

# 19 Law

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*General principles • Legal rights of the mentally ill • Financial affairs  
• Compulsory admission • Consent to medical treatment*

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With one or two exceptions, law in the UK does not distinguish older people with mental disorder from younger people. However, the features of mental disorders in old age, particularly dementia, mean that some legal issues arise more often.

## General principles

### **Individual circumstances**

It is a fundamental feature of the law in the UK that it is the unique circumstances of the individual, at a particular point in time, that determines the relevance, or applicability, of specific legal action. For example, an individual may only be admitted to hospital on a compulsory basis under Section 2 of the Mental Health Act (1983) if three professionals attest to the unique circumstances. Similarly, an assessment of testamentary capacity (under common law) is specific to an individual at a particular point of time.

### **Psychiatric assessment**

The reliability of a medical opinion about the mental capacity of an individual is largely determined by the quality of the psychiatric assessment. It should include information from others about an individual's history, behaviour and functioning, to complement the mental state examination. Psychiatric diagnosis is important because of its major contribution to predicting the natural history, and possible clinical, social and legal outcomes for individuals. For example, the risks of self-neglect or financial incompetence are considerably higher in dementia sufferers than in elderly people with anxiety neuroses. But diagnosis alone does not determine risk or legal competence. The risk of financial disaster will vary between sufferers from dementia, and be related to other variables such as social circumstances and personality. Similarly, one psychotically depressed elderly individual may be capable of consenting to medical treatment with electroconvulsive therapy and another not.

### **Civil rights**

There are powerful ageist beliefs in our society about the incompetence of older people. These beliefs are sometimes associated with moves to protect an elderly individual from risk. There can be collusion between family or carers and health or social care professionals, in which the individual is not validly consulted. Decisions which are central to an individual's welfare and personal liberty, such as where they live, how their money is spent, what clothes they wear and in whose company they spend their time, may be made by others. The fundamental human right to be consulted may be overlooked.

In addition, decisions may deprive an individual of freedoms, and in misjudged cases amount to over-protection. Most older people, whether mentally disordered or not, prefer to choose whether to accept a degree of risk or lose some freedoms. It may be the responsibility of the psychiatrist to support the individual's right to make this choice.

### **Confidentiality**

Doctors have a duty to preserve medical confidentiality, and this applies equally to older patients. Doctors must be able to justify, if necessary to the General Medical Council, any breach of this general rule. The doctor must be able to say why disclosure was in the 'best interests' of the patient. It may be necessary to specify the significant risk to the patient, or to others, that has persuaded them to break medical confidence. The practitioner is likely to be asked what efforts were made to gain consent from the patient or to justify the reasons for not seeking consent.

### **Capacity**

The general test of capacity is an individual's capacity to perform the function in question. It usually depends on whether the individual can understand, in broad terms, what he is doing and the effects of doing it, rather than his capacity to perform the task well or easily. There are two general legal presumptions governing capacity: (a) the person is mentally competent unless proven otherwise; (b) competence (or incompetence) continues unless there is definite proof to the contrary (continuance).

The level of proof for capacity is 'on the balance of probabilities' rather than 'beyond reasonable doubt'. In other words, the degree of certainty required is that of the civil law rather than the criminal law. Capacity is a legal, not medical decision. In disputed cases the medical opinions and evidence are decided by the courts. Although considerable weight is placed on medical evidence, there is a precedent (*Birkin v. Wing*, 1890) where a judge preferred the evidence of a solicitor!

## **Reform**

The Law Commission for England and Wales completed a major review of the law in relation to mental incapacity in 1995 (Law Commission, 1995) and presented a draft bill to the Lord Chancellor. The main focus of the bill is decision-making on behalf of people who lack mental capacity to make decisions for themselves. If some of their proposals are adopted in legislation, much of the current law for incapable people will change. Decisions about a person's individual welfare and medical care will be authorised via a new statutory authority, which will consolidate and modify existing powers for managing property and financial affairs. There are additional proposals to give powers to local authorities to protect vulnerable adults from abuse and neglect.

## **Best interests**

The notion of 'best interests' has been part of accepted clinical practice, endorsed in common law, for some time. This means that, where an individual lacks capacity to make a decision, any act (or omission) taken on their behalf must be in their best interests. The Law Commission has provided a helpful check-list to assist decision-making in these circumstances. Consideration should be given to the:

- (a) past and present wishes of the individual;
- (b) need to maximise the person's participation in the decision;
- (c) views of others as to the person's wishes and feelings;
- (d) need to adopt the course of action least restrictive of the individual's freedom.

