enable them to make a more informed decision. Again, this does not necessarily mean that they lack capacity to make the decision they have made. In all these circumstances it is necessary for the witness to judge whether the decision is:

- merely unwise and imprudent;

or

- based on lack of understanding of, or inability to process, information (which is more likely to indicate incapacity).

Who should be involved?

The preparation of an advance statement should provide the individual with an opportunity, if they wish, to discuss their care and treatment with their RMO, other members of their care team, their mental health officer (MHO) and perhaps their named person, carer(s) and independent advocate. This can promote collaborative working between the individual and mental health professionals, and encourage negotiation about treatment options.

This enables others to give the individual information about the process and effect of making an advance statement. If there is any further information the individual thinks they need in order to make an informed decision about what to include in their advance statement, they should be able to access this.

It is ideal for an individual to consider what they want to specify in an advance statement in collaboration with others as above. However, some individuals may not regard the involvement of the clinical team as positive. They may choose who to involve, but this might be nobody else other than the person they ask to consider witnessing the advance statement.

What advice should be given to individuals who want to write an advance statement?

There is guidance issued by the Scottish Government and by a number of independent advocacy organisations. Anyone who wishes to make an advance statement should be encouraged to read some or all of these documents. There is a list of useful documents in Appendix 3.

We know that some individuals will wish to include matters which, in our view, should not be recorded in an advance statement. Whether or not this is the case, the entries should be clear and it should be easy to understand what they mean.

The Act states that an advance statement has a legal standing in respect of treatment for individuals. There are safeguards in place to ensure that wherever possible the advance statement will be taken account of. If treatment is not in keeping with the wishes of the individual, then this has to be notified in writing to a number of people such as the individual's named person as well as the individual themselves. The Commission also has to be notified within seven days. For this reason it is important that the advance statement is written in such a way that it is clear when an override occurs. Wishes in relation to treatments that are preferred and those that the individual would not wish to be given should be kept separate if at all possible.

What should be included in an advance statement?

Not all aspects of medical treatment as defined by the Act require the specific consent of the individual; they are regarded as part of an overall treatment package. Those that do, medicines, electro-convulsive therapy (ECT), artificial nutrition and neurosurgical interventions, are further regulated under Part 16 of the Act. This requires, broadly, either the individual's consent in writing or, if they are unwilling or unable to consent, a T3 form granted by a DMP, for the treatment to be given. (Guidance on treatment under Part 16, and the safeguards this provides, is contained in the Commission's good practice guidance *'Consent to treatment'*.)

In our view only those aspects of medical treatment over which the individual would normally be offered some choice should be included. These are:

- Whether they are treated in hospital or in the community;
- What medications and other forms of treatment regulated under Part 16 of the Act they will receive;
- What other therapeutic interventions they will receive.

It is not possible to make an advance statement demanding particular treatments if these are not normally available and, in the case of treatment with alternative medicines or similar substances, not authorised for prescription within the NHS.

The Commission does not believe that it is appropriate to include wishes and preferences for such things as single rooms or particular wards as these are aspects of care and treatment over which the individual would not normally be offered a choice as they are dependent on what is available and on the needs of others. However, there may be important wishes about these and other matters that the individual wants to document. This is quite appropriate, but should be done elsewhere in their personal plan, perhaps as part of a personal statement or crisis/care plan. Nevertheless, we understand that many people may wish to include everything in one document. It would be helpful, under these circumstances, if those matters which are clearly appropriate for an advance statement were highlighted. We have included a suggested template for an advance statement in Appendix 1.

Advance statements about treatment already being given

Sometimes individuals want to make an advance statement about treatment they are already receiving or that is being actively considered. There has been confusion about the validity of such statements. The Act intended that advance statements should only 'have effect' after there had been a change in the person's capacity in respect of their consent to medical treatment.

For example; documents written by individuals, already detained under the Act, just before a Tribunal hearing. The Commission has taken the view that whilst they may be valid advance statements they have not yet come into effect as there has been no change in the individual's capacity. They are however, useful contemporaneous statements about their care and treatment and should be considered as such in any discussions. A similar approach should be taken where an individual makes an advance statement about treatment that they are currently receiving. This scenario would, however, lead to a request for a DMP opinion if the wishes specified indicated a refusal of the current treatment.

Who should be told about the advance statement and given a copy? Where should it be kept?

The individual should give a copy of their advance statement to their RMO or consultant so that it is available in their medical notes. In the medical notes it should be clearly 'signposted', perhaps by being filed at the front or, in the case of electronic records, an alert on the front page. It may also be sensible to give a copy to the person who would be their 'named person' in the event that they were subject to compulsory treatment in the future. Other relevant people may be their MHO or solicitor.

