mental welfare commission for scotland

Advance statements in forensic mental health services in Scotland

Research brief 3

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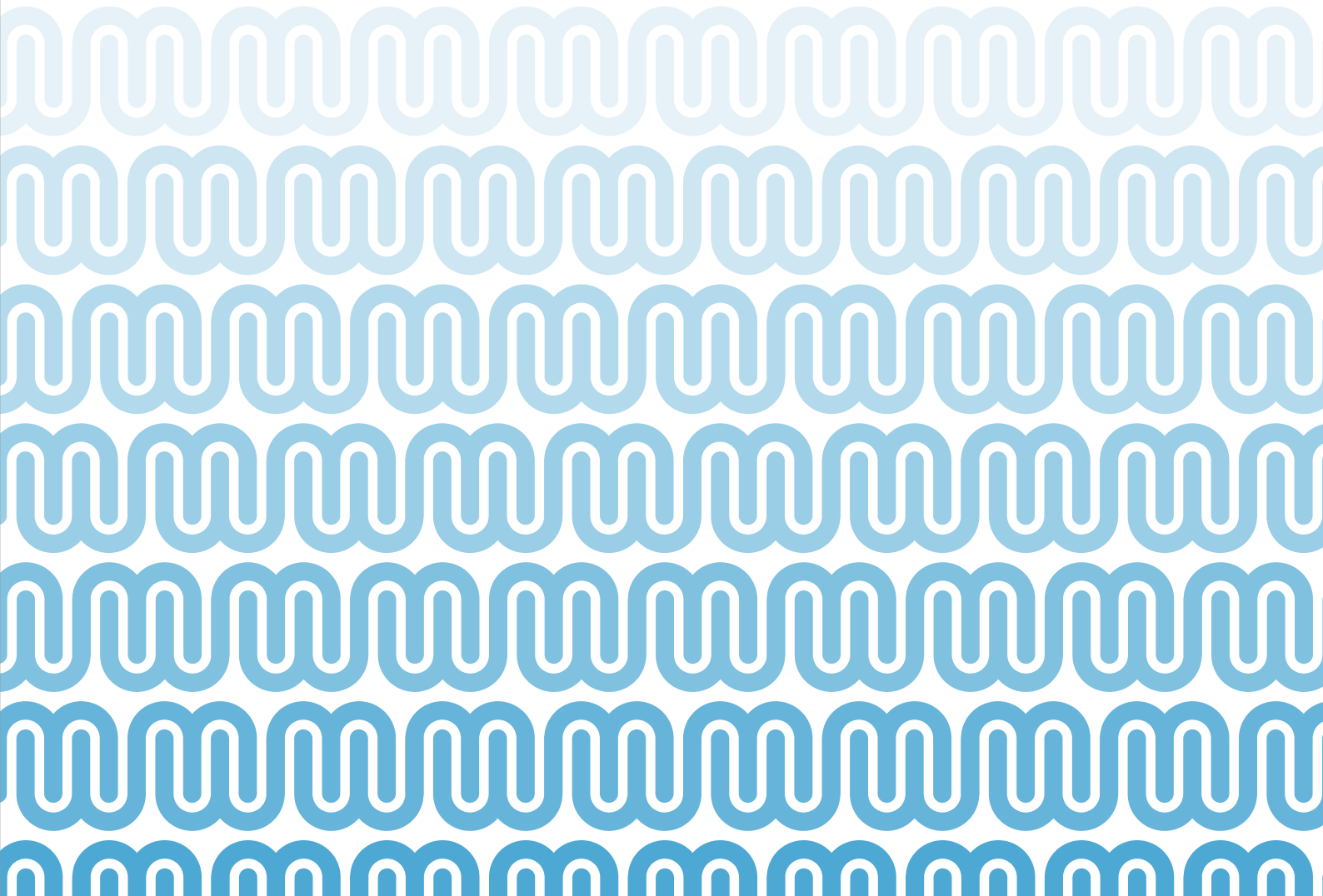


Our mission and purpose

Our Mission

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

Our Purpose

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

Our Priorities

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

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

Our Activity

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

Contents

Executive summary

This report

The Commission has a scheme through which psychiatrists in training can complete placements with the Commission for up to four months. The project on which this report is based was completed as part of a trainee psychiatrist's placement with the Commission.

To better understand how well advance statements are used in Forensic Mental Health Services (FMHS) we aimed to explore how many individuals treated in these services have an advance statement, any differences between FMHS across Scotland, and opinions of how promoting and using advance statements works in practice.

Advance statements are a provision of the Mental Health (Care and Treatment) (Scotland) Act 2003 intended to increase a person's participation in their care and treatment.

Since 2017, health boards have had a duty to promote the use of advance statements. This is consistent with shared decision making which is a key principle of the Scottish Government's Realistic Medicine framework.

In 2021, the Mental Welfare Commission for Scotland ('the Commission') looked at how many people with a second opinion certificate consenting to their medical treatment (called a T3 certificate) had an advance statement in place. The Commission found that overall only 6% of this group had an advance statement, though in some places, for example the State Hospital, this figure was much higher (29%).

Forensic Mental Health Services assess and treat people with mental health conditions who may have committed criminal offences or who pose increased risks to themselves or others and have been unable to be cared for in other mental health settings (for example open adult wards). FMHS are delivered in hospital settings as well as in the community. FMHS deliver care in secure settings which are more restrictive than other mental health services. This is necessary to safely manage the risks that people receiving such care pose to themselves and to others. Given the more restrictive nature of FMHS, it is proportionate that there is additional monitoring of services and safeguarding of the people using them. Ensuring effective use of advance statements is one such safeguard and an important mechanism for people receiving care from FMHS to have their views and preferences taken into account.

