Jankovic et al (2010, this issue) discuss the role of advance statements in England and Wales as introduced in the Mental Capacity Act 2005. My article comments on their views from the different legal position in Scotland. This requires some description of the position of advance statements as introduced in the Mental Health (Care and Treatment) (Scotland) Act 2003.

Scotland is unusual, and possibly progressive, in having advance statements for mental health embedded in its mental health legislation and not as part of a more generic capacity legislation or introduced as an independent piece of legislation (Atkinson 2006). The Mental Health (Care and Treatment) Act also requires a person to have significantly impaired ability to make medical decisions before they become subject to the Act. The review of the mental health act in Scotland has to be seen in the context of pre-existing capacity legislation, the Adults with Incapacity (Scotland) Act 2000, which does not deal with advance directives or advance decisions (Patrick 2006; Atkinson 2007). These remain a matter for common law in Scotland.

**Advance statement in Scotland**

In Scotland, advance statement has a precise legal meaning (Box 1) which is not the same as defined in Jankovic et al’s article. When introduced, it was clear that the intention was that ‘treatment’ should cover clinical treatment but not wider aspects of management or stay in hospital. To accommodate these, the personal statement was introduced, although this did not have the same legal standing as the advance statement. It should be noted that, unlike Jankovic et al’s assumption about advance statements, this does not allow for the appointment of a proxy or surrogate decision maker. The way for this to be done in Scotland is through the Adults with Incapacity (Scotland) Act. The Mental Health (Care and Treatment) Act requires the mental health tribunal (which makes decisions about compulsory treatment) to ‘have regard to the wishes specified in the statement’ (Section 18, para. 276).

The advance statement clearly covers both refusals and requests for treatment, and as neither is legally binding they can be overridden by a
A serious issue could arise if the advance statement and personal statement are combined (since at present it is only the advance statement that has to be formally considered by the tribunal). The relates to the definition of ‘treatment’ and whether it extends beyond what is provided by the clinical team. If someone says that meditating if they need to light candles and burn incense to achieve their meditative state, in contravention of safety requirements on the ward?

The purpose of advance statements

Despite the twin aims of promoting both autonomy and communication, one has to take precedence. In the first case, the statement will be made with a member of the treating team. The latter may more closely resemble a joint (crisis) or treatment plan, and where these are in evidence and work well the need for an advance statement may be limited.
Advantages and disadvantages of advance statements in Scotland

Advantages and disadvantages depend on the person’s relationship to the advance statement. Staff and patients may have very different views and experiences.

It is likely that most people will agree that an advantage of the Scottish system is that advance statements are embedded within the Mental Health (Care and Treatment) Act. This means not only that anyone with a mental illness who may be subject to the Act can make one, but also that information about this option should be routinely given. The mental health tribunal has to give regard to any advance statement made, so, in theory at least, there should be no question of a statement being overlooked.

A positive aspect of advance statements in Scotland is that they allow the person both to refuse certain treatments and to specify interventions they would welcome or accept.

A potential disadvantage is the confusion that exists between what should be in an advance statement and what in a personal statement.

Most other aspects depend on perspective. Thus, the fact that advance statements can be overturned by a tribunal is generally seen as a disadvantage by patients, who question their relevance if they do not have to be followed, but is seen as an advantage by clinicians, who retain the ability to impose their choice of treatment in certain circumstances.

Advance statements have to be witnessed by one of a proscribed set of people. This has advantages in that the statement is ‘validated’, although it is not clear whether the witness is attesting to capacity, but it can be a disadvantage to individuals who have access to only a limited number of such people or who do not want to approach someone.

Having said this, the introduction of advance statements in Scotland was a brave attempt to put them at the core of mental health legislation. Their comparatively low use should not distract from this, nor from their potential.

References