mental welfare
commission for scotland

Advance statement overrides monitoring report 2017-18 and 2018-19

Statistical Monitoring

February 2021

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

Advance statement overrides monitoring report 2017-18 and 2018-19

Advance statements are written statements made by an individual when they are well setting out the mental health care and treatment they would prefer or would not want should they become unwell in the future. They are powerful ways of allowing the voice of a person who uses services or patient to be heard at times when they may be so unwell that, despite support, they cannot fully express those wishes. However sometimes advance statements are overridden. We call these advance statements overrides (ASOs).

An advance statement can be overridden if the professional giving care or treatment does not think what the individual had specified in the advance statement would be in their best interests at that time. If this happens there are safeguards in place to ensure that this is reviewed and the professionals involved have to justify their decision. Safeguards include that the treating psychiatrist, designated medical practitioner or Mental Health Tribunal must provide an explanation in writing of their reasons for their decision and the circumstances. This written explanation must be provided to the individual and the Mental Welfare Commission (who will then review the written explanation). It must also be placed in the individual's medical records.

At the Commission, we determine whether we are satisfied from the explanation that the ASO was clinically justified. If we need more information to help us make this decision, we ask for this. If we were then to reach the view that the ASO was not justified, we would consider what action to take and write to the patient and relevant others to inform them of our actions and the outcome.

This report focusses on advance statement overrides (ASOs). We present the data on:

- the number of overrides the Commission was informed about over the years 2017-18 and 2018-19;
- detail of the wishes and refusals that were overridden;
- and the actions the Commission took in some of these cases.

Summary

The Commission received 137 advance statement override notifications in 2017-18, and 162 in 2018-19. Some patients had several ASO notifications made to us. The Commission's policy is to examine and undertake further monitoring of overrides of advance statement wishes relating to medication, ECT and artificial nutrition ('core treatment' ASOs). Fifty eight individuals had a core treatment ASO in 2017-18, and 80 in 2018-19.

The most common treatment ASO related to medication; of these the most common medication ASO was related to a refusal for depot medication that was overridden.

When we are notified of an override, a Commission medical officer checks that the override notification provides sufficient detail; whether the advance statement was properly regarded; and whether the decision to override the advance statement was necessary and justified. The Commission undertook follow up for 32% of individuals who had an ASO in each year. Where we sought more information about ASO decisions, we were satisfied from our enquiries that

the actual treatment decisions made were justified, and that the decision had been made in accordance with the Principles of the Act.

However, there are clear gaps in the data around the whole process that limits the Commission's ability to provide assurance that the system as a whole is working as well as it could.

We are concerned that the register of advance statements in Scotland - which, since June 2017, has been held by us in the Commission – is incomplete. There has been a renewed emphasis on supporting people to write advance statements, and it is particularly helpful that this is within the Scottish Government mental health quality indicators. However, we found that in some cases we had not been informed of an advance statement's existence although we had been informed that it had been overridden. At other times we noticed that an advance statement that the Commission was aware of had not been regarded.

By the end of March 2019, 411 people had had an advance statement registered on our register for the whole of Scotland. However, the register only contains details of advance statements written after June 2017. It does not contain information about numbers of advance statements still in existence that were written before then. Until the processes around data reporting are improved, we do not know how many advance statements are in operation and therefore cannot meaningfully estimate what proportion of advance statements are overridden.

From the data we do have this report indicates the most common situations in which advance statements about medication are overridden. These are:

- Prescription or authorisation of a depot antipsychotic (almost half of all medication ASOs in both years).
- Other antipsychotic ASOs (30% in 2017-18; 25% in 2018-19)
- An ASO of a wish not to have any medication (around 10%).

Recommendations

This report makes a number of **recommendations**. These are:

To Health Boards, responsible medical officers (RMOs) and mental health officers (MHOs)

- Health boards should ensure that processes for sending the Commission an ADV1 form for all advance statements received, or revoked, are robust. This is necessary for advance statements to be included on the advance statement register.
- RMOs and other doctors treating patients under the Act must make the required s276 notifications if they override an advance statement. Health boards should ensure that this is well known among psychiatrists, and consider quality improvement programmes for this.
- Health boards should ensure that there are robust processes to ensure that, when a patient has made an advance statement, this is well known and easily accessible to professionals who must have regard to these including visiting designated medical practitioners (DMPs) appointed by the Commission. (It is good practice to keep a copy of the advance statement with the patient's medication prescription sheet).

- The MHO should also take steps to ensure that a patient's advance statement is known and regarded.
- If a patient subject to the Act has an advance statement, the MHO and RMO should ensure that they accurately record on detention paperwork that the patient *does* have an advance statement.
- We would encourage health boards to undertake quality improvement work around advance statement management and regard for advance statements.

To the Scottish Mental Health Law Review

- In the context of the increasing numbers of overrides and the scrutiny of these overrides, we would like to suggest that Review considers:
    - what types of wishes should be properly included in an advance statement. This might include discussion of whether it is permissible to state a wish or refusal to be treated in hospital;
    - whether to separate advance statements requesting a treatment from statements that refuse a treatment; and
    - how such a distinction might relate to the mechanism and the powers of oversight bodies with regards to scrutiny and implementation.
- The Scottish Mental Health Law Review might also consider how and when advance statements are written, the status of these documents over time, and clarify when they become operational as advance statements, particularly in the context of the drive towards supported decision making.

Authors

Dr Mike Warwick, Medical Officer

Dr Arun Chopra, Medical Director

Advance statement overrides – monitoring report 2017-18 and 2018-19

Contents

Chapter 1:Introduction

The introduction provides an overview of advance statements; an overview of the Commission's advance statement override (ASO) monitoring, and the numbers of ASOs in previous years.

Readers who are already familiar with advance statements may wish to move on to the next chapter for findings from ASO monitoring in 2017-18 and 2018-19 and recommendations.

The Mental Health (Care and Treatment) (Scotland) Act 2003[1] ('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". 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, ASO notifications are monitored. We check that the ASO treatment decision was necessary, and that adequate reasons have been given for this.

This is our report of our ASO monitoring work for our reporting years 2017-18 and 2018-19, and the numbers of people who had ASOs notified to us.

Advance statements and their content

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.

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

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).

The Commission has published advance statement guidance for individuals ('*Advance statement guidance; my views my treatment'*[2]). This, and other useful information about advance statements, is available on our advance statement webpage[3].

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; and
- Which other forms of therapeutic intervention they do or do not want to receive and why.

Writing an advance statement

On page 7 of '*Advance statement guidance; my views my treatment'*[4]), we outline a step by step guide to how someone can draw up an advance statement and keep it under review.

The steps are:

1. Write the advance statement in accordance with our guidelines (a suggested template is included on our webpage[5]).
2. Discuss the advance statement with the person who will act as witness and confirm that you have the capacity to make the advance statement.
3. Give a copy to your consultant psychiatrist. It needs to be included in your medical notes.
4. Read through it from time to time to make sure the content still reflects your views.
5. Keep a list of anyone else who has a copy of your advance statement. If you later decide to change your advance statement, you should send them a copy of your new advance statement and/or withdrawal document. They should ensure that they replace copies of any old advance statement you have withdrawn with your current one. This should avoid error or confusion.

The criteria for, and steps to be taken, for a person to withdraw an advance statement are the same as when drawing one up. The person needs to do this in writing and a witness must certify that they are capable of deciding to do this.

Personal statements

An individual may wish to record other preferences they have for aspects of their care plan in the event of them becoming significantly unwell in the future. These preferences can be described in a personal statement which can accompany an advance statement.

