Old age psychiatry and the law†

ROBIN JACOBY

Background Old age psychiatry is no less subject to increasing legal and quasi-legal restraint than other branches of the profession, but the emphases are different. Two themes predominate: first, that of capacity or competence; and second, to what extent formal legal measures should be implemented in cases where incapacitated patients do not dissent from, as opposed to giving active consent to, admission to hospital or receiving treatment.

Aims To discuss the issues of capacity or competence, especially in relation to recent legislation and judgements and to proposed legislation in England and Wales.

Method Selective review and discussion of recent case law and current and proposed statute law.

Results and conclusions The Bournewood case threatened but ultimately failed to upset the status quo. However, the European Convention on Human Rights and the British Human Rights Act 1998 may yet do so.

Declaration of interest None.

It is a curious irony that, as the Soviet empire collapsed, Margaret Thatcher presided over the 'sovietisation' (increasing bureaucracy and central control) of many aspects of British life. Whereas business was subject to less regulation, leading directly to the bovine spongiform encephalopathy/Creutzfeldt–Jakob disease catastrophe, the learned professions which had previously operated independently and enjoyed a considerable degree of trust to act in the best interests of their clientele began to be regulated from the centre by means of both legal and quasi-legal restraints. The Mental Health Act 1983 is a case in point. Compared with its 1959 predecessor, the Act imposed more form-filling on doctors and greater restrictions on their freedom to detain patients and to administer treatments such as electro-convulsive therapy and psychosurgery. With the Act came the Mental Health Act Commission (MHAC) and the Code of Practice, which set further (quasi-legal) constraints within which doctors were to operate. When these new structures were introduced many protested at the increasing bureaucratisation, but we have all come to accept them now, and it is probably true to say that most psychiatrists actually approve of the legislation. However, new laws on mental capacity are proposed, as is a new Mental Health Act. Doubtless there will be further protests from the profession, followed by acceptance and eventual introjection of the threatening object. For those who take the long view, however, sovietisation goes on apace and we shall perhaps soon be able to do very little without first checking whether the law permits it, or whether that quasi-non-governmental organisation (quango), the MHAC, sanctions it. The irony has come full circle, since several of the former Soviet republics are now seeking to model their own new mental health legislation on the Mental Health Act 1983. Against such a background, this paper outlines some of the legal issues that have either recently arisen or are envisaged, and that have an impact on old age psychiatry. Many of these relate directly or indirectly to capacity or competence. The choice of issues has necessarily been arbitrary, but they highlight some of the dilemmas faced by old age psychiatry in balancing the rights of the individual against current and historical obligations to society.

CAPACITY, COMPETENCE AND MAKING DECISIONS

In the present context the difference between capacity and competence is one of usage – lawyers use the term 'capacity' and psychiatrists use 'competence'. In this paper the two words have the same essential meaning.

The Law Commission issued a report entitled *Mental Incapacity* in 1995, which was itself based on a number of consultation papers issued between 1991 and 1993. For a list of these see *Who Decides?* (Lord Chancellor's Department, 1997), a consultation document (or Green Paper) issued by the UK Government in 1997. As a result of this consultation the Government has declared its intention, in a document entitled *Making Decisions* (Lord Chancellor's Department, 1999*b*), to introduce new legislation, but at the time of writing no bill has been published and parliamentary time has not yet been allocated for it.

Advance statements about health care (advance directives or 'living wills'), which are currently valid under common law, will not (as had been predicted) be subject to statute legislation, but their validity will continue to be decided on a case-by-case basis (Lord Chancellor's Department, 1999*a*). While advance directives are attractive to many, they are not without problems. First, in the USA, where patients are actively encouraged by some hospitals to make them, the take-up has been low. In a recent Canadian study which took place in nursing homes over a 4-year period, the intervention group were actively encouraged to complete an advance directive, but only 49% of those who were competent did so (Molloy *et al*, 2000). Second, there are three distinct types of advance directive (Hope & Oppenheimer, 1997): (a) instructional directives; (b) statements of general values; and (c) proxy directives. Most are instructional, i.e. give a

