

ARTICLE

Advance statements in adult mental health[†]

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SUMMARY

This article reviews the literature on advance statements, including current mental health law and guidance in England and Wales, ethical and practical advantages, disadvantages and barriers to implementation. The idea of planning psychiatric treatment for a time when mental capacity may be impaired is not new. Yet there has been a renewed interest following the introduction of the Mental Capacity Act's 2005 provision of legally binding advance decisions to refuse treatment. In addition to information on treatment refusals, advance statements provide information on treatment preferences and personal care instructions which, although not legally binding, should inform treatment decisions. Advance statements are not yet widely used, but existing limited evidence suggests that they could reduce coercion and improve service users' satisfaction with treatment.

DECLARATION OF INTEREST

None.

An advance statement is a term used to describe wishes and decisions about future medical treatment for a time when mental capacity for taking these decisions may be impaired. Conceptually, advance statements in psychiatry can be viewed from two angles – from an ethical perspective as a right to self-determination, and from a practical perspective as a collaborative process between service users and mental health professionals, with the potential to reduce coercion and improve therapeutic relationships.

The right for self-determination is an essential moral principle of modern democratic societies and is closely linked with the concepts of human rights and civil liberties. Based on this right is the idea that an individual is entitled to make decisions not only about current medical treatments, but also about future treatments during periods of incapacity. In psychiatry, the concept of advance statements was first proposed by Thomas Szasz (1982) in the form of a 'psychiatric will' mirroring a 'living will' in other medical specialties and referred to advance decisions about involuntary treatment.

Originally, advance statements were used to plan for a time when mental capacity was likely

to be permanently impaired owing to a physical illness such as advanced dementia or a seriously debilitating accident. In contrast, severe mental illnesses are often characterised by fluctuating mental capacity. This can enable a person to reflect on past personal experiences during a period of incapacity and consider these experiences when completing an advance statement about future care. The statements should be regularly revised in the light of new treatment experiences. This distinctive quality of advance statements in psychiatry, as compared with other medical specialties, has led to research and various service initiatives to facilitate the completion of advance statements in the hope that they will empower service users and improve satisfaction with treatment.

There has been renewed interest in the concept of future planning for psychiatric treatment following the introduction of the Mental Capacity Act 2005 in England and Wales. Treatment in patients' best interests is the underlying principle of the Mental Capacity Act and this requires determining patients' personal views, beliefs and values that are likely to influence important treatment decisions. Chapter 9 of the Mental Capacity Act also has a provision of legally binding advance decisions to refuse treatment ('living will'). This is highly relevant in psychiatry as many in-patients lack mental capacity. In a recent study, 86% of detained and 39% of informal (voluntary) in-patients on a general psychiatric ward lacked capacity to make decisions on treatment (Owen 2008).

Many mental health trusts in England and Wales now have policies on advance decisions to refuse treatment and some are introducing initiatives to systematically record advance statements.

This article focuses on mental health legislation of England and Wales, but it is important to note that the Mental Health (Care and Treatment) (Scotland) Act 2003 provides for advance statements.

Terminology

Three frequently used terms describe planning for future mental healthcare: advance statements, advance directives and advance decisions. It is important to differentiate between them to avoid confusion.

[†]For a commentary see pp. 456–458, this issue

An advance statement is a broad term used to describe a range of wishes for future treatment, including treatment preferences and refusals, preferences on important aspects of personal and home life, and the appointment of a surrogate decision maker. This expression is now commonly used in the UK (Henderson 2008).

The term advance directive has been used in two different ways in the UK. Previously, it described specific treatment refusals (Williams 2004), but this has now been replaced in the Mental Capacity Act 2005 with 'advance decision to refuse treatment'. In recent years, 'advance directive' has been used more broadly – National Institute for Health and Clinical Excellence (NICE) guidelines on schizophrenia (National Collaborating Centre for Mental Health 2003) and disturbed/violent behaviour (National Institute for Health and Clinical Excellence 2005) use 'advance directive' to describe 'treatment choices' and 'preferred strategies in the event of violent incident' respectively.

