

The Use of Antipsychotic Drugs in Nursing Homes: Human Rights and the Elderly

Frances Matthews*

Older adults are frequently seen as a collective burden on the healthcare system, rather than the bearers of rights which should be respected and protected. Those in institutions are particularly vulnerable. Their rights to liberty, privacy and the right not to be subjected to inhuman or degrading treatment may all be threatened by the inappropriate use of antipsychotic drugs. This paper describes challenging behaviour in older adults; possible responses to that behaviour, including medication; the nature and use of antipsychotics; the rights threatened by the administration of such drugs; and possible solutions.

I – Introduction

In June 2009, the final report of the Commission of Investigation into Leas Cross Nursing Home was published.¹ As part of its investigation, the Commission received submissions from the families of over seventy former residents concerning complaints they had made to Leas Cross staff about the care of residents. The Commission described common themes and trends arising from the complaints which included rough handling by staff, inappropriate use of sedation, inadequate supervision of residents' food and fluid intake, lack of regard for residents' hygiene and other personal care issues, failure to check on residents or respond to calls for assistance, and loss or mishandling of residents' clothes.² These complaints are not isolated incidents in Ireland or internationally - they are similar in nature to complaints received overseas.³ The treatment complained of reflects the difficulties faced by older people in institutions where poor staffing, inadequate staff training,

*MB ChB MFFLM (UK) MBHL LLM (Otago) DLS (King's Inns), GP Co Monaghan.

¹ Department of Health and Children, *The Commission of Investigation (Leas Cross Nursing Home)*. (June 2009) <<http://www.dohc.ie/publications/pdf/leascross.pdf?direct=1>> (date accessed: 02 July, 2010).

² *Ibid.*

³ See e.g. Age Concern New Zealand, *Age Concern Elder Abuse and Neglect Prevention Services: An Analysis of Referrals for the Period 1st July 2002 to 30th June 2004* (Wellington: Age Concern New Zealand Inc., 2005) at 40, 50. ; Health and Disability Commissioner New Zealand decisions and opinions <www.hdc.org.nz> (Date accessed: 30 June, 2010). For example decision of 31/08/09 08HDC15931: inadequate nourishment, treatment of pressure sores, poor hygiene, use of sedation; decision of 26/08/0908HDC1705: use of sedation, feeding patient; decision of 30/11/07 06HDC0079 care of pressure sore, weight loss. House of Commons Health Committee. *Elder Abuse 2nd Report of Session 2003-2004*, Vol. 1 (London: The Stationary Office Ltd, 2004) at 18-19.

and lack of knowledge or commitment to the rights of older people mean that care is inadequate and/or inappropriate.

Older adults are frequently seen as a collective burden on the healthcare system rather than the bearers of rights which should be respected and protected. The use of antipsychotic (neuroleptic) drugs to control challenging behaviour is particularly problematic as such drugs may not be particularly effective and have serious side effects which include cardiovascular disease and death, in addition to the effects of long term sedation.

The rights of older adults to liberty, privacy and the right not to be subjected to inhuman or degrading treatment may all be threatened by the use of sedative drugs such as atypical and typical antipsychotics, particularly in institutional settings. This paper describes challenging behaviour in older adults, possible responses to challenging behaviour including medication, the nature and use of antipsychotics, the rights of older adults threatened by the administration of such drugs and possible solutions.

A. Challenging behaviour in older adults

Challenging behaviours in older people with dementia are often referred to as behavioural and psychological symptoms of dementia (B.P.S.D.) and include a wide variety of activities ranging from apathy and withdrawal to aggression, wandering, screaming and shouting, irritability, sleep and mood disturbances, delusions and hallucinations, and inappropriate sexual behaviour.⁴ B.P.S.D. is a major feature of dementia which is likely to lead to institutionalisation when carers are unable to cope with the person in the community. The very wide range of symptoms have been criticised as being too broad, which may lead to many behaviours being labelled B.P.S.D. while the underlying cause, for example pain, is missed.⁵

⁴ G.M. Sawa & J. Zaccai *et al.*, "Prevalence, Correlates and Course of Behavioural and Psychological Symptoms of Dementia in the Population" (2009) 194(3) *Br. J. Psychiatry* 212.

⁵ A. Wood-Mitchell & I.A. James *et al.*, "Factors Influencing the Prescribing of Medications by Old Age Psychiatrists for Behavioural and Psychological Symptoms of Dementia: A Qualitative Study" (2008) 37(5) *Age and Ageing* 547.

Sudden onset of confusion or aggression is described as delirium and usually has a physical cause such as infection, pain or other serious illness. It is important to search for physical causes of behavioural change as the treatment of such conditions often settles the challenging behaviour. Mental illness such as schizophrenia, bipolar disorder and depression can also lead to behavioural problems, ⁶ for example, depression may lead to apathy and withdrawal.⁷ Apathy and withdrawal are associated with both cognitive decline and physical decline, with an inability to perform the activities of daily living leading to poor food and fluid intake, incontinence, and diminished communication skills. Frequent wandering may lead to falls, and aggression may result in the person, or others, being harmed.