[2] https://www.mwcscot.org.uk/sites/default/files/2019-06/advance_statement_guidance.pdf
[3] https://www.mwcscot.org.uk/law-and-rights/advance-statements
[4] https://www.mwcscot.org.uk/sites/default/files/2019-06/advance_statement_guidance.pdf
[5] https://www.mwcscot.org.uk/law-and-rights/advance-statements

We have provided information about personal statements, and how to make and use these, in our *'Advance statement guidance; my views my treatment'*[6]. A suggested template for a personal statement is included on our webpage[7].

Including a personal statement can give the individual the added comfort of knowing that they have taken reasonable steps to ensure that, if they become unwell in the future, their individual preferences and personal context will be fully considered by the clinical team responsible for their care.

Promotion of advance statements, support for their use, and sources of information

Since June 2017, health boards have had a duty to promote advance statements and notify the Commission when one has been made, stating where it can be located. The Commission now keeps a register with this information. The Scottish Government has issued interim guidance on advance statements pending the statutory Code of Practice being updated following these changes to the Act[8].

The promotion and use of advance statements encourages collaboration between a clinical team and patients in identifying those aspects of a treatment plan of most importance to the patient, and most likely to build strong therapeutic relationships and promote recovery.

In addition to our guidance for individuals[9], we have published advance statement guidance for professionals[10].

Our webpage[11] also includes short film clips about the experiences individuals have had in the creation of their advance statement and subsequent use during spells when they were most unwell.

The inclusion of an advance statement in the creation of a care plan for an individual provides an opportunity for person-centred care, which is in keeping with the Principles that underpin the use of the Act[12] (these are set out in section 1 of the Act)[13]. It also accords with the principles outlined in our Good Practice Guide *Person Centred Care Plans*[14], published in August 2019.

---

[6] https://www.mwcscot.org.uk/sites/default/files/2019-06/advance_statement_guidance.pdf
[7] https://www.mwcscot.org.uk/law-and-rights/advance-statements
[8] https://www.gov.scot/publications/mental-health-law-in-scotland-interim-guidance-on-patient-representation-provisions/
[9] https://www.mwcscot.org.uk/sites/default/files/2019-06/advance_statement_guidance.pdf
[10] https://www.mwcscot.org.uk/sites/default/files/2019-06/advance_statement_guidancesep2018revision.pdf
[11] https://www.mwcscot.org.uk/law-and-rights/advance-statements
[12] https://www.legislation.gov.uk/asp/2003/13/contents
[13] https://www.gov.scot/publications/mental-health-care-treatment-scotland-act-2003-code-practice-volume-1/pages/0/
[14] https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

The Scottish Government have included the number of people who have an advance statement registered with the Commission per year as a Quality Indicator of mental health services under Action 38 of the Mental Health Strategy 2017-2027.

The Scottish Government see advance statements as a type of patient generated anticipatory care plan that describes preferences for any future treatment under compulsion and as part of the rationale for collecting this information suggest that having an advance statement is closely associated with individual collaborative care planning and health education. https://beta.isdscotland.org/find-publications-and-data/conditions-and-diseases/mental-health/mental-health-quality-indicator-profile/17-september-2019/
(accessed 12 October 2020)

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[15].

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.

For the Commission to be able to place advance statements on the register, we depend on there being good local advance statement management processes.

Advance statements in practice, and issues that can arise

In our guidance for individuals[16], we discuss the potential for advance statements to be overlooked and not taken into account when they are most needed.

Professionals have a duty to enquire if an individual has an advance statement. They should ask the person themselves, and in case of any doubt also their advocate or named person (if the patient has one).

A copy of a patient's advance statement should be made available in their case notes for people making treatment decisions to see e.g. the responsible medical officer (RMO), other

[15] https://www.gov.scot/publications/mental-health-law-forms/
[16] https://www.mwcscot.org.uk/sites/default/files/2019-06/advance_statement_guidance.pdf

doctors, and other visiting professionals such as a designated medical practitioner (DMP)[17]. The advance statement should be clearly labelled and easily found.

Hospitals and community mental health services should make it as easy as possible for clinical teams to establish whether an individual has an advance statement, and to be able to access it in a timely manner.

MHOs and RMOs should accurately answer and record on Mental Health Act paperwork whether or not a patient has an advance statement. They should work together to make sure that, if the patient attends any Tribunal, the Tribunal is shown a copy of any advance statement.

RMOs should make sure that any visiting DMP is aware of an advance statement.

We believe it is important that these system-based steps for advance statement management are reliably in place in order to reduce the likelihood of advance statements being inadvertently overlooked.

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.

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 DMP, 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

[17] 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).

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").

If the 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 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[18] 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 the notifications of ASOs that we receive. This is undertaken by a Commission medical officer.

We note with interest the recommendation made as part of the research gathered to inform the Independent Review of the Mental Health Act for England and Wales regarding the introduction of statutory advance choice documents and that their future MHA should empower a specialised body for England and Wales (which they describe as similar to the Mental Welfare Commission Scotland) to facilitate awareness of mental health Advance Decision Making Documents, provide case review and develop guidelines.[19]

The Commission's policy is to undertake ASO monitoring for notifications of ASOs in respect of wishes regarding:

a) Medication;
b) ECT; and
c) Artificial nutrition.

For brevity, at times in this report we refer to these as "core treatment ASOs".

[18] 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.

[19] Advance decision-making in mental health – Suggestions for legal reform in England and Wales (2019) Owen et al, International Journal of Law and Psychiatry,64,162-177

Our process involves the following steps following notification of an override:

1. We routinely obtain a copy of the advance statement, review the content, and check that it is properly completed, witnessed and valid.
2. 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 notified us of the ASO)).
3. 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.

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).

The Commission's ASO monitoring - previous findings and the context of this report

We have been monitoring advance statement overrides that we have been notified of since advance statements became operational in 2005. We published our figures for ASOs notified to us in our annual Mental Health Act monitoring reports from 2006/7 up to 2016/17. (Our reporting year is from 1 April to 31 March, not a calendar year).

Table 1 shows the last figures we published for ASOs notified to us. This was included in our Mental Health Act monitoring report for 2016/17[20].

[20] https://www.mwcscot.org.uk/sites/default/files/2019-06/10.09.2018_2017-18_awi_monitoring_report_0709_with_appendix_b.pdf

Table 1: Notifications of treatment that is in conflict with an advance statement by year 2009-10 to 2016-17

	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Number of overrides	29	18	19	18	31	47	66	55
Common reasons for override:								
Override of a Refusal of depot injection	16	9	11	5	20	20	29	*20
Override of a Refusal for any medication	5	3	2	6	0	5	13	8
Refusal of or Request for one specific medication				4	6	10	12	*9
Refusal of ECT	1	2	1	1	0	3	2	0
Other	7	4	5	2	5	9	10	18

**One individual was included in both categories*

After 2016/17, we moved to producing detailed reports of our Mental Health Act monitoring for two-year periods.

We present in this report our advance statement monitoring figures for 2017-18 and 2018-19, and our findings. In doing so, we will highlight examples of good practice, and outline those aspects of the process requiring further attention and review – from assisting with the creation of an advance statement (and personal statement), to storing, retrieving, utilising, and steps taken when overriding advance statements.

This is our first publication given over exclusively to monitoring how advance statements have been registered, regarded, and on occasions overridden in Scotland. We have identified some themes for improvement, and provided some recommendations.

The Commission's ASO monitoring systems and comparability of figures

We made some changes to our systems for recording ASOs for 2017-18 and 2018-19.