What should happen to a previous advance statement when a new one is written?

Although the Act does not state that an advance statement should be dated, we strongly recommend that they should be. It will then be clear which is current in the event that more than one is in existence. The Act seems to suggest that each advance statement should be formally withdrawn in a separate document prior to a new one being written. This appears to be excessively bureaucratic. In our view it would be sufficient for the existing advance statement to be scored through as 'cancelled' and signed and appropriately witnessed as for the initial making of an advance statement. It is likely that the witness for this will be the witness for any new advance statement. The new advance statement should also contain an initial sentence formally withdrawing the previous statement.

Wishes on the previous advance statement can be transferred to the new advance statement if they are still relevant. The exception to this would be where the individual does not have the capacity to withdraw the advance statement, or they lack capacity to re-state any wishes that are in it. In these

circumstances the original has to remain in place. Whilst it would be highly unusual for an individual to be able to subscribe to an additional advance statement whilst at the same time as being unable to withdraw a previous one it may happen. Under these circumstances care should be taken to ensure that all involved persons are aware that there are two advance statements and have access to copies of these.

How often should an advance statement be reviewed?

There is no legal requirement for an advance statement to be reviewed. The guidance issued by the Government suggests that it should be reviewed every 6-12 months. This is probably too frequent for most individuals.

The Commission recommends that, unless the individual lacks capacity to properly withdraw or re-specify the wishes in the advance statement, they should review their advance statement after each episode of illness or at least every three years. This allows for changes in diagnosis, treatment availability and service provision to be taken into account. Additionally they could be reviewed as part of the discharge planning process.

Advance statement override procedures and notifications

The Act allows for advance statements to be overridden. The Tribunal, the RMO, and a DMP providing an independent opinion under Part 16 of the Act, can all override a person's advance statement.

The Tribunal can override the advance statement if they make a decision to authorise measures or treatment under the Act that causes, or may cause, treatment to be given in conflict with the wishes specified in the advance statement. For example, if the person's advance statement has a preference for community-based treatment and an order authorising treatment in hospital is granted.

A *'person giving medical treatment'*, who is usually the RMO, can override the advance statement. This happens if they make a decision to give, or not give, treatment in conflict with the wishes specified in the advance statement.

A DMP may override an advance statement if they agree with the RMO about a treatment decision that is in conflict with the wishes specified in the advance statement.

If you are thinking about overriding an advance statement you should carefully consider the principles of the Act. The fact that they can be overridden has been clearly raised with us as a reason to not make an advance statement. If they can be ignored then what is the point? However, as we have noted previously in this guidance, in our view advance statements are a valuable tool in facilitating patient participation in treatment and recovery and therefore any override should be carefully thought through.

If, after careful consideration, it is necessary to override the individual's advance statement then you should provide an explanation to the individual.

Section 276 (8) states what must be done. Anyone overriding an advance statement must:

(a) record in writing the circumstances of their decision, and the reasons why

(b) supply:
  (i) the person who made the statement;
  (ii) that person's named person;
  (iii) that person's welfare attorney;
  (iv) that person's guardian; and
  (v) the Commission,

with a copy of that record; and

(c) place a copy of that record in the person's medical records.

In practice, the Tribunal do this through their written findings, RMOs and DMPs normally by writing a letter explaining their decisions to the individual.

The following case studies illustrate good practice with regard to overriding an advance statement:

Case example 1

Mr X has an advance statement which states that he does not wish to be prescribed 'antipsychotic injections'. His RMO has endeavoured to comply with his wish by prescribing oral antipsychotic medication. However, his compliance with oral medication is very variable and he has been readmitted to hospital following deterioration in his mental state as he had not been taking his medication for some time. In hospital, he agrees to take oral medication but his RMO wishes to prescribe depot medication when he is discharged. As Mr X will not agree to this, the RMO requests a DMP opinion through the Commission. The DMP visits Mr X and authorises the depot medication, thereby overriding Mr X's advance statement. As required by the Act, he informs Mr X about this in the following letter:

> *Dear Mr X,*
>
> *Following my visit to see you on 19th September I have issued a certificate known as a T3, which will allow your RMO to treat you with depot medication. I note that this is in conflict with your advance statement. I have decided to do this for the following reasons:*
>
> 1. *Your presentation demonstrates that you are very unwell at the present and I believe that you have limited understanding of what treatment is best for you at the moment. I note that you are currently taking oral medication but you advised me that you did not think you needed any treatment. I also know that your recent admission to hospital was because you had stopped taking your tablets and become unwell.*
> 2. *Your advance statement states that you do not wish to have 'antipsychotic injections.'*
> 3. *I understand that your doctor (RMO) wishes to prescribe a depot injection when you are discharged because you do not take oral medication regularly and it is in your best interests to remain well. I agree with your RMO that this is the best treatment for you.*

We think that this is a good example of a letter from a DMP to an individual. It demonstrates that the decision has not been made lightly and the reasons for the decision being made.