No previous work has been done to specifically look at advance statement use in FMHS. We therefore aimed to explore how many individuals receiving care and treatment in FMHS have an advance statement, any differences between FMHS across Scotland and opinions on how promoting and using advance statements works in practice. In this report we combine information from individual services, an online survey with Responsible Medical Officers (RMOs), and interviews with RMOs.

Key findings

- The overall proportion of individuals receiving care and treatment within FMHS with an advance statement was 34%. There was great variation between FMHS across Scotland.
- RMOs reported that the most common location for advance statements is in the person's electronic patient record (83%) while the least common is in the medication Kardex (5%).
- Reviews of advance statements were most commonly reported by RMOs as taking place before a Tribunal (76%) and at each Care Programme Approach (CPA) meeting (66%). Forty one percent of RMOs told us that they would review an advance statement prior to considering a new medical treatment.
- Key barriers to reviewing an advance statement were reported as lack of availability or accessibility of the statement, lack of awareness of whether one is in place, reviews not being part of routine clinical steps, and impracticality of review in an emergency situation.
- All RMOs correctly identified that oral and depot psychotropic medication can be included in an advance statement. However, results suggested some uncertainty about other aspects of care that can appropriately be included in an advance statement, such as: other types of medical treatment, other types of therapeutic interventions e.g. group therapy, the place where care can be delivered and the professional who can deliver the care.
- Generally, RMOs we surveyed had a positive view of advance statements and felt that they ensure respect for a person's treatment wishes and preferences. They also believed that advance statements can lead to positive dialogue between the treatment team and the person.
- One important challenge RMOs told us about was that those people deemed to have lifelong incapacity in relation to making an advance statement (for example due to a severe and enduring mental illness and/or intellectual disability) are excluded from having their wishes recorded and respected via the current advance statement process.
- While RMOs were generally positive about advance statements, they felt that there is a lack of consideration for the systems required for their creation, storage and review. They questioned the use of the number of advance statements as a quality indicator, since some individuals may not want to make one. Promotion and documentation about the offer to make one, they believed, would be a better quality marker.

Recommendations

To SMHLR

Consideration of capacity to make an advance statement – The SMHLR should consider the wording in the Mental Health Act and whether to introduce more explicit reference to issues relating to capacity to make an advance statement. This should seek to mitigate any risk that individuals deemed to lack capacity in some areas are excluded from making an advance statement. In such circumstances, measures to enhance capacity could be effective in facilitating an individual's full or partial engagement in the advance statement process.

Introduce a statutory review process – The SMHLR should consider the finding that the majority of survey respondents were in favour of a statutory review process to ensure advance statements remain valid and up to date for detained patients. This is in keeping with the recommendation that the Commission made to the SMHLR about ensuring more robust scrutiny of overrides and Commission guidance advises that advance statements should be reviewed every 6-12 months. It also aligns with our previous recommendation to health boards that there ought to be consideration of at what point in the clinical pathway a person ought to be offered the opportunity to make an advance statement.

Increasing safeguards – The SMHLR should consider the comments from this survey that suggest there may be a requirement for a second opinion in the case of an advance statement override, perhaps due to increased restrictions this patient group are already subject to. This is in keeping with the previous recommendation that the Commission made that a competently made advance refusal for a specific treatment should have a higher bar associated with any override of this.

Introduction

Forensic Mental Health Services (FMHS)

Some people who have a mental health condition[1] and are, or have been, charged with, or convicted of, a criminal offence, are assessed and treated within Forensic Mental Health Services (FMHS). Most individuals receive care and treatment in a secure hospital, ranging from low, medium to high security (Box 1) [1].

Most mainland, territorial health boards, have Intensive Psychiatric Care Units (IPCUs). Not all IPCUs are managed by local FMHS, although they are involved in the care and treatment of individuals referred from police custody, the court, or prison [2, 3]. In Scotland there are 15 prison establishments across most mainland, territorial health boards [4]. They all receive regular, clinical input from a visiting forensic psychiatrist [2].

Of all psychiatric inpatient beds in Scotland, 399 (12%) are FMHS. When including forensic intellectual disability beds the number increases to 467. A proportion of IPCU and rehabilitation beds will additionally be occupied by forensic patients. Finally, there are forensic community mental health teams in all mainland, territorial health boards across Scotland [2, 5].

Box 1. Levels of secure care in Scotland

High secure
The State Hospital, Carstairs, provides a national service for male patients who require high secure care in Scotland and Northern Ireland.

Medium secure
Provided on a regional basis at Rohallion Clinic, Perth (North); Orchard Clinic, Edinburgh (South East); and Rowanbank Clinic, Glasgow (West).

Low secure
Most mainland, territorial health boards provide a local low secure service but there are exceptions e.g., NHS Borders and NHS Lothian. There are two independent sector low secure services: Ayr Clinic and Surehaven [2, 8].

At the time of writing this report, there are 369 restricted patients in Scotland. These are individuals detained under specific sections of the Criminal Procedure (Scotland) Act 1995, where additional oversight of their care and treatment is provided by the Scottish Government Mental Health Directorate [6].

[1] We use the term "mental health condition" in this report in preference to the term "mental disorder" which is the wording used in the Mental Health Act and other associated legislation. Both terms include the categories mental illness, learning disability and personality disorder.