Due to changes in our processes, the figures in this report for numbers of patients with ASOs in 2017-18 and 2018-19 are not directly comparable with those for previous years in Table 1.

We have provided more information in Appendix 1 about our ASO monitoring processes, and changes we have made to these.

Although we explore overrides with regards medication, ECT and artificial nutrition in more depth, we also recorded notifications of overrides of other advance statement wishes that we received in 2017-18 and 2018-19. We did not undertake detailed monitoring or follow-up for those. However, we wanted to ensure an overview of all notifications we received during this period, and what those were.

Chapter 2: Our findings from our ASO monitoring 2017-18 and 2018-19, and recommendations

A good practice example

Mr X, and a DMP's careful regard to his advance statement

Mr X has a long history of schizophrenia. He was admitted to hospital under a short term detention certificate (STDC) following a deterioration in his mental state. He was further detained under a Compulsory Treatment Order. Ten weeks after his admission he wrote an AS in which he said he did not want to receive clozapine. At that time he was being treated with risperidone and depot paliperidone, for which he had given informed consent. This was authorised on a T2B certificate[21].

Five months later, Mr X was still in hospital and experiencing severe, distressing hallucinations. His RMO considered that they should prescribe clozapine, as he had responded best to this in the past. However, this had been stopped due to significant clozapine-induced weight gain (5 stones), about which Mr X had been very distressed.

A DMP visited Mr X to consider whether to authorise clozapine. The DMP had regard for Mr X's advance statement, and undertook a detailed assessment. They explored with Mr X his concerns about clozapine and his previous weight gain.

The DMP wrote a long ASO notification letter to Mr X. They referred to his distressing symptoms, the previous treatments he had had, and how he had very much improved with clozapine previously and been able to return to work. The DMP considered that recommencing clozapine was necessary and in Mr X's best interests. They explained their reasons for authorising clozapine in conflict with Mr X's advance statement, and that they had consulted with several colleagues.

The DMP took particular steps to make sure that Mr X's weight, and the benefit of clozapine vs any weight gain, was carefully monitored and kept under review. They explained all this to Mr X. The DMP specified that, if Mr X gained more than 6kg (around 1 stone), another DMP visit would be required if the RMO considered that clozapine should be continued. They also time-limited the T3B to 4 months, so that further DMP authorisation would be needed if clozapine was to continue after then.

[21] A T2B 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 T2B is required after 2 months of treatment unless the medication is to reduce sex drive, in which case the T2B is required immediately.

Advance statements, overrides and the completeness of the advance statement register

We do not know how many advance statements written after the introduction of the 2003 Act are in existence in Scotland. After the introduction of the advance statement register on 30 June 2017 there is a requirement to inform the Commission of new advance statements.

Forty three of the advance statements for which we received ASO notifications in 2017-18 and 2018-19 were written after the date of the opening of the register. The Commission should have been sent an ADV1 form notifying us of the existence of these advance statements i.e., all of these advance statement overrides should relate to an advance statement that we have a notification of.

This provides an approximation of how complete the register is.

Table 2 shows when these advance statements were written and whether they were on the register.

Table 2: Advance statements written after 30 June 2017 and whether these were on the advance statement register

Advance statement written	**2017-18** (after 30 June 2017)	**2018-19**
Advance statements for which the Commission recorded overrides	24	19
Number of those Advance Statements with ADV1 forms received + entered on the register	11 (46%)	13 (68%)

It is concerning that we were not notified of a significant proportion of these advance statements for which we later received override notifications. We note improvement in 2018-19 numbers.

It is not known how many advance statements that exist were written before 30 June 2017 and are not on the register. Therefore we cannot tell from our ASO monitoring what proportion of extant advance statements are overridden.

Over time, the proportion of the advance statements that are overridden that are on the register will increase and the usefulness of this data point will increase.

Recommendation

Health boards should ensure that processes for sending the Commission an ADV1 form for all advance statements received, or revoked, are robust. This is necessary for advance statements to be included on the advance statement register.

Advance statement override notifications received

We received 137 notifications that content of an advance statement had been overridden in 2017-18, and 162 in 2018-19.

Table 3 shows the numbers of these notifications that were made by RMOs, DMPs and Tribunals.

Table 3: ASO notifications made to the Commission in 2017-18 and 2018-19

ASO notifications made by	2017-18	2018-19
Mental Health Tribunal	83	118
RMO	17	7
DMP	37	37
Total notifications	**137**	**162**

We received fewer ASO notifications from RMOs than from DMPs or Tribunals. RMOs may not always need to make an ASO notification when a DMP or a Tribunal does, e.g. if it is an ongoing ASO situation that the RMO has previously notified. However, we think that RMOs are not always making ASO notifications when they should. We explore this in the section **RMOs and s276 notifications of ASOs below.**

Table 4 shows the types of advance statement wishes that were overridden.

Table 4: Advance statement wishes in ASO notifications to the Commission in 2017-18 and 2018-19

AS wishes overridden in notification	2017-18	2018-19
Medication	108	118
Medication + wish not to be hospitalised	3	3
Medication + other treatment wish		5
ECT	1	
Artificial nutrition		2
Artificial nutrition + other treatment wish		2
Not to be hospitalised	17	20
Not to be hospitalised + other treatment wish		2
Other treatment wish	8	10
Total notifications	**137**	**162**

The total numbers of ASO notifications mentioned above include more than one ASO notification for some individual patients in the same reporting year.

We received one or more ASO notification(s) for 81 patients in 2017-18, and 110 patients in 2018-19.

More detailed information is contained in Appendix 2.

One hundred and twelve of the ASO notifications we received in 2017-18 (82%) were for core treatment wishes (medication, ECT or artificial nutrition). For 2018-19 this was 130 (80%). These are the ASOs that it is the Commission's policy to monitor and follow up if indicated.

There has been an increase in the number of ASO notifications. More resource will be required if all core treatment ASOs notifications are to be routinely monitored at the level that might best protect rights.

Advance statement overrides for medication, ECT and artificial nutrition

The above mentioned notifications that involved medication prescribed or authorised in conflict with the patient's advance statement related to 65 individual patients in 2017-18, and 86 patients in 2018-19.

As we began our process of exploration for some of these patients, we determined that the situation was not an actual advance statement override (eight patients in 2017-18, nine patients in 2018-19). This included circumstances where the patient was not unhappy with the treatment decision, or they had declined to take treatment that they had said in their advance statement that they wanted. We excluded these patients from our figures for medication ASOs[22]. We have provided more information about this in Appendix 3.

Our figures for patients we considered to have had actual medication ASOs are 57 people in 2017-18 and 77 in 2018-19.

We considered that all patients for whom we received notifications of ASO decisions to give ECT or artificial nutrition had had an actual ASO.

Table 5 shows the overall numbers of ASOs.

Table 5: Medication, ECT and artificial nutrition ASOs in 2017-18 and 2018-19

Advance statement wish overridden/ASO type	2017-18	2018-19
Numbers of people:		
Medication ASO	57	77
Wish not to have ECT	1	0
Wish not to have artificial nutrition (nasogastric feeding)	0	3
Total ASOs	58	80

For the majority of patients who had a medication ASO, the primary ASO[23] was the prescription or authorisation of an antipsychotic (77% in 2017-18; 73% in 2018-19). This is shown in Table 6.

[22] We use the term "medication ASOs" to refer to ASOs where medication was prescribed or authorised in conflict with the advance statement. A significant number of ASO notifications we receive are from DMPs authorising treatment on a T3 certificate. In some cases, the medication that is an ASO may not actually be given (e.g. authorisation of a depot antipsychotic in the event that the patient is non-concordant with oral medication, and that does not happen).