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specific instruction (usually not) to treat in a specific way if a certain condition obtains: for example, 'Do not give me antibiotics if I reach end-stage dementia'. It is known, however, that patients who issue such directives earlier in life often change their views, but not necessarily their directives, as they grow older. Another problem is that instructional directives may not and often do not envisage the precise clinical situation that might arise. As the Lord Chancellor himself put it (Lord Chancellor's Department, 1999*a*), 'the patient has to look into a crystal ball and try to guess all the eventualities that may ensue in the future'. A hypothetical example might be that of a woman who states that she does not want to have any medical or surgical treatment if she becomes incompetent by reason of dementia. She develops dementia, becomes incompetent to make medical decisions, and then suffers intestinal obstruction from a carcinoma of the colon, which would normally require at least a relieving operation. This is probably a situation she did not envisage, and had it been explained to her when she was competent she might well have agreed at least to palliative surgery with a defunctioning colostomy to avoid a burst colon.

At present, a statement of general values has no legal force, although a doctor should certainly take it into account when deciding to act in a patient's best interest. A proxy directive – for example 'I hand over health care decisions to my spouse, if I become incompetent to make them' – has no current legal validity in British jurisdiction, but this is likely to alter under the proposed legislation, probably through a new Continuing Power of Attorney, which will replace the existing Enduring Power of Attorney. Contrary to the belief of many now holding an Enduring Power of Attorney on behalf of an incapacitated person, the attorney has rights to make decisions only regarding the patient's financial affairs. The new Continuing Power of Attorney will represent a major change in permitting an attorney to make health care decisions such as admission to hospital and acceptance of treatment. However, as yet it is uncertain whether the attorney will be allowed to refuse life-saving treatment without the donor's advance directive. Rather, it is probable that doctors will be obliged either to act in what they consider to be the best interests of the patient or to seek a court ruling.

In contrast to an Enduring Power of Attorney, a Continuing Power of Attorney will require a medical certificate before it can be registered. This should be welcomed as one safeguard against current abuse of the Enduring Power of Attorney by a small minority of attorneys. However, 'asset stripping' of elderly patients prior to their admission to nursing homes by relatives who want to protect a potential inheritance by making social services pay for the care is said to be a widespread form of financial abuse that will not be stopped by medical certification.

Where no attorney has been appointed, the Court of Protection will appoint managers, who will replace the current receivers. Managers will be able to make health care, property, personal welfare and financial decisions. The Lord Chancellor's document is unclear to what extent or whether managers will have powers to refuse medical treatment on behalf of the person lacking capacity (Lord Chancellor's Department, 1999*b*).

EUTHANASIA

This paper is not the place to contribute extensively to the debate on euthanasia. However, Ann Winterton MP recently had a Private Member's Bill before parliament which, if it had passed, would have had a major impact on old age psychiatry in the UK, except Scotland (House of Commons, 2000). The bill, entitled Medical Treatment (Prevention of Euthanasia) Bill, is brief enough to allow its main clause to be quoted in full:

> It shall be unlawful for any person responsible for the care of a patient to withdraw or withhold from the patient medical treatment or sustenance if his purpose or one of his purposes in doing so is to hasten or otherwise cause the death of the patient.

Fortunately, the bill ran out of parliamentary time and received no support from the Government, but there is no reason to believe it could not reappear in similar guise either in the Commons or the Lords. Certainly, it would run counter to the spirit of most, if not all, actual and proposed legislation in this area, namely the empowerment of people to make decisions for themselves about their own lives. Such a law would presumably mean that a fully competent patient with (say) stomach cancer could not agree with the surgeon to decline the insertion of a feeding gastrostomy. Of more importance to old age psychiatry, doctors would be debarred from implementing the advance directive of a patient with end-stage Alzheimer's disease, stating that no antibiotics or parenteral fluids should be given if the patient develops pneumonia. Should a similar bill reappear, it is to be hoped that our profession would join with the Alzheimer's Society, representing patients and their families, which expressed its vigorous opposition to Ann Winterton's bill.

THE BOURNEWOOD CASE

The bare bones of the case (*R v. Bournewood Community and Mental Health NHS Trust*, 1998) are as follows: H.L., a 48-year-old man with autism, had spent many years in Bournewood Hospital, Chertsey, Surrey, not far from London. In 1994 he went to live with Mr and Mrs E., who cared for him and treated him as one of their family. In July 1997 while attending a day centre he became agitated and was readmitted *informally* to Bournewood Hospital. His admission was challenged in court in October 1997, which ruled that he was illegally detained and that he could be legally detained only if he were admitted formally under the Mental Health Act 1983. The Court of Appeal upheld this decision on 2 December 1997.