Case example 2

Mrs Y has a history of recurrent depressive episodes which have been treated in the past by oral medication and occasionally by ECT. After her last episode of illness she wrote an advance statement indicating that she did not wish to have ECT. She has now been admitted to hospital again and is very unwell, refusing food and only drinking small amounts. She does not comply with oral medication and, in any case, is now regarded as needing urgent treatment with ECT. The consultant looking after her is aware of her advance statement. In view of her presentation it is decided that a short-term detention certificate would be appropriate. The RMO then makes arrangements for a DMP opinion to authorise, if appropriate, a course of ECT. In the meantime, he makes arrangements to give Mrs Y two ECT treatments as a matter of urgency. As he is overriding her advance statement he writes to her in the following terms:

> *Dear Mrs Y*
>
> *When you were admitted to hospital on this occasion you were very unwell indeed. I know that you have an advance statement that says that you did not wish to have ECT but I have considered this very carefully and decided that I must override your wishes. This is because I believe that your life is in danger if you do not get treatment quickly. Unfortunately, you are so unwell that I do not think that you have the capacity to make decisions about your treatment. I therefore asked a mental health officer to see you and to decide if they agreed with me and would consent to the short-term detention certificate. This was necessary so that I could treat you against your wishes and treat you urgently. It also meant I had to ask for a designated medical practitioner from the Mental Welfare Commission to come and see you and decide whether they agreed with my treatment plan. The psychiatrist who came agreed with me and has issued a T3 certificate which authorises the ECT treatment. They will be writing to you to explain about this.*
>
> *It would perhaps be helpful if we were able to discuss your advance statement when you are feeling better.*

Again, this demonstrates that the RMO, in this case, has carefully considered the position and justified the override.

The role of the Commission

The Commission receives notifications of all apparent overrides. This may be by letter, from an RMO or DMP, or may be by virtue of a notification contained within one of the forms such as a CTO1.

The Commission has determined that it will make routine enquiries about overrides in the following circumstances only:

- Where a specific medication or type of medication has been prescribed/not prescribed contrary to the individual's wishes;
- Where ECT has been authorised against the previous wishes of the individual.

When we receive an override notification we allocate it to one of the medical staff who review all the forms and documents associated with the override. In particular, we will want to see that the RMO or DMP has properly explained to the individual why they are overriding their advance statement, (see above) and form a judgement about whether it was reasonable in the circumstances. If we are not satisfied with the amount of information available to us we will write to the RMO/DMP and ask for further information. We may also write to the individual concerned and let them know what we are doing, particularly if we believe that the override was not justified.

If we are satisfied with the information received initially then we will note the override and it will be reported in the overall numbers in our annual report. Sometimes, when we have made enquiries, we find that the individual is now consenting to the treatment or the RMO has changed their mind and there is no longer an override. In the former case, we write and suggest that the individual reviews their advance statement at an appropriate time. Occasionally we find that the information we have been given is incorrect and there is no override of the advance statement.

Where we determine that the override is justified, we will write to the individual and let them know our views unless it is clear from the information that they have been fully informed by the RMO/DMP.

There may be other aspects of care and treatment that are notified to us as 'overrides'. In situations where the Tribunal has made the override we will take no action. This is often in circumstances where the person has stated, in their advance statement, that they do not wish to be in hospital and the Tribunal, having tested all the evidence, have decided that a hospital-based order is appropriate. As the individual concerned is often at the Tribunal and is given a copy of the papers and the decision, then we assume that the decision has been fully discussed with them. In all other circumstances we will make a decision about whether to enquire further on a case by case basis.

Personal statements

The Principles of the Act state that the past and present wishes of the individual, their background, beliefs and abilities, should all be taken account of when making decisions about care and treatment. A personal statement is the opportunity to record this information and ensure that an individual's wishes that cannot/should not be included in an advance statement are taken into account.

The personal statement should record all the information which will help staff care for the individual. This might be practical information about who should be contacted if they become unwell, arrangements for looking after home or pets etc. It may also include information about physical health care, dietary or spiritual needs or family circumstances; in fact anything which will help services provide person-centred care. Any information which will help staff caring for the individual to meet their needs is relevant and, under the principles of the Act, should be taken account of by staff. It may also include matters which would form part of a 'living will' or 'advance directive'. This may be particularly important for people with a diagnosis of dementia who have made 'living wills' regarding their future treatment. Where such a document is in existence it should be appended to any personal statement or advance statement.