In this article we use the term advance statement for a general description of wishes for future mental health treatment, and the term advance decision to refuse treatment for a specific subgroup of advance statements regarding treatment refusal.

Current mental health law and guidance in England and Wales

The mental health treatment of service users who lack mental capacity is guided by the Mental Capacity Act 2005 and, if they are detained, also by the Mental Health Act 1983. NICE guidance on schizophrenia and disturbed/violent behaviour (National Collaborating Centre for Mental Health 2003; National Institute for Health and Clinical Excellence 2005) sets standards on how to incorporate advance statements into standard mental healthcare.

Informal treatment

If a service user lacks mental capacity to make a treatment decision, they are treated under the Mental Capacity Act. The underlying principle of 'best interests' involves finding out about their views, beliefs and values that are likely to influence the treatment decision. If these are not known, efforts should be made to determine them and incorporate them into the treatment plan. If a service user has made a lasting power of attorney, the attorney can be a surrogate decision maker for healthcare decisions. They must therefore be involved in treatment planning as they have been nominated to consent to or refuse treatment on the service user's behalf.

An important provision of the Mental Capacity Act is the advance decision to refuse medical treatment. Advance refusals have been recognised

as legally binding in the UK by case law since the 1990s (*Airedale NHS Trust v. Bland* 1993), but have only recently been included in statutory law in the Mental Capacity Act 2005. The Mental Capacity Act defines an advance decision to refuse medical treatment as legally binding if it is made at a time when a person has mental capacity to make such a decision and the decision is applicable to the given situation. For refusal of life-sustaining treatment, an advance decision has to be in writing, signed and witnessed, and a clear statement must be included in the advance decision stating that it is applicable even if life is at risk.

The Mental Capacity Act 2005 (Chapter 9) states that 'People can only make advance decisions to refuse treatment. Nobody has the legal right to demand specific treatment, either at the time or in advance'. Therefore, unlike treatment refusals, advance statements regarding treatment preferences are not legally binding. Nevertheless, they should be taken into consideration when deciding on the treatment options that are in a service user's best interests if the service user lacks capacity.

Involuntary treatment

The Mental Capacity Act *Code of Practice* states that the Mental Health Act may be used to override a valid and applicable advance decision to refuse (an essential part of) treatment, with the important exception of a valid and applicable advance decision to refuse electroconvulsive therapy (ECT) or the objection to ECT by an authorised attorney or deputy (Department for Constitutional Affairs 2007). Therefore, ECT cannot be given if a service user has made a valid and applicable advance refusal (Box 1).

Chapter 17 of the Mental Health Act *Code of Practice* (Department of Health 2008) further elaborates on 'wishes expressed in advance' and states that clinicians 'should, where practicable, try to comply with the patient's wishes as expressed

BOX 1 Case vignette: overriding an advance statement

A 55-year-old man with a history of severe depression with psychotic symptoms had completed an advance statement outlining refusal of any antipsychotic medication and ECT if he became unwell. He also expressed the wish that his step-son should not be informed of future admissions or allowed to visit him. He presented with low mood and nihilistic delusions. He agreed to an informal admission and was treated with antidepressants; however, his delusional beliefs did not resolve. Although he was not actively refusing medication, his advance decision to refuse antipsychotic medication and ECT was deemed valid and applicable. He therefore had to be detained under Section 3 of the Mental Health Act, which allowed the psychiatric team to administer antipsychotic medication against his advanced decision. His advanced refusal of ECT could not be overridden by the Act. The psychiatric team respected his advance statement regarding information-sharing and visiting rights, and when the patient recovered he appreciated that these wishes had been acknowledged.

in an advance decision and if they make a decision which is contrary, they should record their reasons for the decision'. Clear documentation of the reasons for treatment decisions by clinicians is essential if the content of advance statements is considered but not followed or in circumstances where the Mental Health Act is used to override a valid and applicable advance decision to refuse treatment.