Available data on people treated within FMHS as inpatients shows that there are some key characteristics of this group compared to those treated within general mental health services:

- Of a total of 503 patients (those in forensic settings and those forensic patients in IPCU and rehab settings), the vast majority were male (92.3%), with an average age of 43.6 years, but with some variation depending on security level [7].
- The median current length of stay is 1,037 days; this also varies depending on security level with the longest median length of stay in locked intellectual disability wards [7]. In general mental health and intellectual disability inpatient settings the median length of stay is 142 days (4.7 months) [5].
- Most people receiving care and treatment within FMHS (75.1%) have a diagnosis of mental illness, 15.5% a diagnosis of intellectual disability, and 2% a diagnosis of personality disorder. For 7.3% their diagnosis was unknown [7]. Compared to the general inpatient mental health population they are more likely to have a diagnosis of schizophrenia and psychiatric co-morbidity, including substance use, personality disorder, and intellectual disability. There are higher rates of obesity but not of other physical health co-morbidities [5].
- They are almost always subject to compulsory measures and, in hospital, are more likely to be supported on constant, special or enhanced observations when compared to other inpatient groups [5].
- A high proportion (62%) are from the most deprived areas of Scotland, 81% were unemployed at the time of admission, with 62% having no formal academic qualifications.[2]
- There is an ageing population within FMHS. Often, they have limited access to IT, further alienating them from the digital age found in the community [2].
- Visits to low secure wards in 2017 by the Commission described 61 people waiting to progress towards a rehabilitation facility or the community [8]. This is a particular issue for people with an intellectual disability [9, 10].

Shared decision-making and person-centred care

Shared decision-making and person-centred care are recognised key aspects of modern day health and social care and fundamental principles of the Realistic Medicine framework [10]. Realistic Medicine aims to enable individuals to make informed choices about their care, based on what matters most to them [11]. The nature of some mental health conditions that might impair the mental capacity of a person on a fluctuating, static or progressive basis, and the compulsory powers set out in mental health and related legislation, add complexity when considering shared decision-making in mental health services.

In the *Mental Health Strategy 2017-2027*, the Scottish Government aspired to recognise patients as equal partners in their own healthcare. The strategy outlines an intention to use a human rights-based approach to review the Mental Health (Care and Treatment) (Scotland)

[2]Information presented at the International Association for Forensic Mental Health Services conference in 2017, shared with permission from Jamie Pitcairn, Forensic Network.

Act 2003 ('the Mental Health Act') and Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') legislation [12]. This was reflected when the Scottish Mental Health Law Review (SHMLR) was later established. The SHMLR intends to align Scottish legislation with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) principles for any person receiving care and treatment for a mental health condition. A core work stream of the SMHLR relates to capacity and supported decision-making [13].

Forensic Mental Health Services (FMHS) in Scotland provide mental health care and treatment to individuals with mental health conditions at the interface of criminal justice services. Patients cared for by FMHS can be detained often in highly regulated and restrictive environments, with significant reductions in their autonomy, freedom and self-expression [2]. Efforts to promote shared decision-making as part of person-centred care are therefore of particular importance in FMHS [2].

Advance statements

The Mental Health Act allows an individual to make a written statement setting out 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. The Mental Welfare Commission for Scotland ('the Commission') has produced guidance on advance statements and what they may contain [14]. The Commission guidance highlights the duty on treating professionals to enquire if an individual has advance statement and to check the medical notes to see if one exists. If a copy of an advance statement is included in the medical notes the hospital should ensure it is labelled and can be located quickly.

An advance statement must be signed by a witness who is able to certify that the person is able to make an advance statement. The witness can be an occupational therapist, nurse, social worker, doctor, solicitor, care service manager or a psychologist. 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 person. This can build strong therapeutic relationships and promote recovery [15].

Since 2017, health boards have had a duty to promote advance statements and notify the Commission when one has been made and report its location [16]. Notifications are kept in the Commission's advance statement register and can be accessed by patients 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.

Individuals' perceptions of participating in care and treatment decisions in FMHS varies [2]. While some people describe positive experiences of being able to participate in decision-making regarding their care, others do not. This included experiences of having an advance statement overridden [2].

The restrictive nature of FMHS can present additional challenges to ensuring the voice of people using these services is heard and in implementing a model of true shared decision

making. People being cared for by FMHS may have less ready access to available support mechanisms and means of communicating with individuals and organisations external to the settings in which they are in. Advance statements are therefore an important mechanism for people to make their treatment preferences known. No previous work has been done to look at the use of advance statements in FMHS.

What we did

To get a better understanding of how many individuals in FMHS have an advance statement and to gather doctors' views on how they are working, we collected information in three different ways: i) we asked FMHS to tell us how many people they have on their caseloads and how many of those have an advance statement, ii) we asked RMOs to take part in an online survey, and iii) we interviewed a group of RMOs to get a more in-depth understanding of their views.

FMHS data

We contacted relevant services in each mainland, territorial health board, the two independent sector facilities, and the State Hospital. We received information from all 55 of the services we approached across Scotland. In cases where population data on patients was not provided, we estimated against population data from the Forensic Network inpatient census [7].

RMO survey

We created an online survey and invited all RMOs known to work with forensic patients (N=83) in Scotland to take part. The questions were piloted with three RMOs ahead of sending out the survey and we made minor amendments based on feedback received. The survey was created using SmartSurvey™ and distributed via email. The survey was open for four weeks from June to July, 2021. We received responses from 29 RMOs (35%).

We were interested in RMOs' views on advance statements and asked for information in relation to four areas: i) the RMO's professional background and scope of practice; ii) perceptions and knowledge of advance statements; iii) perceptions and knowledge of advance statement overrides; and iv) views on positive and negative aspects of advance statements and potential considerations in the context of the SMHLR.

We analysed the responses using Microsoft Excel and calculated frequencies for each question. Free-text responses were summarised separately to identify common responses and themes.

Interviews

When completing the online survey, RMOs could leave their contact details if they were interested to take part in a Microsoft Teams interview. An interview guide was developed based on themes we identified from the online survey responses. All interviewees were informed that their responses would be treated confidentially and they would not be identified in any presentation of the findings. Seven RMOs accepted the invitation to be interviewed.