[23] For people who had more than one AS clause relating to medication overridden in the reporting year, we included in our figures what we considered to be the primary ASO.

For almost two thirds of those patients, the antipsychotic was depot antipsychotic in conflict with a clear advance statement wish not to have a depot or injected medication (63% in 2017-18; 66% in 2018-19).

Depot antipsychotic ASOs accounted for almost half of all primary medication ASOs.

Table 6: Focussing on antipsychotic medication (Appendix 4 contains more detailed information)

	2017-18	2018-19
All medication ASO patients	**57**	**77**
Wish not to have depot antipsychotic medication	19	27
Wish not to have injections (general); ASO = depot antipsychotic prescribed/authorised	8	10
Other antipsychotic ASO	17	19
Other medication ASO	13	21

If an individual is to be compulsorily given a depot antipsychotic injection against their wishes, the decisions to authorise and prescribe this must be made with careful regard to the Principles of the Act. The requirements for RMOs and DMPs to have regard for an advance statement and make s276 notifications are important safeguards, and help to make sure that the patient's past wishes are properly considered.

Appendix 4 contains detailed information about the core treatment ASO notifications we received, and the wishes overridden.

Appendix 4, table 10 contains more information about medication wishes overridden. Most primary medication ASOs were overrides of refusals for medications. There were only 3 patients in 2017-18 and 6 patients in 2018-19 for whom the only medication ASO was an override of a preference for a particular medication.

The number of patients who had core treatment ASOs increased significantly between 2017-18 and 2018-19. This may be due in part to the promotion of advance statements and the introduction of the advance statement register after 30 June 2017, and also the Mental Health Quality Indicator in respect of numbers of registered advance statements set by the Scottish Government in September 2018[24].

[24] https://www.gov.scot/publications/mental-health-quality-indicators-background-secondary-definitions/pages/8/

First-time ASO notifications, and further notifications for the same patients

After we are first notified of an advance statement override, we often receive further notifications of medication ASOs for the same patient in the same MHA episode[25]. These are mostly DMP decisions to continue authorisation for the treatment on a T3 certificate, or from a Tribunal.

We have provided information in Appendix 5 about the numbers of patients for whom we had previously recorded ASOs.

In both years, just under half of patients who had medication ASOs were having their first ASO notified to us in the current MHA episode.

For 28 of the 57 patients with medication ASOs in 2017-18 (47%), we received further ASO notifications in 2018-19 in the same MHA episode. These patients thus appear in the ASO figures for both years.

RMOs and s276 notifications of ASOs

As mentioned above we received relatively few ASO notifications from RMOs.

For those patients for whom we recorded a first core treatment ASO notification in the current detention episode in the reporting year, we received an ASO notification from the RMO for 5/29 patients in 2017-18 (17%) and 2/41 patients in 2018-19 (5%).

The RMO may not have considered some of the other override situations to have been actual ASOs, e.g. if the patient had quite recently written an advance statement and in the RMO's view was that it was not yet operational.

In some cases the patient may not actually have been given medication that was the subject of an ASO notified to the Commission, e.g. a DMP making a notification of an ASO when they approve a depot on a T3B, to be given if oral medication is not effective due to non-concordance.

However, a number of these ASO situations will have been circumstances where the RMO commenced a treatment without making an ASO notification. The Tribunal or a DMP's s276 notification will then be the first written notification that the Commission, and presumably the patient, receives.

If there is not enough information in an ASO notification made by the Tribunal or a DMP about the RMO's reasons for the override, our follow up may include contacting the RMO.

As there has been an increase in the number of ASO notifications, consideration of how ASO notifications are all to be routinely monitored at the level that might best protect rights is now required.

Later in this report we make a recommendation considering drawing a distinction between requests for and refusals of certain treatments.

[25] We use the term "MHA episode" to refer, in shorthand, to a continuous period of compulsory treatment authorised under the Mental Health (Care and Treatment) (Scotland) Act 2003, or the Criminal Procedures (Scotland) Act 1995.

It is important that RMOs and other doctors treating patients under the Act are fully aware that they need to have regard for an advance statement and make s276 notifications if they override this. It is not correct to leave this, and consider that the ASO being discussed with a Tribunal or a DMP, and them making s276 notifications, will suffice.

Recommendation

RMOs and other doctors treating patients under the Act must make the required s276 notifications if they override an advance statement. Health boards should ensure that this is well known among psychiatrists and consider quality improvement programmes for this.

Other notifications of decisions in conflict with advance statements

As outlined earlier, the Commission's policy is to undertake ASO monitoring for notifications of ASOs in respect of wishes regarding medication, ECT and artificial nutrition.

We have not previously collated figures for ASOs of wishes to be treated in the community vs hospital, or notifications of decisions conflicting with other advance statement wishes.

For 2017-18 and 2018-19, we collected this information in order to be able to look at numbers of patients for whom we received these notifications, and the range of wishes these included. We have included details of this in Appendix 6.

We received notifications of ASOs concerning detention in hospital in conflict with wishes not to be hospitalised for 14 patients in 2017-18 and 16 patients in 2018-19.

Advance statements as currently formulated can include this desire to not be treated in hospital.

We received notifications of decisions conflicting with other advance statement wishes for seven patients in 2017-18 and 18 patients in 2018-19.

Some of those were wishes about matters that the Commission would advise should not be included in an advance statement, and would more appropriately be documented elsewhere, such as a personal statement e.g. preferences such as single rooms or particular wards.

We have found that there can be lack of clarity among patients and clinicians about what wishes can be included in an advance statement and what should not. We have also mentioned this in the section on content of advance statements below. We think it would be helpful if a review of this could be undertaken as part of the Scottish Mental Health Law Review.

Recommendation

We would like to suggest that the Mental Health Law Review considers what types of wishes should, and should not, be properly included in an advance statement.

The Commission's follow up undertaken following core treatment ASO notifications; problems with advance statement management

We reviewed all ASOs regarding medication, ECT and artificial nutrition to determine whether we were satisfied with the reasons given for the ASO, and that the patient and any named person had been notified (as required under s276).

We undertook follow-up and sought further information where:

- we were not clear what treatment was authorised or being given in conflict with the advance statement;
- we did not feel there was sufficient information in the notifications about the reasons for the ASO, or whether it was justified ;
- an RMO or DMP had not documented that they had made all the notifications required under s276

We were satisfied with the information and reasons given in the notifications we received for ASOs involving artificial nutrition and ECT.

We undertook follow-up actions for 18 patients who had a medication ASO in 2017-18 (32%); and 25 who had a medication ASO in 2018-19 (32%). Further detail about this is given in Appendix 7.

In some cases, the issues that we identified and followed up were not directly to do with the actual ASO decision/notification we were reviewing, but related to other matters we noted when we reviewed the patient's detention history and authority for treatment.

Our follow-up action usually involved phoning or writing to the RMO or DMP to discuss the ASO, and ask for more information or make suggestions.

Where we sought more information about ASO decisions, we were satisfied from our enquiries that the actual treatment decisions made were justified, and that the decision had been made in accordance with the Principles of the Act.

However, in some cases we had concerns about advance statement management, regard for advance statements at other times, or authority for treatment the patient had received.

In two cases we identified that the patient had received treatment that was not covered by a T2 or T3 certificate, and was thus given outwith the authority of the Act. We advised the RMOs to inform the patients of this, and of their rights to advocacy and to legal advice. They did this.

In nine cases we raised with the RMO or a DMP the need to provide notifications of the override to the patient and/or a named person that the Act requires. It is important that doctors are clear that it is a legal requirement that this is always done.