The implications of these two judgements appeared to be wide-ranging for old age psychiatry. In short, it was taken to mean that all patients in hospital who lacked capacity to consent to treatment, *even if they did not dissent* either to remain in hospital or to receive treatment, must be detained under the Mental Health Act 1983. In effect this would apply to large numbers of elderly patients with dementia in hospital, perhaps the majority. The implications for workload alone generated much heat. To the relief of those in the profession who did not want formally to detain all their in-patients with dementia, the judgement of the Court of Appeal was overturned in the House of Lords and the situation has effectively returned to what it was before. However, the tide from Europe that is bringing us a new Mental Health Act could easily sweep Bournewood on shore again.

THE NEW MENTAL HEALTH ACT

The European Convention on Human Rights and its British offshoot, the Human

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Rights Act 1998, implemented in October 2000, have made a new Mental Health Act a necessity. In preparation for this the Department of Health set up an expert committee (the Scoping Group) to advise the Government (Department of Health, 1999*b*). Subsequently, a Green Paper was issued (Department of Health, 1999*a*). At the time of writing the Government has not yet announced its intentions with a bill for Parliament, but because of the Human Rights Act 1998 it will soon certainly do so.

Human rights

It is generally accepted since the Bournewood case that it is still legal for someone incapacitated by dementia to be in hospital and to receive treatment if they are not dissenting from being there and are accepting treatment without duress. However, in his evidence to the Scoping Group on the revision of the Mental Health Act 1983, Professor Michael Gunn, an academic lawyer, argued 'that it is wrong to allow the compulsory admission of patients who do not positively consent (rather than display lack of dissent) . . . without the use of compulsory powers' (Gunn, 2000). Many, if not most, old age psychiatrists might want to disagree with Gunn, and, because of the resource implications, the UK Government would, too. After all, it was the Secretary of State for Health who sought leave to intervene in the Bournewood appeal to the House of Lords. However, there remains untested the effect of the European Convention on Human Rights and Human Rights Act 1998, which state explicitly that no one shall be subject to lawful detention without the speedy decision of a court. Although we do not yet know what the Government will decide, if it follows the Scoping Group's recommendations the 'court' will take the form of an independent reviewer (if detention is to last more than 7 days) or a tribunal (if more than 28 days). Whatever form the final legislation takes, it seems almost inevitable that someone's detention will be challenged on the grounds of infringement of the Human Rights Act 1998. If the challenge is made on behalf of someone with dementia lacking capacity, the Bournewood decision could once more be reversed.

Capacity

The Scoping Group proposed that the criteria for compulsory detention under the new Mental Health Act should be capacity-based. In summary, in addition to mental illness of the requisite severity and the absence of other feasible options, patients who retain capacity to consent to treatment would be admitted compulsorily only if they were to constitute a significant risk to themselves or to others. This recommendation was

> driven by the Committee's desire that the criteria [for formal admission] should be consistent with their overarching principles of non-discrimination and patient autonomy and the aim to treat people suffering from mental disorders, as far as possible, in the same way as those suffering from physical disorders (Department of Health, 1999*a*).

However laudable these principles may be, R. McShane (personal communication, 2000) has argued that the concept of capacity is fundamentally discriminatory. Capacity to make an advance directive, for example, has been shown to be related to premorbid IQ. In a recent study it was found that a person with a higher IQ who has dementia is more capable of making an advance directive than someone with a lower IQ and sometimes with less dementia (Fazel *et al*, 1999). If, as McShane asserts, there is no reason to suppose that IQ will be any less important in the capacity to consent to treatment, then patients with higher IQ who retain capacity, be they suffering from dementia or schizophrenia, are less likely to receive necessary treatment, because they are more able to argue their way out of it.

The Government, in the Green Paper (Department of Health, 1999*a*), appears not to favour capacity-based compulsory detention and treatment, although it could change its mind as a result of the consultation process. At present the Government's view is that capacity may not be relevant at all and that the overriding criterion has to be the degree of risk patients present to themselves or to others.