### **Box 19.1 General principles**

**Individual circumstances:** determine the applicability of law  
**Psychiatric assessments:** collateral information, history, mental state and diagnosis  
**Civil rights:** at risk of being ignored in older people  
**Confidentiality:** a doctor's duty and required by the General Medical Council  
**Capacity:** broadly, understanding what you are doing, and the effects of your actions  
**Reform:** a draft bill on mental incapacity  
**Best interests:** acting for an incapable person

## Legal rights of the mentally ill

### **Voting**

A person is entitled to vote if he is on the Register of Electors, unless he is compulsorily detained in hospital at the time of election. The officer presiding at the polling station can bar someone if it appears to the officer that the person is of 'unsound mind', without the capacity to understand, in broad terms, what he is doing and the effects of doing it. This power is very rarely exercised.

Short-stay hospital patients are likely to be registered at their home address. Long-stay patients may register using the hospital address, unless it is a mental illness hospital or registered mental nursing home. Special provision in the Representation of the People Act 1983 allows informal patients in mental illness and learning-disability hospitals to register in the electoral registration district of previous residence. They must make a declaration indicating their intention to vote, which is attested by a member of the hospital staff.

### **Jury service**

Eligibility for jury service is determined by being on the electoral register, and being under the age of 70. In addition, people receiving in-patient care or treatment for mental disorder are excluded, as are individuals subject to guardianship or whose affairs are under the Court of Protection.

### **Driving**

Individuals in the UK are obliged to apply to renew their driving licence on a regular basis after reaching the age of 70, and are meant to disclose any medical conditions that might affect their ability to drive. Individuals are legally obliged to inform the authorities at any time, of any disability likely to cause the driving of a vehicle to be a source of danger to the public. This may include a progressive illness such as a dementia, which could be notified as a 'prospective disability' because its progress may lead to danger in the future. The outcome, in an early case, might be to issue a licence on a yearly basis, with reassessment before renewal.

Some older patients with dementia or psychotic illness may be unwilling or unable to accept medical advice to stop driving and tell the authorities. Where this is the case, and the doctor believes there is a likelihood of serious danger to the patient or others, the doctor should consider, very seriously, whether to inform the Driver and Vehicle Licencing Agency medical advisor in confidence, recognising that in less serious circumstances this would represent a breach of medical confidentiality, unacceptable to the General Medical Council.

Motor insurers are obliged to notify the Secretary of State if they refuse insurance on health grounds, and some insurers ask for medical certificates before renewing insurance cover with older people. If a doctor issues a certificate of fitness to drive contrary to established clinical practice and guidelines, he could be liable for damages if his patient was responsible for a driving accident. In all cases, doctors should document their opinion and the specific advice given to a patient and their family.

## **Marriage**

The degree of understanding required to enter into a marriage contract is a very simple one, which requires a broad understanding of 'the duties and responsibilities normally entailing to a marriage'. Most older people, even with dementia, are likely to meet this criterion. This test, coupled with the intestacy rules, which allow a new marriage partner to claim the estate (because marriage revokes all previous wills), provide a potential bonanza for the fortune hunter seeking financial benefit from marriage to a mentally incompetent older person.

To prevent a marriage, a rarely used mechanism known as a 'caveat', or objection to the marriage, can be entered with the superintendent registrar (Marriage Act 1949, Section 29). The person seeking to oppose the marriage carries the burden of proof of lack of capacity. Medical opinion that a marriage would not be suitable for an individual is unlikely to persuade the registrar to deny a certificate.

A marriage can be made void if it can be proven that the bride or groom could not understand (at the time of the ceremony) the nature of the contract being entered, and appreciate its basic responsibilities. Alternatively, a marriage may be void if an individual was suffering from a mental disorder 'of such a kind or to such an extent, as to be unfitted for marriage'. Neither is easy to prove, and proceedings must be instituted within three years of the marriage. Even in these circumstances, a marriage is still valid unless one of the parties successfully petitions for nullity (Matrimonial Causes Act, 1973).

If the Court of Protection carries responsibility for the financial and other affairs of a wealthy mentally incompetent individual, it has the power to make a fresh will, or to petition for nullity on the patient's behalf. The new will might disinherit the fortune hunting spouse. Nullity would have the effect of removing the automatic right of the spouse to share in the estate.

## **Divorce**

The sole ground for divorce, following the Matrimonial Causes Act 1973, is that the marriage has irretrievably broken down. Mental disorder may be a relevant factor in certain circumstances. The most obvious might be where a couple are living apart, because one is being treated or cared for

in hospital for mental disorder, on a long-term basis. If the separation has been for a continuous period of five years or more, a divorce can be granted irrespective of the mental capacity, or consent of the parties. If the respondent is able to understand the effect and consequences of divorce, and consents to it, the separation need only last two years.

A distinct ground for divorce (without a waiting time) is if the respondent has behaved in such a way that the petitioner cannot reasonably be expected to live with them. The patient's conduct need not be blameworthy, but simply negative in character, as in *Thurlow v. Thurlow* (1976). In this case it was argued that the husband's health was adversely affected by the burden of caring for his wife's severe neurological disorder, associated with gradual mental and physical deterioration. The Court of Protection also has the power to issue a petition for divorce on behalf of a mentally disordered patient.