In nine cases we followed up advance statement management issues with the RMO that did not directly relate to the ASO notification being reviewed, but which we noted from the patient's Commission records. Eight of these patients had been visited by a DMP who had not been made aware of their advance statement, had thus not had regard for it, and had issued a T3 authorising treatment in conflict with it. Two had had a Tribunal with the Tribunal apparently being unaware of their advance statement. Please note the example below that demonstrates how this might happen:

A missed advance statement

Ms A wrote an AS in February 2018 in which she said that she would prefer her care and treatment to be community-based, and she did not want medication given by injection. Medical Records sent the Commission an ADV1 form, and the advance statement details were placed on the advance statement register.

The RMO completed a determination to extend Ms A's Compulsion Order (CO) in late May 2018, and indicated on the renewal form that, as far as they were aware, Ms A did not have an advance statement.

Ms A was visited by a DMP in June 2018 who saw her advance statement and gave good ASO reasons and notifications for issuing a T3B authorising depot antipsychotic and "if required" IM medication.

Ms A applied for revocation of the determination to extend her CO. The Tribunal saw the RMO's determination that indicated there was no advance statement. The Tribunal was not shown the advance statement, and made the decision to refuse Ms A's application for revocation without seeing it.

We found these advance statement override situations that had been missed when we reviewed ASOs that had been recognised and notified at a different point. There may be other patients whose advance statements have not been regarded that we do not know about.

We are very concerned about the incidents of poor advance statement management that we saw. When a DMP or a Tribunal are unaware of a patient's advance statement, and make decisions without having regard for it, the patient does not benefit from these important safeguards in the Act.

Where there is disorganisation about the regard for advance statements, and the steps required if they are to be overridden, then there is less likelihood of producing care plans that are truly person-centred. We see the importance of getting this right on the ground for patients as a quality issue for mental health services to address.

Recommendations

- Health boards should ensure that there are robust processes to ensure that, when a patient has made an advance statement, this is well known and easily accessible to professionals who must have regard to these including visiting DMPs appointed by the Commission. (It is good practice to keep a copy of the advance statement with the patient's medication prescription sheet).
- The MHO should also take steps to ensure that a patient's advance statement is known and regarded.
- If a patient subject to the Act has an advance statement, the MHO and RMO should ensure that they accurately record on detention paperwork that the patient *does* have an advance statement.
- We would encourage health boards to undertake quality improvement work around advance statement management and regard for advance statements.

Overrides of advance statements written recently

A significant number of ASO notifications are for decisions in conflict with advance statements that the patient has written quite recently.

We have included more information about this in Appendix 8.

We found that 24% of first-time core treatment ASOs in 2017-18 were in respect of advance statements that had been written within the previous 6 months. This rose to 34% in 2018-19.

This slight increase in 2018-19 may have been partly due to increased information provision about advance statements, and the introduction of the advance statement register from 30 June 2017. These ASO notifications involved 13 advance statements, of which 10 were on the advance statement register (77%).

There has been considerable confusion about the status of statements that have been recently written, sometimes very recently (occasionally even on the day of a Tribunal).

The witness has a duty to ensure that the person has capacity to make an advance statement. Some statements are written by patients who are already being treated under the Act. These patients by definition would have significantly impaired decision-making ability (SIDMA) for treatment of mental disorder but they may retain capacity to express wishes about aspects of their treatment. These can include wishes not to have medication that they are being given compulsorily, or that their RMO has been discussing prescribing for them.

The intention of the Act is to allow an individual to complete a written statement when they are well, saying how they wish to be treated (or not treated) *in the event* that they become mentally unwell, and have significantly impaired ability to make decisions about the matters referred in their advance statement.

The Commission has taken the view that a recently written statement may be a valid advance statement that has not yet come into effect as although the person may have SIDMA with regards to treatment of mental disorder, they may still retain capacity to hold and express wishes about the matters in the advance statement they are writing. While they can capably express those wishes there is no need for the advance statement to do this at this time and we do not think it should be operational. However, it is a useful contemporaneous statement of the person's views about their care and treatment, and should be considered as such in any discussions.

This is a complex area and hinges on a lack of clarity between SIDMA for treatment for mental disorder, SIDMA with regards to the matters on the advance statement and notions of capacity.

The Commission made some attempts in the past to exclude from ASO figures circumstances where an (advance) statement had recently been written, and appeared still to be a statement of the patient's current wishes rather than an operational advance statement. However, this can be very difficult or impracticable for us to determine with consistency.

We therefore took the decision to include in our ASO monitoring for 2017-18 and 2018-19 all notifications we were sent that told us that treatment had been given in conflict with an advance statement even though, as above, we don't think all of those advance statements were actually operational.

Thus, some overrides of very recent statements are included in our figures as ASOs, including one statement made day of the Tribunal that made a notification of treatment with medication in conflict with it.

We appreciate that some patients who are being treated under the Act write new advance statements because they have reviewed their thoughts about treatment, and their existing advance statement no longer fully reflects their current wishes. A mental health professional might have suggested to them that they consider doing this.

Generally, people write all their current wishes into a new advance statement and withdraw their old one, although some of their wishes may be unchanged from before. Therefore, while the current statement may be recent, the patient may actually have had an advance statement with some of the wishes it contains for a long time.

We hear questions from psychiatrists such as:

- When an individual writes an advance statement, they are recording their current wishes and are capable of expressing those. If they express those wishes again soon afterwards, is the statement an "advance" statement? (We don't think so as above.)
- Is an advance statement an advance statement immediately, with the need for s276 notifications if it is overridden? (We don't think so, as above.)
- If a patient makes an advance statement saying they do not want treatment that they are already receiving under the Act, how will I know if their decision making ability has changed sufficiently for the advance statement to have become operational? Should they be able to make an advance statement about that treatment?

We do not think there are clear answers to all the questions that arise about this. It may be quite difficult for RMOs and DMPs to decide that they do not think they should consider a patient's advance statement operational, and also when they should. We advise RMOs to contact the Commission when faced with a difficulty as we may be able to advise.

We think that issues to do with when an advance statement becomes valid when a person is subject to the Act and therefore has SIDMA for treatment for mental disorder but may, in the view of the witness, retain capacity to refuse or state a wish for a specific treatment requires review and clarification, and are pleased that the current Scottish Mental Health Law Review provides a forum to do that.

Recommendation

To the Scottish Mental Health Law Review

- In the context of the increasing numbers of overrides and the scrutiny of these overrides, we would like to suggest that Review considers:
    - what types of wishes should be properly included in an advance statement. This might include discussion of whether it is permissible to state a wish or refusal to be treated in hospital;
    - whether to separate advance statements requesting a treatment from statements that refuse a treatment; and
    - how such a distinction might relate to the mechanism and the powers of oversight bodies with regards to scrutiny and implementation.
- The Scottish Mental Health Law Review might also consider how and when advance statements are written, the status of these documents over time, and clarify when they

become operational as advance statements, particularly in the context of the drive towards supported decision making.

Content of advance statements that we saw

We have included below examples of clauses that were contained in advance statements for which we received ASO notifications.

Some advance statements we saw contained clearly written wishes, and information about the reasons for the individual's decision. It was easy for those involved in the person's care to know when treatment would or would not be an ASO.

> *I do not like taking chlorpromazine. It affects my speech and my vision and totally inhibits my natural sleep.*
>
> *I would not like to be given clozapine as it makes me salivate, gives me difficulty urinating and diarrhoea.*
>
> *I would prefer to be prescribed sulpiride medication. It worked in the past.*
>
> *I do not wish Acuphase, which I reacted to with a twisted tongue.*

Other advance statements contained wishes that did not stand alone as clear statements. In some cases, the person having regard for the AS might have needed to look for more information to know exactly what the patient meant in their AS.