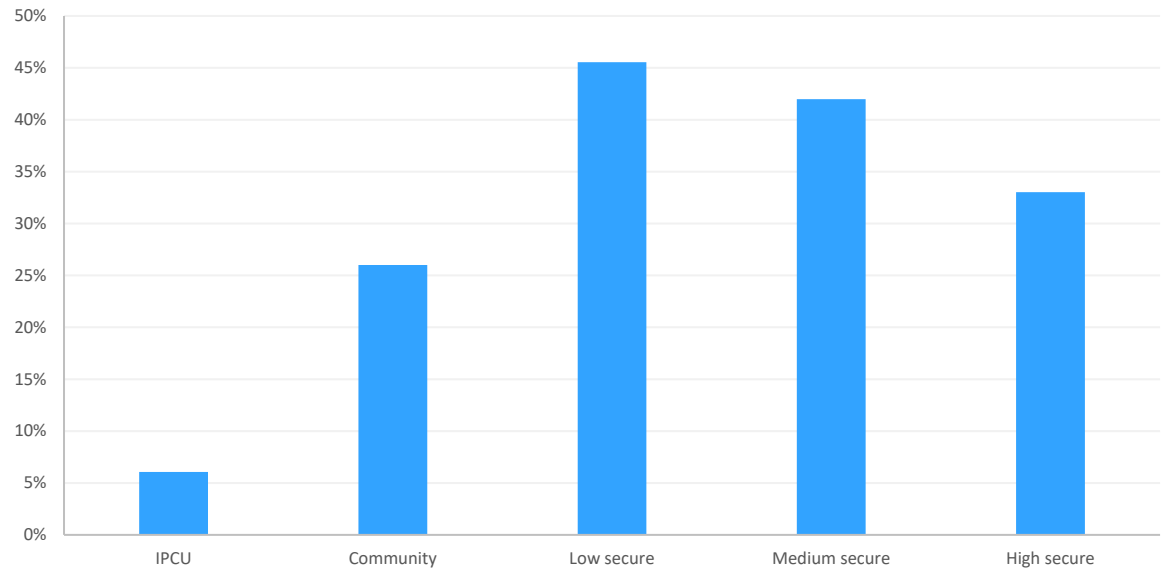
Detailed notes were taken during the interviews which were analysed using the structure of the online survey as a framework. Responses were compared, summarised and triangulated with the survey findings.

What we found

Prevalence of advance statements in the FMHS caseload

We received community and inpatient information from eleven territorial health boards, the two independent services, and the State Hospital with a total caseload of 997. Overall, 34% of people across these services had an advance statement; ranging from 6% in IPCU to 46% in low secure settings (Figure 1). These are average percentages and within specific services the proportion was higher or lower than what is presented as an overall figure. We noted that very few people in intellectual disability services had an advance statement.

Figure 1. Average proportion of people with advance statements by service type



RMOs' views on advance statements

Survey respondents

Most respondents were consultants, around half had 5–9 years of experience and about half had more than 15 years of experience, most worked in high or medium secure settings, and had done their Approved Medical Practitioner (AMP)[3] update in the last three years (Table A1). RMOs worked across a wide range of patient groups (Table A1). There was a relatively equal split for caseload of restricted patients.

Existence and location of advance statements

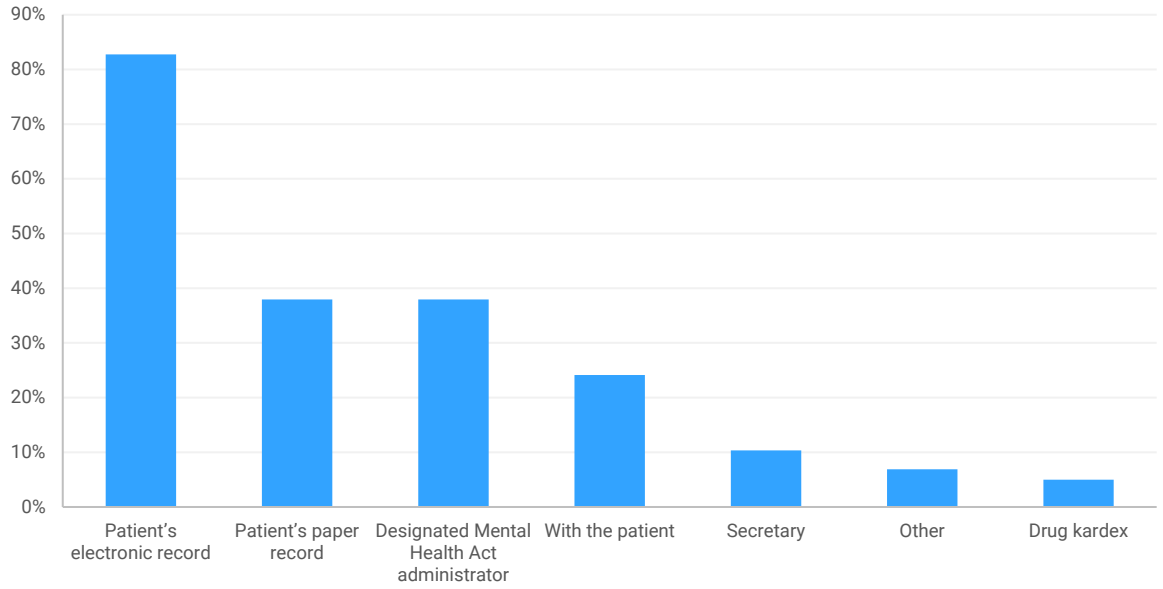
We asked RMOs what proportion of their caseloads had an advance statement; most (71%) reported that less than half of their caseload had an advance statement.

Advance statements were most commonly located in a patient's electronic record, followed by paper records and held by a designated Mental Health Act administrator (Figure 2). Around

[3]AMPs are psychiatrists in Scotland approved under Section 22 of the Mental Health Act, as having special experience in the diagnosis and treatment of mental disorder. This would coincide with a recent mandatory requirement to complete this training, issued by NHS Education for Scotland to all AMPs [18]

a fifth reported the statement is located with the person themselves. 5% reported it is located with the medication Kardex.