The Mental Health Act *Code of Practice* explains that in some circumstances detention under the Mental Health Act may be the only way to ensure that necessary treatment is given for a service user who has made an advance decision to refuse treatment. This situation could arise when all, or most, psychotropic medication has been included in the person's advance decision to refuse treatment, leaving limited possibilities for effective treatment with non-refused medication. Consequently, this could lead to potential difficulties. In order to override an advance decision to refuse treatment, a service user who is acutely unwell and has lost mental capacity could be detained even if they are not actively opposing treatment or could be treated informally, if it were not for their advance decision to refuse treatment. In practice, however, refusal of all psychotropic medication is very rare (Amering 2005a; Srebnik 2005; Swanson 2006).

Concerns have been raised that psychiatry is the only area of healthcare where advance decisions to refuse medical treatment could be overridden for a substantial number of service users (those treated involuntarily) and that this could be viewed as discriminatory against mental health service users compared with other health service users. There has been one successful legal challenge in the USA – the case of *Hargreave v. Vermont* in 2003. The decision by the Court of Appeal struck down a state law that allowed mental health professionals to override Nancy Hargreave's advance refusals of all psychotropic medication after detention (Allen 2004; Appelbaum 2004a,b). However, the applicability and implications of this decision are still unclear.

In the UK, the Mental Health Act Commission (2008) has issued revised guidance on the imposition of medical treatment on detained patients refusing consent if a valid and applicable advance decision to refuse treatment is overridden by the Mental Health Act. The guidance clearly states that the 'best interests' test needs to be applied when service users are treated against their wishes and that service users' views must be taken into account when determining their 'best interests'.

NICE guidance

Recently revised NICE guidelines on schizophrenia (National Collaborating Centre for Mental Health

2010) specify that advance decisions and advance statements should be developed collaboratively with people with schizophrenia, especially if they have been treated under the Mental Health Act. A copy of the advance statement should be included in the care plan and given to the service user, their care coordinator and their carer if the service user agrees. Although advance decisions can be overridden using the Mental Health Act, healthcare professionals should endeavour to honour advance decisions and statements wherever possible. The previous version of the NICE guidelines on schizophrenia (National Collaborating Centre for Mental Health 2003) included advance directives as a standard of care. The standard was set at 100% of service users having an advance directive, with the exception being if a service user is unable to participate in an informed discussion about treatment choices.

In a meta-analysis of NICE guideline implementation, an advance directive was the standard with the lowest adherence rate (29%) and with the largest variation within different mental health trusts (Mears 2008). Guidelines on the short-term management of disturbed/violent behaviour advise that service user's care plans contain an up-to-date advance directive detailing the individual's preferred strategies (rapid tranquillisation, physical intervention and/or seclusion) in the event of an incident of violence or other disturbing behaviour (National Institute for Health and Clinical Excellence 2005).

How to make an advance statement

Advance statements can be given in either written or oral form (with the exception of an advance decision to refuse life-sustaining treatment, which has to be written, signed and witnessed in order to be valid). Written statements are generally a more accurate reflection of the service user's views and should be kept in their medical records as these are easier to access at the time of crisis. Service users can complete an advance statement on their own, informally with help from friends, family or an advocate, or formally with help from an independent mental health professional or a member of their own mental health team. An advance statement can be made at any time, provided that the service user has mental capacity to make the decisions it contains. Usually advance statements are created after an in-patient admission or as part of an ongoing treatment plan in the community. If advance statements include decisions about treatment refusal, the decision-making capacity at the time of completion should be documented. This will avoid possible uncertainty that may arise at a later date from retrospective attempts to decide whether a

service user had mental capacity at a time when the advance statement was completed.

Several interventions have been shown to be effective in helping service users complete an advance statement. These include semi-structured interviews and guided discussions on choices (Swanson 2006), computer software with a list of pre-established choices that guides a service user through the process (Srebnik 2005), or using a hypothetical psychiatric scenario to elicit treatment preferences (Van Citters 2007).