> *I do not want my clozapine to be increased. I do not feel that I need to be on any more than I am just now.*
>
> *I would like my depot injection reduced.*

Some advance statements contained wishes other than treatment matters that we would advise someone to include in an advance statement. Such wishes and information can be very important and helpful, and can be included in a personal statement or other document as appropriate, e.g. a Recovery Plan, or a relapse prevention plan.

> *I would like to be supported to give presents to my sons via the social work department.*
>
> *I do not like sleeping in a room with the window open.*
>
> *I would like someone to ensure I am on the right benefits and if I am working then to re-establish housing benefits and council tax rebates from being off sick.*
>
> *Would like to try and budget my own money at some point in the future.*
>
> *A sign of unwellness is when my character changes e.g. agitated, aggressive.*

Conclusion

We are concerned that the register of advance statements held by the Commission remains incomplete because we are not always notified by health boards.

A number of advance statements contained information besides wishes about treatment, therapeutic interventions, and being treated in the hospital or community. This can sometimes make it less easy for those involved in a person's care to find their wishes about treatment in their advance statement.

People who support others to write advance statements and personal statements, and those witnessing advance statements, can play an important role in making suggestions to the writer to help make their wishes clear, and express them in the most appropriate document.

Overall, this review of advance statement overrides suggests that there are significant policy issues with the Advance Statement safeguard that require clarification.

The advance statement overrides that we explored and sought further information on were justified. However we note that there are examples where advance statements are not regarded because of a lack of awareness.

Advance statements are an important safeguard to respect people's wishes. Further work needs to be done on implementation and scrutiny mechanisms.

Chapter 3: Appendices

Appendix 1: The Commission's ASO monitoring systems, changes to those, and comparability of figures

We made some changes to our systems for recording ASOs for 2017-18 and 2018-19.

Due to changes in our processes, the figures in this report for numbers of patients with ASOs in 2017-18 and 2018-19 are not directly comparable with those for previous years (in Table 1).

The Commission's policy is to undertake ASO monitoring for notifications of ASOs in respect of wishes regarding medication, ECT and artificial nutrition (for brevity, at times in this report we refer to these as "core treatment ASOs".)

In the past, the Commission made some attempts to exclude from ASO figures circumstances where an (advance) statement had recently been written, and appeared still to be a statement of the patient's current wishes rather than an operational advance statement. This can be very difficult or impracticable for us to determine with consistency. We have included further comment about overrides of recent statements in this report.

For 2017-18 and 2018-19, we undertook ASO monitoring for, and included in the ASO figures, all patients for whom we received a notification that treatment had been authorised or prescribed in conflict with an advance statement, even if that statement had been quite recently written.

In previous years, we did not record details in our data collection system of ASO notifications for medication if these were further notifications of an ongoing ASO that we had already recorded in the past three years. We did review the clinical circumstances of the ASO and whether it was still justified. In 2017-18 and 2018-19 we recorded those notifications, as we did for first-time ASOs, but noted for our data collection that this was an ongoing ASO situation.

Many individuals have advance statements with multiple clauses regarding medication wishes. Sometimes ASOs of more than one advance statement clause for the same patient occur in the same reporting year. While we monitor all overrides of core treatment advance statement clauses, for 2017-18 and 2018-19 we coded what we considered to be the primary ASO for each patient. This is the ASO that we included in the overall numbers of patients who had medication ASOs in each reporting year.

If we receive a further ASO notification for a patient for the same AS clause in the same reporting year, this does not alter the overall figures reported for the number of patients who had ASOs during that year.

Appendix 2: Advance statement override notifications received

Table 7: ASO notifications made to the Commission in 2017-18 and 2018-19 - who sent the notifications; advance statement wishes overridden

AS wishes overridden in notification	2017-18	2018-19
Medication	108 *15 - RMO* *36 - DMP* *57 - Tribunal*	118 *4 - RMO* *35 - DMP* *79 - Tribunal*
Medication + wish not to be hospitalised	3 *3 - Tribunal*	3 *1 - RMO* *2 - Tribunal*
Medication + other treatment wish		5 *5 - Tribunal*
ECT	1 *1 - DMP*	
Artificial nutrition		2 *1 - DMP* *1 - Tribunal*
Artificial nutrition + other treatment wish		2 *1 - DMP* *1 - Tribunal*
Not to be hospitalised	16 *16 - Tribunal*	20 *20 - Tribunal*
Not to be hospitalised + other treatment wish		2 *1 - RMO* *1 - Tribunal*
Wanted shorter hospital admission	1 *1 - Tribunal*	
Other treatment wish	8 *2 - RMO* *6 - Tribunal*	10 *1 - RMO* *9 - Tribunal*
Total	**137**	**162**

The total numbers of ASO notifications include more than one ASO notification for some individual patients in the same reporting year.

We received one or more ASO notification(s) for 81 patients in 2017-18, and 110 patients in 2018-19.

Table 8: Number of patients for whom we received an ASO notification in 2017-18 and 2018-19, per health board area.

Health Board	**Number of patients with an ASO notification made**	
	2017-18	**2018-19**
Ayrshire and Arran	8	9
Borders	1	0
Fife	10	11
Forth Valley	6	5
Grampian	3	5
Greater Glasgow and Clyde	17	30
Highland	5	6
Lanarkshire	5	9
Lothian	16	17
The State Hospital	2	2
Tayside	8	16
Total	**81**	**110**

Appendix 3: Notifications of medication prescribed or authorised in conflict with an advance statement in 2017-18 and 2018-19, and whether the Commission considered these actual ASO situations

We received notifications that 65 patients had medication prescribed or authorised in conflict with their advance statement in 2017-18, and 86 patients in 2018-19.

We reviewed these notifications and excluded patients for whom we determined that the situation was not an actual advance statement override as the patient was not unhappy with the treatment decision, or they had declined to take treatment that they had said in their advance statement that they wanted.

These included circumstances such as the patient saying they were willing to take the treatment in question and that their advance statement no longer reflected their current wishes, and being advised to review their advance statement.

Table 9 contains more information about these cases, and the numbers of patients that we considered to have had actual medication ASOs.

Table 9: Patients with notifications of a medication ASO in 2017-18 and 2018-19, and whether the Commission considered this to be an actual ASO.

	2017-18	**2018-19**
All patients with notification of medication prescribed or authorised in conflict with AS	65	86
Those considered not actual ASOs by the Commission:		
Patient discussed with DMP their agreement with the treatment	3	2
Patient consenting to treatment and T2 in place	1	
Tribunal recorded the patient's agreement with the treatment	3	3
AS no longer relevant – patient had refused the treatment requested in AS	1	4
Total considered not actual ASOs	8	9
Total actual medication ASOs	**57**	**77**

Appendix 4: Detailed information about ASO notifications for medication, ECT and artificial nutrition – core treatment ASOs

We obtained copies of all the advance statements overridden in respect of wishes regarding medication, ECT and artificial nutrition (core treatment ASOs). We checked the content and that they were witnessed and valid.

Table 10 contains detail about advance statement wishes that were overridden. For people who had more than one AS clause relating to medication overridden in the reporting year, we included what we considered to be the primary ASO. We monitored the additional medication ASO treatment decisions but we are unable to report this due to confidentiality and data suppression rules as this relates to individual patients quite specifically.

Table 10: Medication, ECT and artificial nutrition – AS wishes overridden in 2017-18 and 2018-19

(If the individual had more than one advance statement wish in respect of medication overridden, we have included here what we consider to be the primary ASO.)