Electroconvulsive therapy

The Scoping Group made three recommendations: (i) that electroconvulsive therapy (ECT) should never be given to a patient with capacity who does not consent; (ii) that ECT not be given to an incapacitated patient without express approval of a tribunal; and (iii) 'that ECT should not be available on the equivalent of Section 62' (Department of Health, 1999*b*). Stated explicitly, ECT would *not* be permissible if 'immediately necessary to save the patient's life' or 'to prevent serious deterioration of his condition' or 'to alleviate serious suffering by the patient'; or if 'immediately necessary and represents the minimum interference necessary to prevent the patient behaving violently or being a danger to himself or to others' (Section 62, Mental Health Act 1983). This is perhaps the recommendation of the Scoping Group most likely to arouse bitter opposition from old age psychiatrists. The seriously ill, psychotic, probably suicidal, depressed patient, whose physical reserves are tenuous because of inadequate nutrition and hydration, is the common currency of old age psychiatry. Electroconvulsive therapy is an evidence-based effective treatment for major depressive disorder. No one with any clinical experience can doubt the suffering of such patients. Should we, therefore, conclude that the Scoping Group was either misled in some way, or contained persuasive members opposed to ECT on ideological grounds? It is to be hoped that the Government will categorically reject this part of the committee's advice.

Community treatment orders

Community treatment orders are hardly likely to be of much importance to old age psychiatrists and would need no mention here were it not for the completely spurious clinical example of a 79-year-old woman with depression given on page 39 of the Green Paper (Department of Health, 1999*a*).

> Mrs O is a 79 year old woman. She lives in Part 3 accommodation. Her memory is deteriorating slightly but she has been well-settled in the accommodation. Over the past few weeks she has become agitated, depressed and adamantly refused the medication her GP has offered her. The local old age psychiatric team has been called in, and decides to call for a gate-keeping assessment. Mrs O meets the criteria for formal assessment. Everyone (including Mrs O) agrees that it is unnecessary to admit her to hospital. The team members visit Mrs O and draw up a care plan, which includes drug treatment as well as Community Psychiatric Nurse support – all to take place in the community for up to 28 days. Mrs O complies with the order and is discharged to informal status by the team after 17 days without ever needing to leave her home.

A few exceptional cases of schizophrenia (none of them involving the elderly), in particular that of Christopher Clunis, who killed Jonathan Zito in the London Underground, have caused outrage in the (mostly tabloid) press and propelled the Government into insisting on a community treatment order.

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However, it is a tenet of lawyers that extreme cases make bad law. Perhaps those who drafted the Green Paper understood this and invented something innocuous as a smokescreen. Whatever the motive, to choose such an irrelevant and unrealistic case as an example of the working of a community treatment order is bizarre, to say the least – as bizarre as *not* seeking the opinion of an old age psychiatrist to assess General Pinochet for disability in relation to trial. (Augusto Pinochet, the former Chilean dictator, was held under house arrest in England for 509 days from October 1998 pending a request from Spain to extradite him to face trial for human rights violations. The then Home Secretary, Jack Straw, eventually had him released on the grounds that he was unfit to face trial, although he was not examined by an old age psychiatrist with expertise in assessment of disability in relation to trial.)

CLINICAL IMPLICATIONS

- Recent and future legislation will require all old age psychiatrists to have strabismus – one eye on the patient and the other on the law.
- The Human Rights Act 1998 is bound to be used to challenge the decisions of old age psychiatrists, with far-reaching implications for clinical practice, possibly in relation to incapacitated patients who do not dissent from hospitalisation (i.e. Bournewood revisited).
- Future legislation will empower elderly patients to make more decisions for themselves about their own health care, including the donation of power to make proxy decisions on their behalf.

LIMITATIONS

- This paper is necessarily based on proposals for future legislation rather than the legislation itself. The government could change its mind before it comes to pass the laws discussed here.
- Although the author predicts a challenge to old age psychiatry under the Human Rights Act 1998, it is impossible to foresee exactly what it will be.
- Although legislation on mental incapacity and a new Mental Health Act for England and Wales are certain, much day-to-day law will be made by judges (common law) and its nature cannot be predicted.

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ROBIN JACOBY, FRCPsych, University of Oxford, Department of Psychiatry, The Warneford Hospital, Oxford OX3 7JX, UK

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