Individuals who have already had experience of mental illness may wish to include information about how to recognise when they are becoming unwell and what has been found to be helpful or otherwise. They may have included it within other plans such as wellness recovery action plans (WRAPs), crisis plans etc. and these can then be incorporated into, or appended to any personal statement.

Unlike an advance statement, a personal statement doesn't need to be witnessed to be recognised. However, it should be dated and signed. This makes sure that the information is up to date. Many people find it helpful to complete their advance statement and personal statement at the same time and have them kept together in their notes; this means staff have access to both documents. Independent advocacy can be helpful in supporting people to complete a personal statement as well as an advance statement.

We have included a template for a personal statement as an appendix (see Appendix 2), with suggested headings. The list is not exhaustive and the personal statement can include anything which is relevant to the individual's care.

mentalwelfare commission for scotland

MY VIEWS
MY TREATMENT

ADVANCE STATEMENT
MADE UNDER THE MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003

Name of person making this statement: .....

Address: .....

.....

This advance statement supersedes any previous or existing statement.

I ..... [name] wish the following views to be taken into account, in the event of decisions about my care and treatment being made under the Mental Health (Care and Treatment) (Scotland) Act 2003, and my being unable to express my views about my care and treatment at that time.

1. I would like to receive the following treatments:

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

2. I would **not** like to receive the following treatments:
(It would be helpful to explain why, e.g. previous side effects)

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

3. Signature: ..... Date: .....

I certify that in my opinion ..... has the capacity of properly intending the wishes set out above. (note you are certifying capacity not agreeing with the person's wishes).

Witness signature: ..... Date: .....

Full name of witness: .....

Address of witness: .....

.....

Occupation/category which enables the witness to act as a 'prescribed person'

Those who can witness an Advance Statement are: a clinical psychologist entered on the British Psychological Society's register of chartered psychologists, a medical practitioner, an occupational therapist registered with the Health Professions Council, a person employed in the provision of (or in managing the provision of) a care service, a registered nurse, a social worker and a solicitor.

What to do with your advance statement

You should send a copy to your local hospital medical records department so that your statement can go in your records. The person witnessing your statement may be able to help with this.

You should also give a copy to any professional involved in your care and treatment, for example your psychiatrist, community psychiatric nurse, mental health officer or general practitioner. Your independent advocate, lawyer and named person may want to have a copy too.

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MY VIEWS
HOW YOU CAN HELP ME

PERSONAL STATEMENT

This information is intended to help staff support and care for you. It will help them know what is important to you. Below are some suggestions of the kind of things you may want to include.

Personal statement of .....

Date of Birth: .....

I prefer to be called .....

If I am admitted to hospital please let the following people know:

Name	Relationship (i.e. parent, employer, friend)	Contact details

Anything which needs to be dealt with if you are admitted to hospital such as:

If you have pets, who will take care of them or what arrangements should be made?

If you have carer responsibilities, how will these be managed whilst you are unwell?

How will your bills be paid and your mail be dealt with if you are in hospital for a while?

Who should have access to your home whilst you are in hospital, i.e. is there someone who you would wish your keys to be given to?

Your physical health: Include any physical disabilities, health problems or concerns which you feel staff should know about, information about any medication or treatment relating to physical health problems or dietary information.

Relationships and information sharing: Who you would like information to be shared with? Anyone you do not wish information to be shared with or do not wish to visit you?

I find the following things help cope with my illness and help my recovery:

.....

.....

.....

.....

.....

These things make me feel worse:

.....

.....

.....

.....

.....

Spirituality/religious beliefs: Any information which you feel would help staff to support you in observing your religious beliefs.

.....

.....

.....

.....

.....

Signed: .....

Date: .....

Appendix 3

Useful information about advance statements for service users and carers

1. Planning Ahead with an Advance Statement. – Bipolar Scotland
   http://www.bipolarscotland.org.uk/leaflets/planning-ahead-with-an-advance-statement.pdf

2. Frequently Asked Questions About Advanced Statements, User and Carer Involvement
   http://www.userandcarer.co.uk/publications/our-own-publications/

3. Advance Statements: A service user's guide to Advance Statements. –
   The Consultation and Advocacy Promotion Service (CAPS) and Advocard.
   http://www.advocard.org.uk/pdfs/advance-statements-guide-july-2012.pdf

4. The New Mental Health Act – A Guide to Advance Statements. – The Scottish Government
   http://www.scotland.gov.uk/Resource/Doc/26350/0012826.pdf

5. Our Guide to Advance Statements - The Mental Welfare Commission
   http://www.mwcscot.org.uk/get-help/getting-treatment/advance-statements/


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