Content of advance statements

The most common wishes recorded in advance statements refer to medication preferences and refusals, with antidepressants and second-generation antipsychotic medication being most frequently preferred, and first-generation antipsychotic medication most commonly refused mainly because of side-effects (Srebnik 2005) (Box 2). Refusal of all psychotropic medication is very rarely recorded in advance statements (Amering 2005a; Srebnik 2005).

In addition to preferences and refusals of medication, other aspects of healthcare planning are very important for service users. These include methods of de-escalating a crisis (most often privacy or being offered time out), the appointment of a surrogate decision maker, wishes on whom to notify (and whom not to) about admission, assisted devices (e.g. corrective lenses, dentures), dietary preferences, and organising care of dependants and pets while in hospital (Srebnik 2005). It is particularly important to look at non-medication preferences, which can be easily overlooked in a crisis. Many aspects of advance statements can be respected even if a service user is detained and receiving treatment against their will, thus preserving some aspects of their autonomy.

Studies of the content of advance statements completed by service users rated them as highly consistent with standards of clinical practice (Srebnik 2005; Swanson 2006).

Advance statements as a process

Drawing up an advance statement starts with an interest in planning future healthcare, reviewing past experiences and mobilising resources. A number of factors can facilitate this process, such as the effect of admission to a psychiatric hospital on family members or a partner (Amering 2005a), or a good therapeutic relationship with a mental health professional. Once drawn up, an advance statement needs to be regularly revised so that new experiences with treatment and any changes in the individual's personal life can be taken into account.

BOX 2 Content of advance statements

- Medical treatment instructions
- Medication preferences
- Medication refusals (and reasons why)
- Preference/refusal of ECT
- Preferred method of de-escalating crisis
- Preference of hospitals/hospital alternatives
- Information on side-effects and allergies
- Description of crisis symptoms and response to hospital admission
- Appointment of a surrogate decision maker
- Personal care instructions
- Individuals to be notified of hospital admission
- People not authorised to visit during hospitalisation
- Assisted devices (e.g. corrective lenses or dentures)
- Persons to notify about care of finances, dependants or pets
- Dietary preferences

Clinicians' views

Clinicians' support of advance statements varies. In one study, the level of support varied from 29 to 89% and psychiatrists were much less supportive than other stakeholders (Atkinson 2004). Clinicians with a better knowledge of the legal implications of advance statements had more positive attitudes towards the process (Elborgsen 2006).

Can advance statements reduce coercion and improve the therapeutic relationship?

A randomised controlled trial (RCT) conducted in the UK by Henderson *et al* (2004) showed that advance statements in a form of a 'joint crisis plan' resulted in a significant reduction of compulsory admissions and a reduction in overall admissions, which was close to statistical significance. The study included service users who had been admitted to a psychiatric hospital in the previous 2 years (either voluntarily or under the Mental Health Act) with an operational diagnosis of psychotic illness or non-psychotic bipolar disorder. Joint crisis planning involved the service user, their psychiatrist and care coordinator and a project worker negotiating a plan together.

Another UK RCT (Papageorgiou 2002) showed no significant difference in compulsory admissions between an intervention and a control group. However, this study differed from that of Henderson *et al* (2004), mainly in that it included only in-patients receiving compulsory treatment under Sections 2, 3 or 4 of the Mental Health Act who were due for discharge. In addition, intervention did not involve the service user's mental health team. It consisted of a facilitated session with a researcher to complete a booklet on preferences for care, which was then circulated to professionals involved in the care of the patient.

As regards the therapeutic relationship, an RCT in the USA (Swanson 2006) showed that a guided discussion on choices in the planning of mental healthcare led to a better working alliance and improved service users' perception that they were receiving the services they needed at 1-month follow-up. Despite these results, some authors have raised concerns that the RCT model is inadequate to examine the effectiveness of advance statements as they are a complex social intervention occurring in an 'intricate web of personal and professional relationships that are characterised by contesting and competing values' (Thomas 2003). Although various numerical variables such as re-admission rates are easy to collect, they are only a crude indicator of the 'success' of advance statements. Changes on more relevant constructs such as empowerment, self-esteem, engagement and satisfaction with services should also be considered (Antoniou 2006).

'Revocability' of advance statements and the Ulysses contract

The concept of an irrevocable advance statement during periods of incapacity is referred to as the Ulysses contract (Srebnik 1999), derived from Homer's *Odyssey* when Ulysses asked shipmates to bind him to the ship's mast and keep him there regardless of any requests he might subsequently make to be taken down. Although sorely tempted, he could not order his men to follow the voices of the sirens to their collective destruction. Even when a service user wants the advance statement to be irrevocable, it may be practically and ethically difficult to ignore service users' current wishes even at times when they do not have capacity.

Advance decisions to refuse treatment can be revoked when a service user has capacity, but not when the service user has lost capacity for the treatment decision. However, if only their wishes have been expressed in advance, the Mental Health Act 1983 *Code of Practice* (Department of Health 2008: Chapter 17) advises that changes in a service user's opinions need to be taken into account:

The fact that a patient has expressed their wishes about a particular matter in the past is not a substitute for seeking their views on it when the situation actually arises, even if they are no longer in a position to think about their views as clearly as they did when they expressed their wishes previously. Everyone has the right to change their mind.

Advantages and disadvantages of advance statements

Implementing advance statements into routine clinical practice can bring many advantages, which have been discussed by service users, clinicians and researchers (Box 3).

BOX 3 Advantages and disadvantages of advance statements

Advantages

- Empowerment of service users
- Improving engagement and the therapeutic relationship
- Promoting responsibility in service users for the management of their illness
- Promoting shared decision-making
- Reducing coercion

Disadvantages

- If overridden, it may have a detrimental effect to the therapeutic relationship and increase a sense of disempowerment
- In some cases it may increase coercion

First, advance statements can serve as a tool for empowerment and self-determination (Kim 2007), particularly as there are concerns that, despite various initiatives, empowerment has been introduced at an organisational but not at an individual level (Laugharne 2006). Empowerment is one of the essential elements of the Royal College of Psychiatrists' (2008) Fair Deal campaign. Many patients speak of loss of control over aspects of their life because of the effects of medication. It can be a very disempowering experience and patients give it as one of the main reasons for their disengagement from psychiatric services (Priebe 2005). Honoured advance statements can have a positive impact on building therapeutic relationships, improving engagement and regaining some control over treatment in the acute phase of illness (Box 4).

Second, the process of making an advance statement itself could enhance a service user's sense of trust and collaboration, improving engagement and the therapeutic relationship (Srebnik 2005) and enhancing communication through open collaborative discussion (Williams 2004). It can also promote responsibility in service users for the management of their illness (Amering 2005a).

Third, if an advance statement is completed with a mental health professional, discussing past experiences, previous efficacious treatments and planning future treatments can promote shared decision-making. It can also reduce involuntary admissions, particularly if advance statements have been created together with the treating psychiatric team (Henderson 2004).

However, there are some concerns (Box 3). For example, if an advance statement is overridden, this may have a detrimental effect on the therapeutic relationship and increase the patient's sense of disempowerment. Also, if the statement contains

explicit refusals (advance decision to refuse treatment) of all psychotropic medication, this may increase the probability of detention under the Mental Health Act in the event that treatment is deemed necessary.

In terms of completing an advance statement, concerns have been raised that there is a possibility of covert coercion if a mental health professional is helping to complete it. For example, in 1989 a self-advocacy group in the UK, Survivors Speak Out, launched 'crisis cards' (mental health emergency cards) as an advocacy tool. On the cards people gave instructions for further psychiatric care and nominated a contact person in the event of a crisis. However, these cards were withdrawn following complaints that mental health professionals were helping service users complete their cards and this may have resulted in service users being coerced into including potentially damaging information on the card (Weston 1997).

How many service users want an advance statement?

Despite the possible advantages, only a relatively small number of service users complete an advance statement. The Mental Welfare Commission for Scotland (2007) found that 60% of service users subject to compulsion in 2006–7 knew about advance statements, but only 2–3% completed one. Likewise in the Bradford Project, which was run in conjunction with the Mental Health Foundation (Thomas 2004), very few service users took the opportunity to make an advance statement even following significant developmental work. This led the authors to conclude: 'The idea that we can soothe the pain of greater compulsion with the balm of advance statements is simplistic'.

In a research setting, intense facilitation has been found to increase the completion of advance statements, but the number of service users who do not complete one remains substantial. In a study by Swanson *et al* (2006), 61% of service users completed an advance statement following guided discussion on choices compared with only 3% of those who received information only.

Barriers to advance statements

The reasons for such a low uptake remain unclear, and even a study aimed at exploring the views of service users who decided against drawing an advance statement failed to recruit sufficient numbers of people (Amering 2005a). Several possible explanations have been given by service users, clinicians and researchers, and involve barriers to completion as well as implementation of advance statements (Box 5).

BOX 4 Case vignette: service user empowerment

A 35-year-old woman with a long-standing history of paranoid schizophrenia and previous admissions under the Mental Health Act was admitted under Section 3 of the Act because of relapse with prominent agitation and persecutory delusions. She had completed an advance statement in which she refused medication for rapid tranquillisation when agitated and described in detail de-escalation techniques that had been useful in the past. These involved being escorted to her room, seated to look through the window and held gently by her arms by two nurses until she was calm.

Initially on admission she was agitated for short periods of time. Her advance statement to refuse treatment was deemed valid and applicable but, if necessary, could have been overridden by the Mental Health Act. The psychiatric team's decision was to first proceed with the preferred de-escalation technique and only if it was not successful to administer psychotropic medication. However, de-escalation techniques were successful and no medication for rapid tranquillisation was required.

Barriers to completion

Service users may be reluctant to plan ahead because they prefer not to consider the possibility of readmission (Thomas 2004) and reviewing past experiences may be upsetting and could be feared as a possible trigger for relapse (Amering 2005a). Service users may not remember an episode of acute illness well enough to be able to reflect on it, but this may be helped by a discussion with mental health professionals who were treating them during the crisis. Many service users feel demoralised, disempowered and oppressed (Thomas 2004), and they may lack the motivation to complete a statement that mental health legislation can override. There is anecdotal evidence that service users who have a good relationship with their mental health team feel that they will receive their preferred treatment without the need for an advance statement, whereas service users who mistrust the system do not see the

BOX 5 Barriers to completion and implementation of advance statements

- Lack of knowledge and motivation in service users
- Difficulties with accessing advance statements at a time of crisis
- Reviewing past experiences may be distressing
- Potential conflict in the role of a surrogate decision maker
- Complexity of filling in forms and signing documents
- Difficulties if at a time of crisis, when a service user lacks mental capacity, different views are expressed to those reported in the advance statement
- Negative attitudes towards and limited knowledge of advance statements by mental health professionals
- Difficulties with interpreting advance statements if there are concerns about mental capacity at the time of completion
- Lack of trusted person who could act as a surrogate decision maker
- Different treatment decisions may require different 'thresholds' for mental capacity
- Lack of resources in terms of professionals' time to facilitate completion of advance statement
- Difficulties in communicating the content of advance statements to staff

MCQ answers

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point of making any plans (or past plans have been overridden when they were compulsorily admitted, thus adding to their mistrust) (Antoniou 2006).

Practically, forms may be complex and difficult to fill in and sign, service users may lack information about advance statements (Foy 2007) and there may not be a trusted person who could act as a surrogate decision maker. Mental health professionals may have limited knowledge (Kim 2007) and negative views about advance statements and lack resources in terms of the time it takes to complete a statement. This is particularly important as studies have shown that the deliberation phase in completing advance statements can be long (Amering 2005a).

Difficulties with implementation

Service users may experience problems in communicating the content of advance statements to staff (Kim 2007) and there may be difficulties with accessing advance statements at the time of crisis. A recent study (Srebnik 2007) showed that only 20% of advance statements were accessed during a crisis. New electronic records hold a promise of overcoming this barrier. There may also be a potential conflict in the role of a surrogate decision maker – for example, a family member may be in a difficult position in deciding between a service user's previously expressed choice and the best treatment as advised by the medical team (Swartz 2004). If at the time of crisis a service user lacks mental capacity but expresses views that are different from those documented in an advance statement, this can lead to a complex clinical situation where both past and present wishes need to be carefully considered. Difficulties in accepting the validity of an advance statement may arise if there are concerns about mental capacity at the time of completion of the statement. Advance statements may include various decisions about treatment that require different thresholds of mental capacity, therefore a service user may have capacity for some but not for all decisions, which may complicate completing and implementing the statement.

Many of the described barriers can be overcome through better organisation and clearer policies. However, hurdles such as low motivation, negative views and concerns regarding potential disadvantages are less amenable to organisational improvements and may require further research to better understand the processes underlying them.

Conclusions

Good psychiatric practice involves discussing and negotiating treatment plans and whenever possible honouring service users' wishes. Despite this, many service users do not feel involved in treatment

decisions (Borneo 2008). Introducing structured and formal discussions about wishes for future treatment through completing advance statements may help to actively involve service users in treatment planning and consequently raise standards of routine care. This could be achieved through incorporating discussion on advance statements into the care programme approach process.

Completing an advance statement may have many advantages, such as reducing coercion, improving the therapeutic relationship and empowering service users, and it should be seen as a process that is regularly reviewed rather than as a one-off decision. Implementing advance statements can be met with some obstacles that need to be addressed as 'Rights are only as visible as the mechanisms put in place for their exercise' (Amering 2005b). Even when these obstacles are overcome, not all service users would wish to complete an advance statement and an individual's reasons for not completing one need to be respected.

Future experience and research will help to ascertain the general usefulness of advance statements, as well as identify which service users and in which therapeutic contexts advance statements would be particularly beneficial. At the same time, the use of advance statements is a right for all service users, independent of potential clinical or other benefits. Mental health services need to develop a routine practice to implement that right in the most appropriate manner.

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MCQs

Select the single best option for each question stem

1 Advance statements:

- a were initially introduced by Szasz as a concept of 'psychiatric will'
- b are based on a new concept first introduced by the Mental Capacity Act 2005
- c are irrevocable, and once drawn, cannot be altered even when a person has mental capacity
- d are unrelated to advance decisions to refuse treatment
- e always prevent involuntary admission.

2 Advance refusals:

- a ECT can be given under the Mental Health Act 1983, against the service users' valid and applicable advance decision to refuse ECT
- b ECT can be given under the Mental Health Act 1983 even if an authorised attorney or deputy objects to ECT
- c are the only important aspect of advance statements as treatment preferences are not

legally binding and therefore not important in treatment planning

- d psychotropic medication cannot be given against a person's valid and applicable advance decision to refuse it unless it the decision is overridden by the Mental Health Act
- e advance decision to refuse treatment can be revised by the service user at times of incapacity.

3 Advance statements:

- a are synonymous with advance directives
- b are not included in the NICE guidance on any mental health disorder
- c can serve as a tool for empowerment
- d do not need to be updated
- e do not have any potential disadvantages.

4 Advance statements:

- a include only refusals and preferences of medication
- b cannot include information about a surrogate decision maker

c cannot include preferred methods to de-escalate a crisis

- d contain personal care instructions that can be very useful to inform a care plan
- e cannot include information on ECT.

5 Barriers to advance statements:

- a lack of resources is not recognised as a potential barrier
- b everyone has a positive attitude towards advance statements
- c reviewing past experiences may be distressing for a service user
- d all treatment decisions have the same threshold for mental capacity
- e every service user wants to make an advance statement.