Number of patients with this ASO	**2017-18**	**2018-19**
All ASOs	**58**	**80**
Wish not to have depot antipsychotic medication	19	27
Wish not to have injections (general), depot antipsychotic prescribed/authorised	8	10
Wish not to have an antipsychotic that was prescribed/authorised	16	19
Wish not to have injections (general), IM “if required” antipsychotic prescribed/authorised	1	
Wish not to have injections (general), IM “if required” anxiolytic prescribed/authorised		1
Wish not to have any medication	5	8
Other medication ASO – other medication or dose of medication prescribed against AS wishes	3	6
Not prescribed preferred antipsychotic	2	4
Not prescribed preferred medication (medications other than antipsychotic)	0	1
Wish for medication that RMO did not consider clinically indicated	1	1
Medication in conflict with AS unspecified	2*	0
Wish not to have ECT	1	0
Wish not to have artificial nutrition (nasogastric feeding)	0	3

*Tribunal notifications for 2 patients referred to them receiving medication that was not in accordance with their advance statement, but did not specify details. Both were not yet due a T2B or a DMP visit (to

consider issuing a T3). We received later ASO notifications for both these patients, and they are also included in the 2018-19 figures.

Of the 77 patients who had an AS wish in respect of medication overridden in 2018-19, 28 of them had also had a medication ASO in 2017-18. Those individuals are thus represented in the figures for both years.

In addition to those ASOs specifically categorised in Table 10 as relating to depot antipsychotics, another two individuals had named an antipsychotic that they did not want to receive and were prescribed this in depot form as an ASO. They had not specified whether they meant the oral or depot preparation of that drug, or both.

Five patients had said in their AS that they did not wish to receive clozapine, and were prescribed this as an ASO (two in 2017-18; three in 2018-19). Clozapine is an antipsychotic indicated in schizophrenia that is resistant to other treatment. It can have side effects, including sedation and significant weight gain, and requires regular blood monitoring.

Appendix 5: First-time ASO notifications, and further notifications for the same patients

Table 11 shows the numbers of patients among the medication ASO cases for whom we had previously recorded ASOs during the current Mental Health Act (MHA) episode (28 in 2017-18; 29 in 2018-19).

The majority of these previous ASOs were of the same advance statement, but not necessarily the same medication clause of that advance statement.

Table 11: Medication ASOs 2017-18 and 2018-/19, and whether the Commission had previously recorded a medication ASO in the same MHA episode

	Previous ASO in current MHA episode prior to 1 April 2017			**First time ASO in this MHA episode**	**Total medication ASOs**
	Of the same AS	Of a previous AS	Total		
2017-18	24	5	29	28	**57**
2018-19	31	8	39 [1]	38 [2]	**77**

[1] 27 of these individuals had a medication ASO in 2017-18, and are thus included in the figures for both years.

[2] One individual had a medication ASO in 2017-18, became informal, then was re-detained and had a further medication ASO in 2018-19. This patient is thus also included in the figures for both years.

All patients who had an ECT or artificial nutrition ASO had not previously had an ASO in the current MHA episode.

Appendix 6: Other notifications of decisions in conflict with advance statements

Advance statement overrides of wishes not to be treated in hospital

Table 12 shows patients for whom we received ASO notifications in respect of their detention in hospital in conflict with wishes not to be hospitalised (14 patients in 2017-18; 16 patients in 2018-19).

Table 12 Patients for whom the Commission received ASO notifications for compulsory detention in hospital in 2017-18 and 2018-19

2017-18	14 patients	(4 of them who also had a medication ASO notified that year)
2018-19	16 patients	(4 of them who also had a medication ASO notified that year)

Three of these patients had their AS wish not to be treated in hospital overridden in both years, and are thus represented in the figures for both years.

None of these patients also had an ASO for ECT or artificial nutrition.

These figures include people who had been in hospital for some time, and had a Tribunal that made an ASO notification about continuation of detention in hospital.

One further patient in 2017-18 had specified that they would want a shorter admission than was deemed necessary. An ASO notification was made by the Tribunal.

Notifications of decisions conflicting with other advance statement wishes

Table 13 shows details of notifications we received of decisions that conflicted with other advance statement wishes.

Table 13: Notifications of decisions conflicting with other advance statement wishes 2017-18 and 2018-19.

Advance statement wish	2017-18	2018-19
Location - Ward preference	2	1[1]
Location - wants different hospital	1	1
Location - wants hospital in home area	1	
Location - named hospital does not want admitted to		1
Location - Wants to live in own flat (was in supported accommodation)		1
Wants to be in locked ward		1
Wants a side room		2
Level of security - Not to be transferred to State Hospital (high security)		1
Level of security (wants lower security)		1
Wants unescorted passes from ward	1	
Wants more suspension of detention		1
Does not want restraint		1
Wish to be treated by specific individual		1
Wants treated by general adult rather than forensic psychiatry		2
No coping strategies for brain injury	1	
No nursing care		1
Wishes re not having physical activity limited (anorexia)		1
Does not want oral nutritional supplements (anorexia)		1
Specific wishes in relation to physical symptoms linked to mental disorder	1	
Wants to be on Care Programme Approach		1
Total number of patients	7	18

[1] This patient is also one of the 2 patients with a "Location – ward preference" ASO in 2017-18. This is the only patient to appear in the figures for both reporting years in this table. They also had a medication ASO in each reporting year.

Two of these patients in 2017-18 also medication ASOs that year (one of them also had a medication ASO in 2018-19). Eight other patients in 2018-19 had other ASOs that year (five for medication, two for artificial nutrition, and one of a wish not to be admitted to hospital).

Appendix 7: Follow up undertaken following ASO notifications; problems with advance statement management

Follow-up actions for patients for whom we received notifications of medication ASOs, as summarised in Table 14.

Table 14: Follow up undertaken by the Commission following ASO notifications - contacts made. 2017-18 and 2018-19

Follow up with:	**2017-18 ASOs**	**2018-19 ASOs**
RMO	8	18
DMP	6	4
Both RMO and DMP	1	1
DMP + Ward		1
Ward for more information about the patient's treatment	3	1
Total	**18**	**25**

The issues that we contacted RMOs and DMPs about are summarised in Table 15. Some of these were not directly to do with the actual ASO decision/notification we were reviewing, but related to other matters we noted when we reviewed the patient's detention history and authority for treatment.

Table 15: Follow up undertaken by the Commission following ASO notifications – matters raised, 2017-18 and 2018-19

Follow up undertaken:	**2017-18 ASOs**	**2018-19 ASOs**
RMO – re need to make ASO notification to patient or named person [1, 4]	3	2
RMO - advised to provide more detailed written reasons in ASO notification	1	
RMO for more information about the ASO / treatment [1]	2	3
RMO for more information about patient's consent to treatment	0	5
RMO re AS management issues	2	7
RMO re non-ASO matter: T3 >3years old [2]	2	2
DMP re need to have regard for current AS (having seen an old one)	1	
DMP – re need to make ASO notification to patient or named person [2, 5]	2	2
DMP for more information about the ASO + treatment[3]	2	
DMP re not having recognised further ASOs concerning treatments authorised on T3	1	
DMP - advised re ASO they had not recognised + to ensure T3 fully covered treatment [4]		1
DMP – Commission provided advice on ASO good practice	1	1
DMP – Commission provided advice on T3 completion[3]	1	2
Phoned ward nursing staff for further information re patient's treatment [5]	3	2

Numbers in superscript each represent one patient for whom two follow up actions were undertaken, as indicated.
2017-18 – patients indicated by numbers 1, 2 and 3
2018-19 – patients indicated by numbers 4 and 5

For four patients, follow up actions were undertaken for 2017-18 and 2018-19 ASOs. They therefore appear in the figures for both periods.