Figure 2. Location of the advance statement

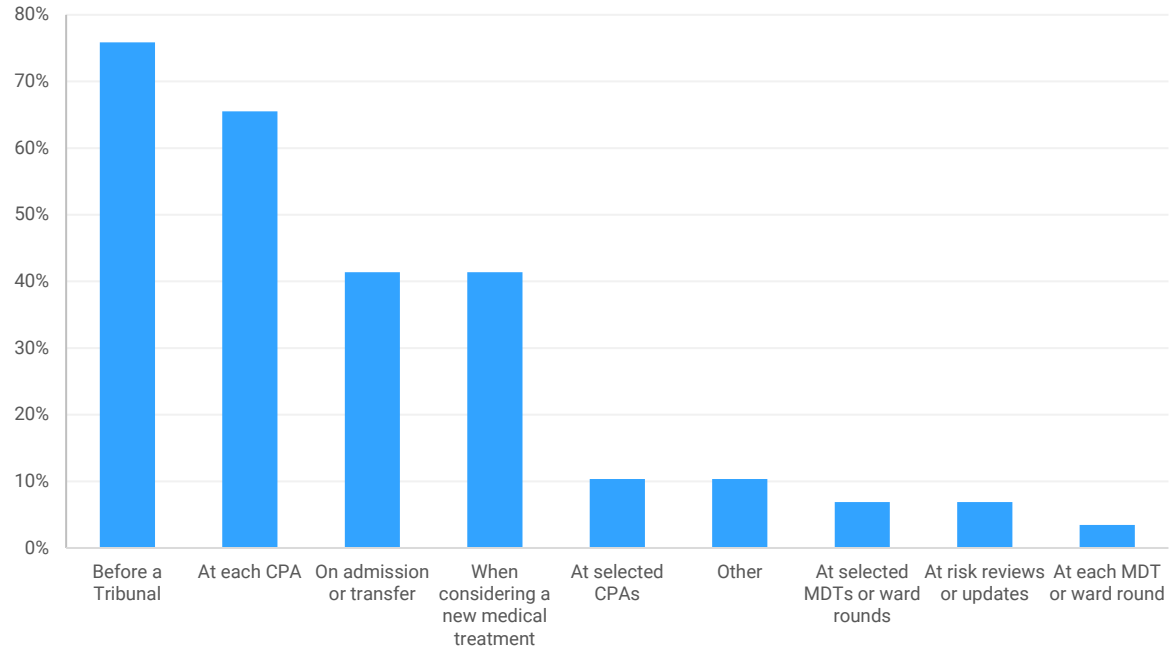


Advance statement reviews

RMOs who responded to the survey most commonly told us that they review advance statements at the time of tribunals (76%) and at each care programme approach (CPA)[4] meeting (66%) (Figure 3). While we considered changes to new medical treatment as an important time to also review the advance statement only 41% reported doing so.

[4] CPA is the process used as standard by FMHS to review and plan patient care. It is a multidisciplinary process which includes the patient and carers and in most cases involves meetings every six months or at key stages of the rehabilitation process (i.e. to plan transfers or discharges).

Figure 3. Times when advance statements are reviewed



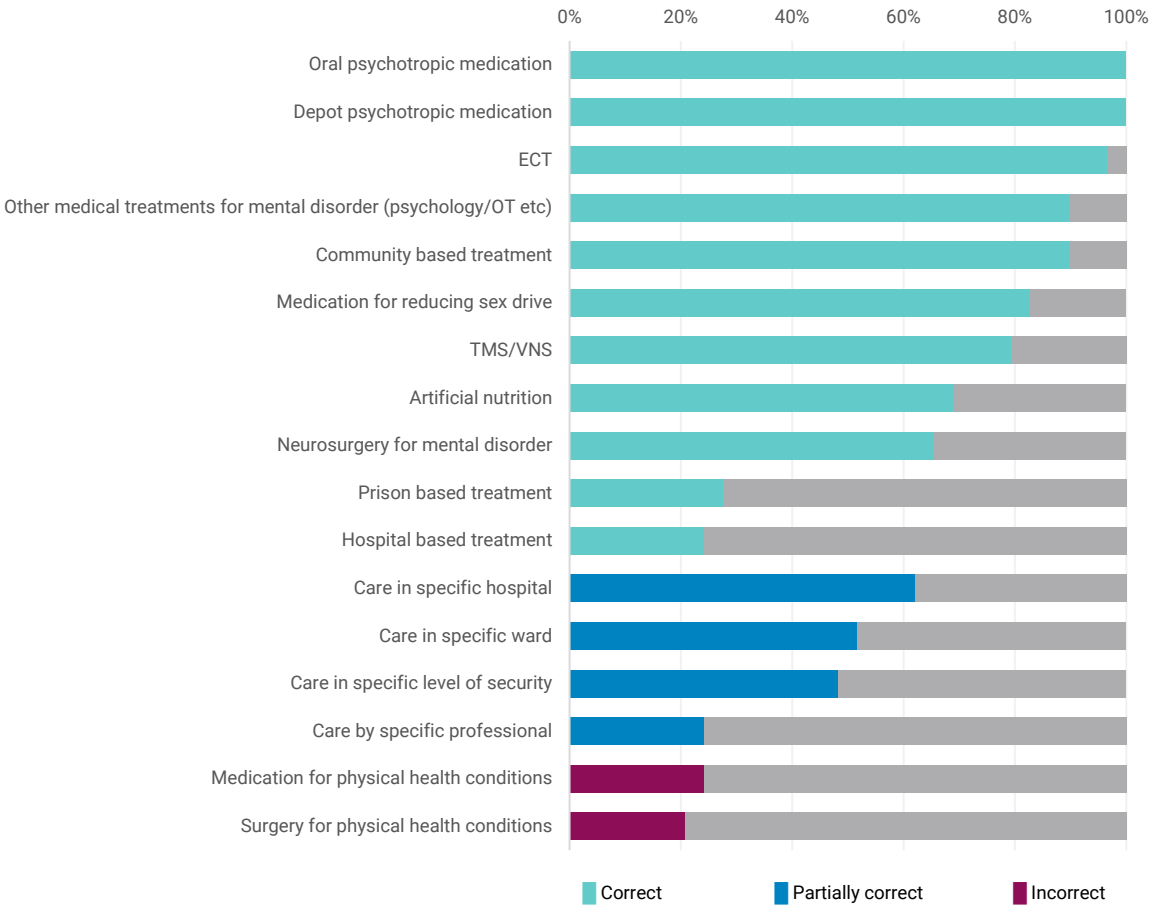
We followed up on this question in interviews and found that barriers to reviewing advance statements include that they are not readily available or accessible, lack of awareness that one is in place, and that reviews may not be a routine clinical step. Another common theme was that it was often impractical to review an advance statement in an emergency situation when restraint and rapid tranquilisation is needed.

RMOs suggested potential solutions to improve practice. This included having the advance statement near the medication Kardex, having an alert on electronic prescribing systems, and uploading the advance statement onto the individual's patient record and creating an alert for review.

Content of advance statements

We asked RMOs what wishes can appropriately be included in an advance statement. Most correctly identified that treatments for physical disorders cannot be included (Figure 4). There was variation in responses with regards to prison-based treatment and specific aspects of care. The latter can be included in the individual's personal statement but is not considered an appropriate wish to include in an advance statement.

Figure 4. RMOs' responses of what an advance statement can include



ECT: Electroconvulsive therapy; TMS/VNS: transcranial magnetic stimulation (rTMS), vagus nerve stimulation (VNS)

In interviews, RMOs told us that wishes expressed in a personal statement should be taken into consideration, but felt that these wishes should not bear equal weight to advance statement wishes. They described situations where a personal statement can have a clear benefit to the person, such as being cared for by a specific team that knows the individual well.

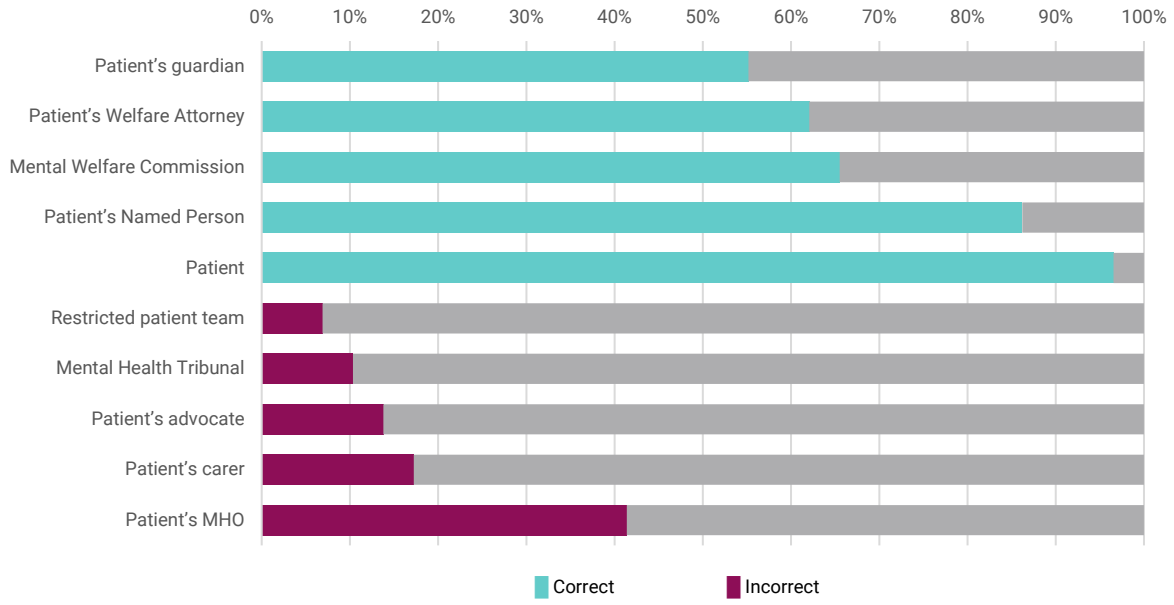
The main concern was that a person's wishes to be cared for at a specific level of security, ward, hospital, or by a particular professional may be used as a form of protest against their care and treatment, to the detriment of their own health. The barriers to accommodating specific requests within a highly specialist service, and within the context of the NHS, was another concern.

Some interviewees mentioned other relevant safeguards in the Mental Health Act. For example, there are existing mechanisms to appeal against level of security, to appeal against hospital transfer, and to request a change of RMO. Related to this, two RMOs we interviewed felt that location-based treatment wishes (hospital, community or prison) should not be considered appropriate advance statement wishes or require an override notification to the Commission.

Advance statement overrides

Advance statement overrides were relatively uncommon; 18 (62%) of the survey respondents had not overridden any advance statements within the last year. Most respondents correctly identified the relevant persons that are required to be notified in the event of an advance statement override (Figure 4). Whilst there are statutory requirements relating to override notification, we recognise and support that, in practice, there may be other individuals or organisations whom it is helpful and appropriate, within the bounds of patient confidentiality, to inform of such overrides also, for example, carers, independent advocate, the Mental Health Tribunal etc.