### **Making a will**

Testamentary capacity is the degree of understanding, required in law, to make a valid will. It must apply at both stages in will making, namely the giving of instructions for the preparation of the will and the executing or signing the will. It depends on the extent of the individual's understanding of the particular transactions concerned. As a consequence, greater mental capacity is likely to be required to make a complex will, by a wealthy individual, than a simple will by someone of limited means. No distinction is made between detained and informal patients. The essential test for testamentary capacity is that the individual should have, in simple terms: an appreciation of the nature of the act and its effects; an understanding of the extent of the property he or she is disposing; be able to receive and evaluate information from others; be able to distinguish and compare potential beneficiaries; and be able to arrive at some sort of judgement.

An individual suffering from fluctuating or relapsing mental illness, may have the capacity to make a valid will in a brief 'lucid interval'. Someone with symptoms of memory impairment, as part of dementia, may be able to concentrate sufficiently to make a valid will on a 'good' day. Individuals may make eccentric, cruel, foolish or improvident dispositions without invalidating their wills. The presence of delusions does not automatically negate testamentary capacity, although specific delusions about a close relative who would be a natural beneficiary are likely to do so.

In complex cases, when a will is drawn up for a seriously ill older person, or for someone receiving in-patient psychiatric treatment, solicitors are likely to request a psychiatric opinion or medical witness. Doctors should take care in these circumstances, following a judgement in *Kennard v. Adams* (1975), where the judge assumed that the doctor would not only make a formal assessment of capacity but also record his or her examination and findings.

Since 1969, the Court of Protection has been able to make a statutory will, where the patient is incapable of making a valid will for himself. The court is obliged to make a will, consistent with the one the patient would have made for himself, within reason, and with competent legal advice. In some circumstances, the outcome, reflecting the patient's likely views when of sound mind, may be far from impartial. In such circumstances, as with an ordinary will, it is open to members of the patient's family, if they are disinherited, to apply under the Inheritance (Provision for Family and Dependents) Act 1975 after the death.

A will is automatically revoked on marriage, but in other circumstances the standard required to revoke a will is the same as to make a valid will in the first place. In *Re Sabatini* (1969) the act of tearing up a will was not accepted as revoking it, because medical evidence showed the presence of severe dementia at the time.

### **Gifts**

A family dispute may be triggered when a confused elderly person makes a 'gift' of property, such as jewellery, to another family member or even to a stranger. The judgement in *Re Beaney (Deceased)* (1978) set out the criteria for the capacity to make a lifetime gift. In this case, a widow with severe dementia, when admitted to hospital, 'gave' her home to a daughter. It was ruled that the extent of understanding required is relative to the particular transaction. So if the value of a gift were trivial, a low degree of understanding would suffice. But if the effect were to dispose of their only asset of value, the degree of understanding required is as high as that necessary for a will. Gifts by people with advanced dementia to charities, or seasonable gifts to relatives can be made by the holder of an Enduring Power of Attorney. They may specifically apply for permission to make more substantial gifts to the Public Trust Office or Court of Protection.

### **Contracts**

The capacity of an individual to make a contract, like making a will, is determined by whether he understood the nature of the contract at the time. It is important to protect those who cannot help themselves, but the law also protects the other party who may have had no reason to believe that an individual was mentally capable. The general rule is that a mentally incapable person is bound by a contract he has made, unless there is proof that the other person knew of the incapacity. Even in these circumstances, the mentally incapable person must pay a reasonable price for 'necessaries' such as essential food and drink, and services such as accommodation.

Once a patient is under the jurisdiction of the Court of Protection any contract he makes does not bind the patient or his estate. Regrettably

there is no legislative equivalent to the Race Relations Act 1974, or the Sex Discrimination Act, protecting mentally disordered or elderly people from discrimination in relation to housing, accommodation or financial services.

### **Arrest**

The Code of Practice relating to mentally ill and learning-disabled persons, under the Police and Criminal Evidence Act 1984, indicates the steps to be followed by the police who detain and wish to interview such a person. Essentially, the Code of Practice requires the police to ask an independent 'appropriate adult' (such as a relative, social worker or health professional) to attend the police station and join any interview between the police and the mentally disordered person. The purposes of this presence are to:

- (a) advise the person being interviewed;
- (b) observe whether or not the interview is being conducted properly and fairly; and
- (c) facilitate communication with the person being interviewed.

The appropriate adult must be given an opportunity to make representations about the need for continuing detention, and hear any charge made. In all circumstances, where a person brought to a police station appears to be suffering from mental illness (other than drunkenness alone) the custody officer must immediately call the police surgeon or, in urgent cases, send the person to hospital.