Appendix 8: Overrides of advance statements written recently

For patients with ASOs relating to medication, artificial nutrition or ECT (core treatment ASOs), Figure 1 shows the length of time between the date the advance statement was written and the date of the ASO (expressed as a percentage of the total ASO cases for 2017-18 and 2018-19).

Figure 1 shows all individuals, including those with ASOs in both years, or for whom we had recorded previous ASOs in previous reporting years.

Figure 1: The interval between the advance statement date and core treatment ASO (all core treatment ASO patients)

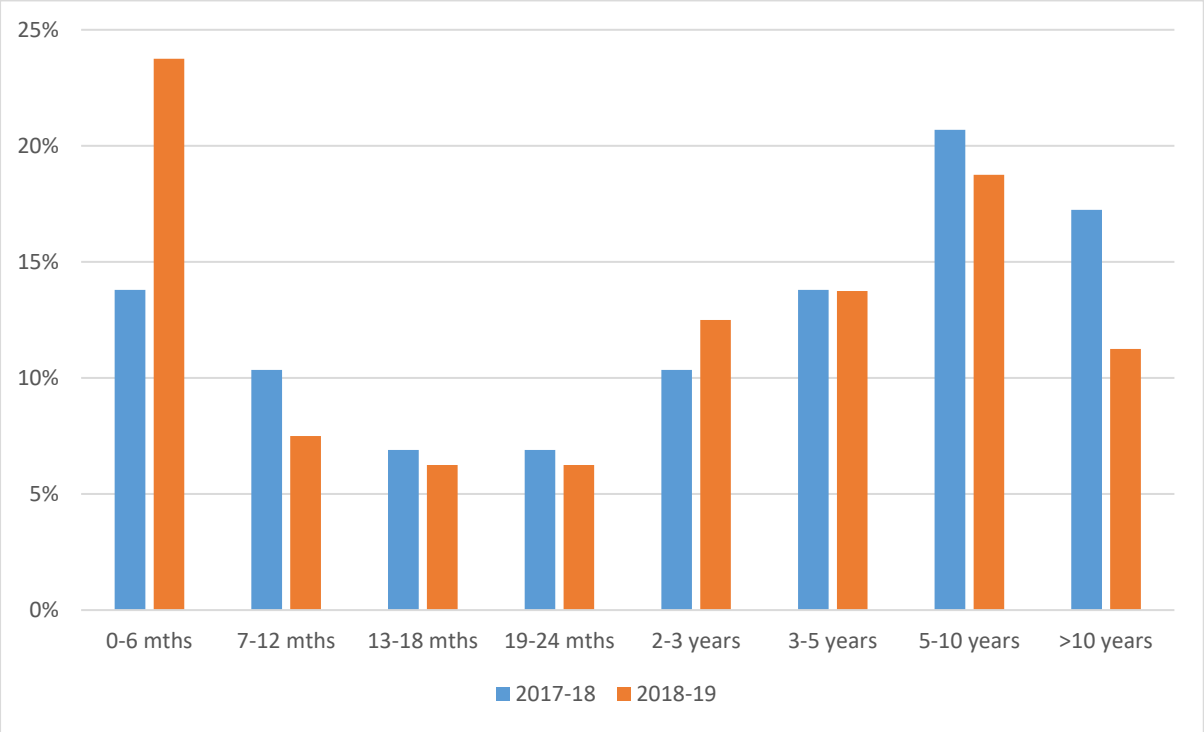

Figure 2 shows only those patients for whom we recorded a first core treatment ASO notification in the current detention episode in each of 2017-18 (29 patients) and 2018-19 (41 patients).

Figure 2: The interval between the advance statement date and core treatment ASO (first-time core treatment ASO patients only)

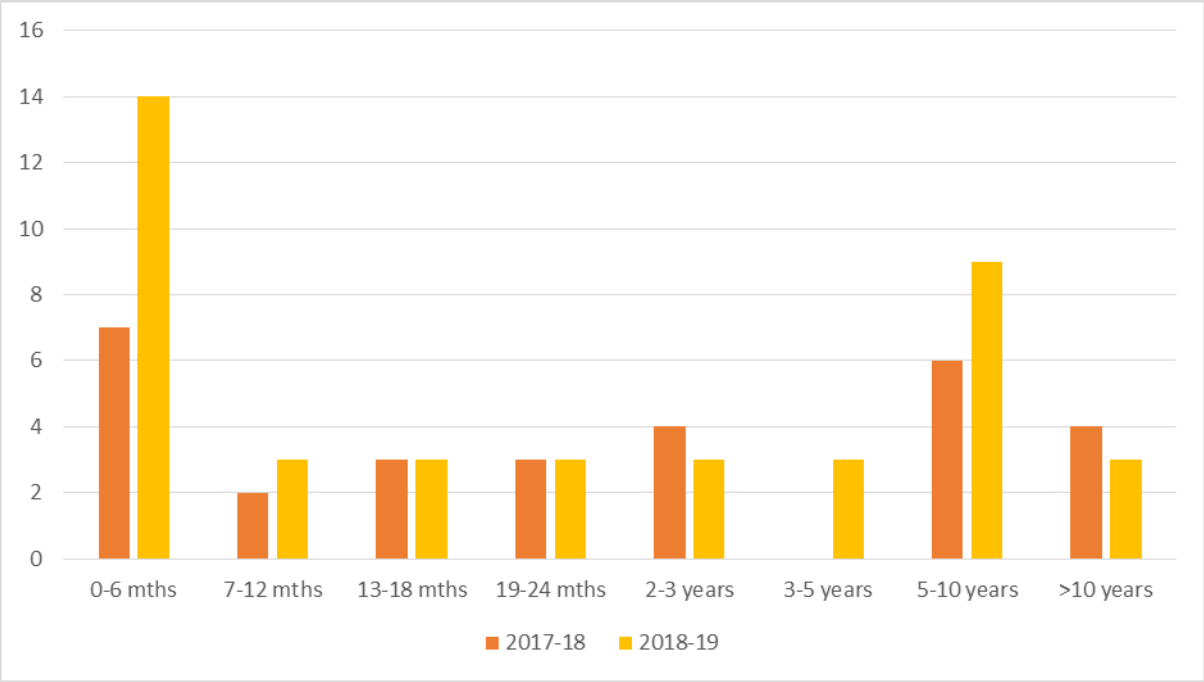

Table 16 shows in more detail the intervals between these statements being written and the date of the ASO notified, for these first-time ASO notifications (where the interval was ≤ 6 months).

Table 16: Time periods between date of statement and date of first-time core treatment ASO notification in current detention episode

Days/weeks since statement written	2017-18	2018-19
0 days (i.e. "ASO" on day of statement)	1	
2 days	1	
4 days		1
6 days		1
1-2 weeks		3
3-4 weeks		2
5-6 weeks		1
7-8 weeks		2
Up to 3 months	2	
Up to 4 months	1	2
Up to 5 months	1	
Up to 6 months		1
Total*	**6**	**13**

*NB these figures differ slightly from those in the Figures 1 and 2. Table 16 shows the numbers up to the period stated, whereas the 0-6 month figures in Figures 1 and 2 includes the period >6 and <7 months (calculated in Microsoft Excel).

Mental Welfare Commission for Scotland
Thistle House,
91 Haymarket Terrace,
Edinburgh,
EH12 5HE
Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk