

Introduction:

As a community mental health nurse (CMHN), I will reflect upon a critical incident that occurred with one of my clients, using the Gibbs reflective cycle (1988). I will reflect on my learning and development through this experience, highlighting how this has enabled me to become more effective in achieving desired practice.

Description of the Incident:

Pete was a caucasian man in his early 60s, known to mental health services for the last 20-years or so and he was accepting treatment. He was regularly seen by the doctors in the out-patient clinic, by a support worker and by

myself, as his CMHN. Pete used to abuse alcohol and on many occasions had been referred to local drug and alcohol services, although he inevitably failed to attend his appointments. Earlier last year, he was transferred from a third floor to a ground floor flat, which he had been wanting for some time as he suffered from chronic obstructive airways disease. However, within nine months of his move, he was admitted to a local mental health unit on three separate occasions, reporting suicidal ideas on each occasion—he had not previously acted on such thoughts.

Pete was prescribed depot medication (*an anti-psychotic injection*), which was administered weekly, in addition to an

A Reflection on the Use of Advance Statements in Clinical Practice: a service user and service provider perspective

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SERVICE-USER INVOLVEMENT

Advance Statements: what are they?

'An advance directive (also known as an 'advance statement', 'advance refusal' or 'living will') is a way of making a persons' view known if he or she should become mentally incapable of giving consent to treatment, or making informed choices about treatment, at some future time. Doctors and healthcare workers must usually take these wishes (advance statements) into account. There are however certain conditions which need to be satisfied before an advance directive can be valid and there are some limits to what a person can direct.' (Mind 2004)

The British Medical Association has developed a code of practice (BMA 1995) about advance directives and advance statements, the use of which has increased over recent years and has raised ethical and legal issues throughout the profession. The code takes a practical approach and acknowledges a 'limited value' in the use of advance directives (refusals) and advance statements (preferences) in relation to the treatment of recurrent episodes of mental illness, and

especially in light of the overriding powers of the Mental Health Act 1983. (BMA 2004)

How do advance statements apply to mental health service users and professionals?

A service provider perspective

The use of advance statements in mental health practice is clearly advocated by the NICE Guidelines for Schizophrenia (NICE 2002: 7). The guidelines give a brief description of what an 'Advance Directive' is and what it could be helpful in achieving. They, however, do not provide advice on producing these directives, although they point out that there are limitations regarding choice of treatment and that doctors may not follow the directive for 'medical reasons'.

As a health professional working in the community, I could see the potential of the advance directive in enabling the service user to feel listened to and having some 'choice'.

Early in 2003 I was engaged in discharge planning with a client who had received treatment for a relapse of schizophrenia. The gentleman concerned, whom I shall refer to as 'H', had become familiar with admissions to psychiatric hospitals, and he has a 10 year history of mental health problems. Despite recurrent episodes of psychosis, 'H' remains extremely articulate, and intelligent.

The experiences that 'H' had regarding care and treatment of his mental health problems were negative from the very start. His treatment with medication had resulted in distressing negative side

effects and he has now lost count of the different types of medication he has been prescribed, usually when under the Mental Health Act and in hospital. 'H' felt like he was being experimented on, not in a delusional context, but as a result of having been given so many different medications as treatment, that had made him feel, in his words, 'depressed, agitated, restless, and sometimes suicidal'. He expressed distrust and open disgust at psychiatric services. This anger and hurt magnified significantly when he became unwell.

Following each admission, 'H' would discontinue his medication and there began the slow inexorable slide towards the next relapse. As I gained a better understanding of the illness experience from his perspective, I began to appreciate that, for him, being 'ill' was preferable to being 'treated for illness'.

Having read about them in the NICE guidelines, I introduced the possible use of an advance directive to 'H' in discussions about relapse prevention. The intention was that by addressing the issue of his fear of being prescribed medication that had given unwanted side effects, that 'H' would feel listened to, and by ensuring effective distribution of his treatment wishes, these would be respected where possible. These discussions engendered a more positive approach to treatment options, despite the fact that the resultant directive was quite simple.

At this time, there was little guidance available to me about the formulation of an advance statement. Therefore I followed the basic guidelines from Rethink (Rethink 2003). 'H', at the time of compiling the advance statement/directive, was competent to make those decisions, but I failed to provide formal

evidence for this. Whilst it is not imperative to have a witness signature for an advance statement, in retrospect, it would have been advisable for me to have done this as a health professional, especially given that 'H' has a long history of relapse in his mental state and past episodes where he has not had the competence to make appropriate decisions in his own best interest. It was also suggested, by Rethink, that such statements should be carefully drafted so that its terms are clear and it is obvious as to what treatment is being refused or consented to.

Unfortunately the preferred treatment also produced some 'intolerable side effects', namely akathisia and a period of depression, which were the reasons 'H' had declined to continue on this treatment from May. A further relapse did occur, towards the end of 2003, and despite being treated under the Mental Health Act, which overrides an advance directive, the treatment prescribed was the preference expressed in the advance statement.

I have subsequently appreciated the need to revisit advance statements as part of care plan reviews or if treatment preferences change: it is appropriate to do so as long as the individual is competent to make those decisions.

When his insight fully returned in April 2004 it enabled him to consider possible alternative treatments for future relapse episodes, as again he was clear that the drawbacks to his current treatment outweighed the benefits. He discontinued this treatment prior to discharge.

Providing valid and effective information to 'H' about medication based on his experiences, he explored the possible

use of an alternative atypical antipsychotic and even discussed this with fellow patients on the ward at the time. He carefully read through the information leaflets and researched side effect profiles. Discharge planning again involved the use of a further advance directive, superceding the previous one. (Practitioners should note that it needs to be made clear on the most current advance statement that it supercedes any or all previous statements.) This time, use was made of a format produced by Rethink, which includes issues wider than just medication preferences. Again it does not provide for a witness signature.

Despite being discharged without the prescribing of any medication, 'H' subsequently commenced olanzapine of his own volition, to avoid future relapses – something he has never done before. The use of an advance statement was by no means the only reason for this, but I feel that it played a valuable part in changing his experience of mental health services. By viewing the client as an authority on their illness, a sentiment strongly advocated in the use of 'The Tidal Model' (Buchanan-Barker 2004), and relapse episodes as a learning opportunity, it is possible, in collaboration, to enable the client to reach their own conclusions about their need for treatment and for them to exercise some control over what that may constitute.

A service user perspective

'Nobody should underestimate the lengths a person will go to in order to avoid the side effect terrors of drugs prescribed for schizophrenia. For me, living anonymously on the street in another part of the country is easily the

preferable alternative to drugs like Depixol. Any legal document lessening the possibility of the patient being terrorised with them is likely to reduce the possibility of the patient running away, or worse, committing suicide. I think it a vital part of treatment.' 'H' (July 2004)

Buchanan-Barker P (2004) The Tidal Model: Uncommon Sense. *Mental Health Nursing* 24(3): 6-10

Mind (2004) Legal Briefing: advance directives. Available on-line from: <http://www.mind.org.uk/Information/Legal/Legalbriefing+advancedirectives.htm> (accessed on: 04.07.04)

References

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NICE (National Institute for Clinical Excellence) (2002) *Schizophrenia: Core interventions in the treatment and management of schizophrenia in primary and secondary care*. London: NICE

British Medical Association (2003) *Advance Statements about Medical Treatment: Code of Practice*. Available on-line from: <http://www.bma.org.uk/.../code> (accessed on: 29.01.03)

Rethink (2003) *Advance Statements*. Available on-line from: <http://www.rethink.org/information/legal/advance1.html> (accessed on: 29.01.03)

CELEBRATING SUCCESS IN QUALITY IMPROVEMENT

When? Wednesday, 6th October 2004
Time? Registration and Coffee from 17.30
Start time: 18.00
Finish time: 21.00 (supper provided)
Where? Silsoe Conference Centre

How to book a place? Call the Clinical Audit Department on ext 7146 (external 01234 310146)

ALL WELCOME