Figure 4. RMO's responses on who legally need to be informed about an override



The most common reasons RMOs gave for an override were:

- To provide more effective pharmacological treatments when other alternatives have been exhausted.
- When the individual's wishes in the advance statement would lead to an unacceptable level of risk.
- To provide medical treatment to prevent serious deterioration.
- Medical treatment considered life-saving.
- To switch from oral to depot treatment or from community to hospital-based treatment.
- In the best interest of the patient and to provide the least restrictive alternative (principles of the Mental Health Act).

One survey respondent commented:

> *The course of action or treatment required in order to prevent serious deterioration of their physical or mental health is contrary to the wishes expressed in an advance statement and there is no other suitable option available. For example, after trialling other medications for a catatonic state, there is no improvement. The patient is not eating and drinking. ECT is the only option remaining, but they have outlined in an advance statement that they do not wish this treatment.* **RMO survey respondent**

Finally, a number of responses highlighted other ethical and legal considerations. These included situations where following advance statement wishes would negatively impact on a third party, compromise the legal duties of the RMO, would include unlicensed or non-evidence based treatments, particularly ones where the risk of harm may outweigh the benefits.

Advance statements' influence on decision making

The most common way advance statements might influence decision-making is when they include wishes for or against a specific medical treatment. Other common responses included preference for one treatment over another and descriptions of when a specific medical treatment had led to significant side effects in the past.

> *I try to be mindful and respectful of patients' advance statements and ensure that wherever possible any interventions do not go against the patient's expressed wishes. I consider the reasons behind specific requests as well - e.g. if a patient has asked not to be prescribed a particular medication due to a distressing side effect, then I would be careful to discuss and involve the patient in any consideration of medications with similar side effect profiles, ensuring that they were aware of similarities between medications so that they could make an informed choice.* **RMO survey respondent**

Some respondents described occasions when they have followed the wishes in the advance statement for the sake of keeping a good therapeutic relationship with the individual. They would then accommodate personal statement wishes with regards to environmental considerations and family involvement.

RMOs felt that clearer guidance for patients, witnesses and professionals could make advance statements more impactful. Such guidance should clarify what can appropriately be included in an advance statement and in a personal statement. This was consistent with our survey findings which highlighted that not all RMOs were aware of what can and cannot be included.

Some responses addressed issues particular to individuals who suffer from an intellectual disability. There was support for more equal recognition of advance statement wishes related to non-pharmacological medical treatments. There was also support for the provision of easy-read materials to support individuals with intellectual difficulties who have communication

and capacity difficulties. There were a variety of responses which suggested that advance statements would be more impactful if they were dynamic, specific, organised and legible.

Professionals' role in developing advance statements

While most RMOs told us that there is a clear role for independent advocacy services in supporting development of advance statements, they felt health professionals and advocacy services need guidance. There was general support for the involvement of members of the multi-disciplinary team in supporting an individual to understand the positives and negatives of medical treatments in their areas of expertise. The involvement of speech and language therapy was mentioned specifically for their role with individuals who have communication and capacity difficulties. Several interviewees, however, warned that the involvement of the clinical team may compromise the independence of this process, as some people may be vulnerable to suggestibility, compliance or acquiescence.

Challenges and opportunities

RMOs felt that advance statements are a positive feature of the Mental Health Act and highlighted that they are an important mechanism for respecting an individual's wishes and preferences. Some suggested it can be reassuring to individuals that their wishes will be respected. Others suggested that their inclusion in the Mental Health Act promotes the use of advance statements which can generate a positive dialogue about care and treatment between the clinical team and the individual. Despite the positive views on advance statements several challenges were identified:

- Individuals making an advance statement when they were acutely unwell, often with unrealistic or impossible wishes to respect, though not recognised as something happening in practice.
- Those with lifelong incapacity in relation to medical treatment due to severe and enduring mental illness and/or intellectual disability are excluded from having their wishes recorded and respected via current advance statement processes.
- The legal authority of advance statements in relation to what wishes can, or cannot, be included.
- A shift to the involvement of solicitors may make the process inappropriately adversarial to the detriment of the underlying Part 1 principles of the Mental Health Act of participation, shared decision-making, and person-centred care, particularly when the necessary safeguards and access to independent advocacy are already in place.
- The lack of a statutory review process and advance statements are often not accessible or are out of date.

One survey respondent told us:

> *I think emphasis around capacity not being all or nothing and that those without broad capacity can still be supported to give views as to how they would wish their future care to be provided. This might increase the numbers of those currently holding statements.* **RMO survey respondent**

In response to the challenge of lacking a review process, RMOs we spoke to were generally in favour of such a process and suggested tying this review process into the Designated Medical Practitioner (DMP) request for a second opinion for a T3 consent to treatment authorisation certificate. This process occurs at least every three years at its least frequent, though RMOs acknowledged that individuals who can consent to treatment under T2 provisions and informal patients would not have the same review prompt.

Considerations for the SMHLR

RMOs felt that one of the most common reasons there is a higher uptake of advance statements in FMHS is because individuals are almost always subject to detention. Interviewees felt that forensic patients are managed in highly systematised, protocol-driven services with proportionately greater resources and smaller caseloads, and are almost always managed under enhanced CPA. The on average longer length of stay in FMHS was mentioned as a potential reason why individuals receiving treatment within those services might be more likely to make advance statements with greater opportunity for relapse prevention planning and the making of advance statements.

RMOs did not, however, feel that forensic patients require special considerations or safeguards under the Mental Health Act and did not see this group as different to other detained patients. Some interviewees highlighted that there is perhaps a greater emphasis on the principle of "reciprocity" when considering the use of advance statements in FMHS. Specifically, forensic patients are subject to significant restrictions and where it is possible to do so, they should be given autonomy with regards to their care and treatment.

While RMOs were positive about advance statements, they felt there has not been enough consideration for the systems required for their creation, storage and review. Interviewees questioned the use of number of advance statements in existence as a quality indicator for health boards, since some individuals may not want to make one, and suggested promotion and documentation about offer to make one would be a better quality marker.

What this means

This is the first piece of work to explore how advance statements are perceived and operationalised within FMHS. We believe that this information gives some insight into how advance statements work in practice in Scotland.

One key finding is that the uptake of advance statements within IPCUs is low. Within this setting, individuals are almost always acutely unwell and, for some, the admission might be their first contact with mental health services which would make it unlikely for them to have an advance statement. This is likely to particularly be the case for forensic patients who have been detained under the Criminal Procedure Act.

We recently published a report which estimated the prevalence of advance statements among individuals who were treated under a T3 certificate; a group likely to benefit from an advance statement. Only 6% of these individuals had an advance statement [17]. From this piece of work we conclude that the uptake in forensic populations appears much greater. Is this group different to others within mental health services? We do not think this is the case, but there are some factors that might explain a higher uptake:

- Individuals within forensic settings are usually cared for under a legal framework and therefore also have closer links to independent advocacy services.
- In general, the systemised and protocol-driven feature of FMHS might make it more natural to review advance statements, for example as part of enhanced CPA.
- FMHS have proportionally greater resources which may mean that professionals and others involved have more time to consider the development of advance statements.
- The caseload within FMHS is smaller than in the wider mental health services, possibly offering more time to consider developing advance statements.
- Longer length of stays where people require a rehabilitation phase before they can leave hospital offers the opportunity to consider advance statements to form part of relapse prevention.

Our recent report on advance statements among individuals treated under a T3 certificate indicated higher prevalence among males, and those living in the more deprived areas of Scotland. The median age of people with an advance statement was 47 years (compared to 54 years for those who did not have one) [17]. These demographic characteristics are similar to individuals within FMHS.

Generally, RMOs in FMHS had a positive view of advance statements and felt that they ensure the person's treatment wishes and preferences are respected. They also believed that advance statements can open a positive dialogue between the clinical team and the patient and having them enshrined in the Mental Health Act ensures that they are promoted by health boards. The "reciprocity" principle was reported as most relevant for forensic patients, given the restrictive conditions they receive their care and treatment in, it is vital that where possible people have autonomy and can participate in decision-making as part of person-centred care to have their individual wishes and preferences respected.

We note the responses from some RMOs that there are some challenges, including that some people might be ambivalent towards making an advance statement, they may feel disempowered and feel that their statement might be overridden in the future, people might worry that making an advance statement could lead to prejudice within future care, and that advance statements might be perceived as overly legalistic. The current paucity of research on individuals' views on advance statements suggest that there is more to be done to ensure that we fully understand not only how practitioners implement this aspect of the Mental Health Act in practice but also how well the principles are realised for those receiving care and treatment.

Limitations

This is the first time work has been done to look at advance statements in FMHS in Scotland. The information is limited to the views of 29 RMOs; the views of people receiving care and treatment, nursing, allied health professionals, MHOs, and advocacy staff might well differ.

As the response rate includes only around a third of RMOs in Scotland, the views of those who did not want to or were not able to participate might differ and we are not able to say for certain that these findings are generalisable across all practitioners.

While this project aimed to specifically understand the role of advance statements in forensic settings, replicating the study in other mental health settings across Scotland would potentially be beneficial in furthering our understanding of the current use of advance statements, their impact and how best to promote their use and quality. Such a project could also usefully contribute to the SMHLR.

Recommendations

To SMHLR

Consideration of capacity to make an advance statement

The SMHLR should consider the wording in the Mental Health Act and whether to introduce more explicit reference to issues relating to capacity to make an advance statement. This should seek to mitigate any risk that individuals deemed to lack capacity in some areas are excluded from making an advance statement. In such circumstances, measures to enhance capacity could be effective in facilitating an individual's full or partial engagement in the advance statement process.

Introduce a statutory review process

The SMHLR should consider the finding that the majority survey respondents were in favour of a statutory review process to ensure advance statements remain valid and up to date for detained patients. This is in keeping with the recommendation that the Commission made to the SMHLR about ensuring more robust scrutiny of overrides [17]. It also aligns with our previous recommendation to health boards that there ought to be consideration of at what point in the clinical pathway a person ought to offered the opportunity to make an advance statement.

Increasing safeguards

The SMHLR should consider the comments from this survey that suggest there may be a requirement for a second opinion in the case of an advance statement override, perhaps due to increased restrictions this patient group are already subject to. This is in keeping with the previous recommendation that Commission made about that that a competently made advance refusal for a specific treatment should have a higher bar associated with any override of this including greater scrutiny [17].

Acknowledgments

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Glossary

AMP	Approved Medical Practitioners
CPA	Care Programme Approach
DMP	Designated Medical Practitioner
FMHS	Forensic Mental Health Services
Kardex	The paper or electronic form where medications are prescribed
RMO	Responsible Medical Officer
SMLHR	Scottish Mental Health Law Review
UNCRPD	United Nations Conventions on the Rights of Persons with Disability

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Appendix

Table A1. Background characteristics of survey respondents

Grouping	Category	n (%)
Job title	Consultant	19 (66)
	Higher trainee	10 (34)
Experience	0–4 years	<5
	5–14 years	14 (48)
	15+ years	13 (45)
Setting[a]	High secure	11 (38)
	Medium secure	10 (34)
	Low secure	7 (24)
	IPCU	7 (24)
	Open rehabilitation	6 (21)
	Community	*
	Prison	*
	Other	*
Patient group[a]	Male	27 (93)
	Mental illness	24 (83)
	Acute	18 (62)
	Personality disorder	17 (59)
	Rehabilitation	17 (59)
	Female	11 (38)
	Long-Stay	9 (31)
	Other	*
	Intellectual disability	*
Last AMP update	2017-18	8 (28)
	2019-20	21 (72)

[a]Not mutually exclusive, some worked in multiple settings; *n<5

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