### **Serving as a witness**

Successful prosecution of individuals who may have abused mentally ill older people may be undermined because of the difficulty in providing reliable evidence in the witness box. Even if the potential witness satisfies the judge beyond reasonable doubt that he can take the oath, their reliability may be challenged because of the presence of a mental illness. Other strong, corroborative evidence is likely to be needed.

### **Litigation**

There are special provisions concerning mentally disordered people in terms of their representation and ability to make claims in any high court or county court proceedings. Actions cannot be brought, or defended, in the courts unless the mentally incapable 'patient' is represented by a 'next friend' (if the patient is the plaintiff, petitioner or applicant) or a 'guardian ad litem' (if the patient is the defendant or respondent). The

### **Box 19.2 Legal rights of the mentally ill**

Voting: able to vote unless compulsorily detained

Jury service: not if over 70, or receiving treatment for a mental illness

Driving: must renew licence at 70 years of age, and inform the Driver and Vehicle Licencing Agency of any illness

Marriage: need to understand duties and responsibilities

Divorce: if marriage has broken down, or unreasonable to live with partner

Will: need to appreciate the act, effects, your estate and potential beneficiaries

Gifts: depends upon value of gift

Contracts: understand the nature of the act

Arrest: 'appropriate adult' present or police surgeon

Witness: reliability may be questioned

Litigation: 'next friend' or guardian may represent you

court approves the appointment and the official solicitor often acts for these patients. The criteria for incapacity, which is decided by the court, is mental disorder resulting in an inability to manage property and affairs.

## **Financial affairs**

### **Capable person**

#### *Bank or building society accounts*

A competent individual can arrange for a third party mandate to be drawn up, authorising someone else to use a bank or building society account on their behalf. It can be cancelled by the person holding the account at any time. Having a joint account has the advantage that a trusted relative or friend can have easy access to the funds. But it can get difficult if account holders disagree. There is less financial independence for those involved, with the potential hazard that one person can be individually liable for debts arising from a joint account incurred by the other account holder.

#### *Social security benefits*

An individual can select another person, called the authorised agent, to collect their social security benefits or state retirement pension. The order slip in the benefit book has to be signed each time.

***Ordinary power of attorney***

An individual (the 'donor') can appoint someone else to act on their behalf (an 'attorney') in relation to their financial affairs, using a power of attorney. The donor may limit its extent, both in time and in the range of transactions for which the attorney is authorised to act. Close relatives or friends are generally chosen. Although the legal form completed by the donor is usually simple, it is generally advisable to seek legal advice. A medical opinion about competence is an additional safeguard for people receiving psychiatric care. An ordinary power of attorney can be cancelled, at any time, by the donor or by the attorney. The main drawback is that the power is automatically cancelled if the donor becomes mentally incapable, for example, if they develop a significant dementia.

***Incapable person***

The presence of a mental disorder such as dementia or manic-depressive illness may cause a significant reduction in an individual's understanding and judgement, to the extent that they are mentally incapable of managing their own finances. There is no legal link between the presence of any specific mental illness, or the fact of being compulsorily detained (Mental Health Act) and the legal capacity to manage one's affairs.

***Social security benefits***

The appointeeship system enables someone else to receive and administer social security benefits or pension on behalf of the mentally incapable person. The local Department of Social Security office is informed that the individual is no longer capable. A confirmatory letter from a doctor may be requested as evidence, or a home visit may be made by a social security officer. When satisfied, the Department of Social Security appoints a suitable person (a relative, friend or caring professional) to receive and manage the benefits. The appointeeship can be cancelled if there is evidence that the appointee is not acting in the best interests of the individual. It is sometimes possible to make a similar appointee arrangement to manage some public service or private pensions. The appointeeship arrangements are likely to be insufficient safeguard for the mentally incapable individual with significant income from other sources, or where there are property or investments which require active management.

***Enduring Power of Attorney Act***

The Enduring Power of Attorney Act 1985 provides a procedure where power of attorney can continue after someone becomes mentally incapable. The power granted can be general or more limited, and can

range from selling shares or property to paying bills. The individual and the proposed attorney sign an enduring power of attorney form which must be independently witnessed. The power is then 'live' and can be used by the attorney concurrently with the donor.

At the stage when the individual becomes mentally incapable, the attorney applies to register the enduring power with the Court of Protection. The individual and close relatives (who have to be notified) have an opportunity to object to the power being registered. Once the enduring power has been registered it cannot be revoked or cancelled by the donor. The Court of Protection can remove an unsatisfactory attorney. It is possible for the power of attorney to be shared between more than one person.

There was uncertainty after the new legislation came into operation in 1986, about whether individuals already suffering from dementia had the legal authority to create an enduring power. The test cases *Re K.* and *Re F.* (1988) have established that a power can be created, provided the individual understands in broad terms the nature and effect of the document at the time he executed it. This applies even when the person is incapable, by reason of mental disorder, of managing his property and affairs, and personally unable to carry out the transactions the attorney might undertake on his behalf. For example, an individual suffering from dementia in a more focused moment may create a valid enduring power which could be registered very shortly afterwards with the Court of Protection. Solicitors are advised that when a donor is of borderline capacity the power is witnessed, or approved, by a doctor who should record their findings.

The Law Commission of England and Wales has proposed an extension of this power to decisions about personal welfare and medical treatment. This requires new legislation.

### *Court of Protection*

Where someone becomes incapable, by reason of mental disorder, of managing and administering their property and affairs, and they require active management, and they have not made an enduring power of attorney, application to the Court of Protection may be required.

**History** The power and duty of the Crown to look after the property of lunatics and idiots was recognised in English law before the reign of Edward II. The function was delegated by the King to the Lord Chancellor, and later to other judges. Its role was redefined by the Mental Health Act 1959, which established the Court of Protection on a fully statutory basis, dealing only with the 'property and affairs' of a patient. It is an office of the Supreme Court headed by a judge (the Master). The court's powers and procedures are governed by Part VII of the Mental Health Act 1983 and by the Court of Protection Rules 1984. Its administrative functions

are now carried out by the Public Trust Office, which has a Protection Division which deals with external receivers, and a Management Division which acts as receiver when no one else can be found.

**Procedure** An application is made to the court, usually by a close relative of the person concerned, or by another relative, friend, business adviser or officer of the local authority. It must be accompanied by details of the individual's family circumstances and financial affairs. In urgent cases the court can proceed without a written application. A single medical certificate on a prescribed form is also required affirming that the patient is incapable, by reason of mental disorder, of managing and administering his property and affairs. In response to criticism about the quality of some medical certificates the court now provides notes prepared by the British Medical Association (1995) and Royal College of Psychiatrists to assist the doctor. In most cases it is advisable that certification is completed by a specialist. Objections to the process can be raised by relatives, or the patient at a formal hearing, at which a receiver is usually appointed.

A short procedure order can be made which allows the court to direct one of its officers, or some other person, to take a specific action, and is used, for example, when the patient's property is worth no more than £5000 and the appointment of a receiver is unnecessary because there is no continuing need for the court to be involved. It can be quick and inexpensive.

Relatives are usually appointed as receivers, but in complex cases, or where there may be a conflict of interest, professional people may be more appropriate. The receiver is accountable to the court for any decisions that are taken and is expected to visit the patient, and be consulted about significant changes in their care. The court monitors the performance of receivers. However, the receiver has no power to consent to medical treatment on the patient's behalf, nor to dictate where the patient should live (in contrast to a guardian under the Mental Health Act 1983).

### **Box 19.3 Court of Protection procedure**

An application is made to the court, usually by a close relative  
It must be accompanied by details of family circumstances and  
financial affairs

A medical certificate is completed on a prescribed form, stating  
that the patient is incapable, by reason of mental disorder,  
of managing and administering his property and affairs

This is usually completed by a specialist

Objections to the process can be raised by relatives, or the  
patient at a formal hearing

**Box 19.4 Financial affairs of an incapable person**

Social security benefits: Department of Social Security may make an appointee to collect and manage benefits

Enduring power of attorney: powers continue if the person becomes incapable

Court of Protection: appoints a receiver on behalf of an incapable person

The court charges an annual fee for individuals under receivership in proportion to the value of the persons assets, in addition to a commencement fee. There is power to displace an unsuitable receiver and for the court to revoke the authority if convinced by medical evidence that protection is no longer required and an individual has regained the capacity to manage their own affairs. If the court wants a specialist opinion about a person's mental capacity, one of the court's medical visitors may be asked to give one.

## Compulsory admission

### **National Assistance Act 1948**

Section 47 of the National Assistance Act 1948 provides a power to remove an elderly person from their home, without their consent, and place them in institutional care. The origins of this provision are in the public health slum clearance programme, which was central to the activity of most urban local authorities, from the end of the 19th century until the middle of this. It is rarely used today.

The person concerned must be suffering from grave chronic disease, or be aged, infirm or physically incapacitated. They must be living in insanitary conditions and be unable to devote to themselves, or receive from other people, proper care and attention. The magistrates order will direct that person's removal to a suitable hospital or other place (such as a residential home) to 'secure the necessary care and attention'.

The original procedure required a certificate from the public health physician to the district local authority, who in turn applied to the magistrates court, giving seven days notice to the individual. Because many people died at home during the period of notice, an emergency procedure was introduced in the National Assistance (Amendment) Act 1951. If a public health physician and one other doctor certify that removal without delay is necessary, the former may apply direct to a magistrate

for an order to remove. Its duration is three weeks, but can be renewed by the local authority.

Controversy has surrounded Section 47, and partly as a consequence, some public health physicians will not use it. There is the limited protection of the civil liberty of the individual. The individual is not represented before the magistrates when an order is made, and cannot apply for revocation of a Section 47 order during the first six weeks after admission. The doctors involved do not need to have any special experience or knowledge of the elderly, or those with mental disorder. The safeguards in the Mental Health Act 1983 for mentally disordered individuals are stronger. In addition, the decision is based primarily on the opinion of the professionals concerned. Terms such as 'insanitary conditions' and 'ill treatment or neglect' are difficult to define, and depend ultimately on a value judgement about the balance between the individual's right to live as he wishes, even if such wishes are delusory or extremely eccentric, and the need for protection from unnecessary suffering or danger.

### **Mental Health Act 1983**

#### *Sections 135 and 136*

These provisions can be applied in an emergency to remove an individual from their home (Section 135), or from a public place (Section 136), and to take them to a place of safety for assessment. Both make provision for a fuller assessment at the latter venue by a medical practitioner and approved social worker, with the possible outcome of a detention under Part II of the Mental Health Act. Detention at the place of safety cannot exceed 72 hours, and medical treatment cannot be imposed under Part IV of the Act.

An approved social worker may apply to a magistrate for a warrant to enter (if need be by force), search and remove to a place of safety any person believed to be suffering from mental disorder. There must be reasonable cause to suspect he has been ill treated, neglected or kept other than under proper control, or is unable to care for himself and is living alone. The police constable exercising the warrant must be accompanied by an approved social worker and medical practitioner, and the latter should be able to advise the policeman on whether the person should be removed to a place of safety. The legal definition is quite wide (Section 136, 6); and includes residential accommodation, a hospital, a police station or any suitable place (such as the home of a friend), where the occupier is willing to receive the patient.

The police have similar powers, not requiring a certificate from a magistrate. In Section 136, a police constable may remove to a place of safety, for up to 72 hours, any person found in a public place and appearing to be suffering from mental disorder, and to be in immediate need of care and control.

### *Section 115*

This section provides approved social workers with a power to enter and inspect premises where a mentally disordered person is living, if there is reasonable cause to believe that the patient is not under proper care. But the social worker is not empowered to force entry. If access is gained, the subsequent removal of the patient to hospital without their consent, would then require completion of medical recommendations, and application under Part II of the Act.

### *Sections 2, 3, 4 and 5*

The circumstances and requirements of Part II of the Act apply equally to patients of all ages, and the advice in the Department of Health's memorandum on the Mental Health Act, and the Secretary of State's Code of Practice, is of general relevance. It is not appropriate to summarise the provisions here, but some misunderstandings that have arisen with elderly people are discussed:

- (a) It is sometimes held that because dementia is associated with ageing, it is not a mental disorder or mental illness as defined in Section 1(2) of the Act, and individuals cannot be detained. This belief is false, as is the view that a Treatment Order (Section 3) cannot be applied to a patient with dementia because there is no effective medical treatment for dementia. Medical treatment is defined far more widely in the Act.
- (b) Detention under the Mental Health Act may not be applicable in some situations where an individual suffering from physical illness and mental disorder requires hospital admission for assessment or treatment of a physical illness. Detention can only be used when the primary objective of hospital admission is the assessment or treatment of the mental disorder. Therefore, a woman with a stable, chronic depressive illness requiring hospital treatment for a fractured femur could not be compulsorily admitted under the Act. By contrast, a man with an acute confusional state triggered by a chest infection might be detained, even though the main specific treatment for both the infection and the confusional state was antibiotics.

### *Guardianship*

The Percy Commission, which preceded the Mental Health Act 1959, proposed a modern form of guardianship which would enable community care to be extended to all groups of mentally disordered people. After 1959, patients could be received into the guardianship of a local social services authority or a private individual. A guardian had the powers

which would be exercisable by the father of a child under 14, which certainly included power to consent to medical treatment. The power was not widely used, and there was wide discussion about alternatives during the period leading to the 1983 Act. A new type of community care order proposed by the British Association of Social Workers was rejected, and a much reduced guardianship power was incorporated into the 1983 legislation.

**Powers** The guardian has power only to require the patient to live at a specified place, to attend for medical treatment, occupation or training, and to require access to be given at any place where the patient is living to people such as doctors and social workers. The patient cannot be compelled to undergo medical treatment, which he can refuse.

**Procedure** A guardianship application must be made to the local social services authority by an approved social worker (or nearest relative) and be supported by two doctors. Medical recommendations must indicate the category of mental disorder present, and the evidence for it, and affirm that guardianship is necessary for the patient's own welfare or for the protection of others. The guardian may be either the local authority, or a private individual, and the latter must be acceptable to the local authority. The order has effect when accepted by the local authority, and initially lasts six months, but it is renewable. Nearest relative consent is required, and people placed under guardianship have a right to apply to a mental health review tribunal. An alternative route for guardianship is via the courts (using Section 37), with power given to a magistrate or higher court to make a guardianship order, subject to acceptance by the local authority and the provision of two medical recommendation. A responsible medical officer (RMO) may also make a guardianship recommendation for a detained hospital patient (Section 3 or Section 37), provided the local authority accepts it.

**Comment** The limited use made of guardianship since 1983 reflects, in part, the limited power of the guardian. Although the guardian can insist that a patient attend a clinic for treatment, there is no power to force it on him should he refuse. There is no power to force entry if the patient refuses access. The Code of Practice (para 13.9) advises that it should not be used solely in order to transfer an unwilling person to residential care. There was no specific power to transport people against their will to day centres or new accommodation.

It was argued that guardianship had no teeth and was unworkable with people who are unprepared to recognise the guardian's authority. Not everyone accepted this view and there are examples of its positive value for some dementia sufferers, where real consent to living in residential care is absent, and care staff are legally supported by the guardianship

authority. In the discussions arising from the Beverley Lewis case, where a learning-disabled woman cared for by her mother with schizophrenia died of neglect, the additional point was made that nearest relative consent is required and guardianship is therefore likely to provide long-term protection against neglect or abuse in the patient's own home by close family members.

Finally, because guardianship is essentially a social services function, it is acknowledged by the Mental Health Act Commission that some departments are reluctant to use it because of demands made on residential facilities or staff time. Fear that a social services department might be pilloried in the event of a disastrous outcome with a guardianship client, has also contributed to its cautious use. It is largely for these reasons that recent legislative change has not extended guardianship powers, but provided for a supervised discharge order where lead responsibility is with the doctor.

### **After-care and supervision**

The limitations of the Mental Health Act 1983, coupled with shortcomings in communication and clinical practice, in ensuring safe supervision of vulnerable mentally ill people, following hospital admission has led to administrative changes and to amendments in the law. Although much of the drive to change practice and amend the law has come from pressure groups concerned with younger patients, the changes are relevant for vulnerable older people.

### ***Care Programme Approach (CPA)***

All NHS mental health providers are now expected to have systems in place to ensure that all patients discharged from hospital leave only after the risks of discharge have been fully assessed. There must be a plan setting out the after-care that will be provided, and a keyworker appointed with specific

#### **Box 19.5 Compulsory powers**

National Assistance Act: to place an elderly person in institutional care (rarely used)

Sections 135/6: to remove someone from home/public place to a place of safety

Section 155: to enter and inspect premises

Sections 2/3/4/5: to admit or detain someone in hospital

Guardianship: to enforce abode, attendance for training and treatment, access to professionals

tasks. Systematic review of the after-care should be arranged. The CPA encapsulates what should be good practice in old age psychiatry services.

### *Supervision register*

This system was introduced to improve communication about patients who may present a substantial risk of harm to themselves or others. It involves the patient's doctor putting them on the register. It is an administrative decision, and like the CPA is part of NHS departmental guidance rather than the law. It is unlikely to be used often in old age psychiatry.

### *Extension of leave of absence (Section 17)*

It has always been possible for a detained patient to live outside a hospital while on leave under Section 17 of the Mental Health Act. This allows the doctor to set conditions such as compliance with medication, with recall to hospital as a sanction for non-compliance. The recent Mental Health (Patients in the Community) Act 1985 has extended the period allowable, from six months to the time the hospital detention is set to expire. It has relevance for a small number of more vulnerable patients, particularly with functional psychosis.

### *Supervised discharge order*

This new provision in the Mental Health (Patients in the Community) Act 1995 arises because of concerns voiced by the public about community management and treatment of people with serious mental disorder. Mental health professionals acknowledged the limitations of guardianship, and were concerned about people who stopped treatment and lapsed from supervision following hospital care. Although the most common group of patients subject to the new order are likely to be younger psychotic patients who present substantial risk of serious harm to others, it is likely be useful for some older patients with dementia, or suffering from chronic or recurrent psychosis.

**Conditions** The RMO applying for supervised discharge has to make application while the patient (under Section 3, 37, 47 or 48) is still detained. The patient must be suffering from mental illness, psychopathic disorder, mental impairment or severe mental impairment. The doctor must state that there is substantial risk of serious harm to:

- (a) the health or safety of the patient, or
- (b) the safety of others, or
- (c) a risk that the patient will be seriously exploited if the after-care services provided under Section 117 were not received.

**Powers** The RMO can specify specific requirements, which echo those of guardianship. These could be: to live in a specified place; to attend a particular place at set times for medical treatment, etc; or allow access to his or her residence to anyone authorised by the supervisor.

In contrast to guardianship, there is now a power to convey the person, although no power to force entry to their home or to compel medical treatment (such as medication) without the individual's consent.

**Process** The process is complicated, with the RMO taking the lead, but involving consultation with relatives, other agencies and a second doctor, as well as an approved social worker, who have to certify support for the RMO's application. The proposed after-care plan must be specified, and agreement from the case supervisor (such as a community psychiatric nurse or social worker) confirmed. The initial duration of an order is six months, and there are rights of appeal to the mental health review tribunal.

It remains to be seen how useful this power will be in the community management of the fairly small number of older people for whom it could apply. It is unlikely to be used to a significant extent for people with dementia and self-neglect, who would be safer in staffed accommodation.

## Consent to medical treatment

### **Capable patient**

Most elderly people are capable of giving valid consent to common medical treatments. The presence of an early dementia, or a depressive illness, need not adversely change capacity. The provisions of Part IV of the Mental Health Act 1983 acknowledge that even a detained patient may be capable of consenting to treatment. In the latter circumstances, the RMO certifies the individual's consent after negotiating it with him.

### **Section 58**

This applies to a detained patient who does not consent to medication after three months, or electroconvulsive therapy. The RMO must seek a second opinion from a doctor appointed by the Mental Health Act Commission. After examining the patient and consulting with others, the appointed doctor has the authority to issue a Certificate of Second Opinion, which allows the imposition of the specified treatment to the capable patient.

The provisions in the Act allowing the imposition of treatment only apply to specified treatments for mental disorder, and not to unrelated treatment such as surgery for a fracture. There is no explicit legal provision for imposing medical treatment (other than for mental disorder) on a capable patient. However, the courts have recently decided that a broad view could sometimes be taken, so that treatment for mental disorder

includes treatment for its consequences. In the case of *B. v. Croydon District Health Authority* (1995) it was decided that a detained patient with the capacity to refuse feeding, could nevertheless be treated against their will for extreme weight loss, because the physical condition was a consequence of their mental disorder. This has potential application for psychotically depressed patients refusing to eat.

### **Incapable patient**

Statute law is generally unhelpful about the wide range of circumstances in which an incapable elderly person may require medical treatment. The two exceptions are:

- (a) Section 58 of the Mental Health Act 1983 which allows treatment for mental disorder to be given to an incapable patient, provided a Certificate of Second Opinion has been issued.
- (b) Section 62 of the same Act, which allows urgent treatment in certain circumstances to be given to detained patients.

In practice, many people with dementia are admitted to hospital or residential care without real consent. They may receive medication to relieve mental distress, or treat physical disorders, without either real consent, or detention under the Mental Health Act. Technically the interventions amount to assault. There is continued debate about the absence of statutory protection for the patient and professional staff in these circumstances.

It is fairly common for incapable elderly people to need surgical investigation, or treatment because of their physical morbidity. A common example is hip surgery for a person with dementia sustaining a fracture after a fall. No-one can give valid legal consent for the procedure. Consultation with relatives and others is good practice, but the legal defence of the operating surgeon against a claim of assault is the more nebulous 'duty of care'.

Much of the debate about medical treatment in mentally incapable people in recent years has been triggered by some cases concerning abortion, or sterilisation in learning-disabled people. Some of the legal points have relevance for old age psychiatry, although the medical treatments are different. The leading case is *Re F. (Mental Patient: Sterilisation)* (1990). This concerned the question of what treatment could (and should) be given in the absence of valid consent. The House of Lords held that there was no procedure for giving someone else the right to decide on behalf of a mentally incapacitated person, and that the court had no jurisdiction to approve or disapprove the giving of treatment. It was held that the court could grant a declaration that it would be lawful to proceed in the absence of consent, if the treatment was justified on the principle of necessity. This principle was further held to mean that

**Box 19.6 Consent to medical treatment**

Consent is required for medical treatment.  
 This applies to compulsorily detained mentally ill patients.  
 Incapable people are generally not covered by law.  
 Clinicians may act in the patient's 'best interests'.  
 Consent by relatives is 'good practice' only.  
 Complex situations may need to be decided in the courts.

the lawfulness of operating upon or otherwise treating a mentally incapacitated person depended upon whether such treatment was in a patient's best interest.

In practice, applying this judgement to treating the elderly mentally incapable patient, the doctrine of necessity means that the doctor is justified in providing treatment of a routine nature as well as more urgent treatment, provided it will ensure improvement of or prevent deterioration in health. If the patient is known to have objections to some specific treatment (before they became incapable) doctors may not be justified in proceeding.

In addition, it is expected that the doctor should act in accordance with a practice accepted as proper by a responsible and competent body of relevant professional opinion. In complex cases, independent confirmation and support of the medical treatment plan by other medical colleagues is likely to be a safeguard, by confirming lack of consent, and that the treatment is in the patient's best interests.

Most treatment decisions can be taken by the clinician, the patient and people providing care, but some decisions are so serious that the courts want each case brought before them, such as the withdrawal of hydration in the Bland persistent vegetative state case (1993). There will be other procedures where the courts may wish to become involved. Hospitals will need to take legal advice in cases of doubt.

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## Additional reading

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