Doctors treating older adults are called upon to help deal with such behaviour, often by prescribing medication. Treatment guidelines recommend thorough evaluation including a search for physical illness, psychiatric assessment, and an assessment of the type of dementia from which the person is suffering.⁸ Most guidelines suggest that neuroleptics are of limited use and the treatment of last resort.⁹

B. Responding to B.P.S.D.

After treatable physical causes of challenging behaviour have been excluded, non pharmacological treatment should be offered initially, unless the person is severely distressed and poses a risk of harm to others or themselves. These treatments include changing the person's environment, for example by changing the lighting, moving them to a different room, using music therapy, encouraging family visits, massage, and the use of aromatherapy. In short, the guidelines suggest treating the person in a humane way.¹⁰

⁶ C. Omelan, "Approach to Managing Behavioural Disturbances in Dementia" (2006) 52 *Canadian Family Physician* 191.

⁷ New South Wales Department of Health, *Guidelines for Working with People with Challenging Behaviours in Residential Aged Care Facilities* <http://www.health.nsw.gov.au/policies/gl/2006/pdf/GL2006_014.pdf> (date accessed: 02 July 2010).

⁸ National Institute for Health and Clinical Excellence, Clinical Guideline 42, *Dementia: Supporting People with Dementia and their Carers in Health and Social Care* <<http://www.nice.org.uk/nicemedia/pdf/CG042NICEGuideline.pdf>> (Date accessed: 01 July 2010) at 25.

⁹ *Supra* note 7.

¹⁰ *Supra* note 8 at 34.

Psychosocial factors contributing to the person's behaviour should be addressed. These include overcrowding, lack of privacy, lack of activities, inadequate staff attention, poor communication between staff and the person and weak clinical leadership.¹¹

If a decision is made to use sedative drugs, those administering them should be aware that the person may become over sedated and be less alert, so may eat and drink less, and be more likely to fall. Poor mobility may lead to incontinence and bedsores. Over use of the sedative may lead to loss of consciousness rather than sedation which may lead to problems with breathing and risks of inhaling vomit or developing chest infections. In addition, the use of sedatives may damage the relationship of trust between carers and patients.¹²

Psychiatrists have commented that this use of non-pharmacological treatments is far removed from the reality of clinical practice. There is often insufficient staffing or resources to offer non-pharmacological interventions for B.P.S.D.: "They're put in an environment that is crap, the patient reacts to the crap environment and society's response is to get the psychiatrist involved - who is then told to give an environmental intervention."¹³

One psychiatrist commented that children in institutions were not medicated when they misbehaved, but adults were.¹⁴ There was widespread use of antipsychotics to control perceived B.P.S.D., often because no other options were available.

In the U.K. in 2009, a report commissioned by the Department of Health found that 180,000 older adults were prescribed antipsychotics each year, but only 36,000 would actually experience any benefit. There would be an additional 1,800 deaths per year due to antipsychotic use, and 1,620 adverse cerebrovascular events (strokes, for example).¹⁵ A U.K. study in 2006 found that the use of non-pharmacological

¹¹ *Ibid.* at 37.

¹² *Ibid.* at 38-39.

¹³ *Supra* note 5 at 547-552 (see Table 1).

¹⁴ *Ibid.* at 547-552.

¹⁵ S. Bannerjee, "The Use of Antipsychotic Medication for People with Dementia: Time for Action" A report for the Minister of State for Care services for Department of Health (October 2009)

strikingly more effective.²⁰ In 2004, in evidence to the House of Commons Health Committee, the Alzheimer's Society described over use of neuroleptics as a common form of physical abuse, often used to sedate people with dementia in care homes and hospitals.²¹ In Ireland in 2004, the Irish Medicines Board warned of the risk of stroke and death for elderly patients with dementia treated with atypical antipsychotics,²² with an updated warning regarding both typical and atypical antipsychotics in 2009.²³ Similar warnings had been issued by the Food and Drug Administration (F.D.A.) in 2005.²⁴ Psychiatrists' professional bodies acknowledge that drugs may sometimes be necessary in the treatment of B.P.S.D.. Guidance for psychiatrists acknowledges that the use of antipsychotics in dementia may be necessary in the short term. The Royal Australian and New Zealand College of Psychiatrists' guidelines state that the evidence base supporting both pharmacological and non-pharmacological strategies for B.P.S.D. is modest in both quality and quantity.²⁵ They advise psychiatrists to monitor those treated with antipsychotics and to withdraw treatment when symptoms have settled. In Ireland, the National Health Information and Quality Authority (H.I.Q.A.) guidelines advise cautious use of neuroleptics if non-pharmacological treatments are unsuccessful, using the lowest possible dose followed by close monitoring and review and withdrawal if necessary.²⁶

Risperidone is the only atypical antipsychotic authorised for short term treatment of persistent aggression in Irish patients with dementia. The behaviour

²⁰ Royal Australian and New Zealand College of Psychiatrists, Practice Guideline 10, *Antipsychotic Medications as a Treatment of Behavioural and Psychological Symptoms in Dementia* (June 2009)

<http://www.ranzcp.org/images/stories/ranzcp-attachments/Resources/College_Statements/Practice_Guidelines/pg10.pdf> (date accessed: 02 February 2010).

²¹ House of Commons Health Committee, *supra* note 3 at 19.

²² Irish Medicines Board, *Drug Safety Newsletter*, 19th ed. (June 2004)

<http://www.imb.ie/images/uploaded/documents/7191315_Drug&Safety19th.pdf> (date accessed: 30 June 2010).

²³ Irish Medicines Board, *Update on the Safety of Antipsychotic Medicines* (July 2009)

<http://www.imt.ie/mims/2009/07/update_on_the_safety_of_antips.html> (date accessed: 02 July 2010).

²⁴ United States Food and Drug Administration Public Health Advisory, *Deaths with Antipsychotics in Elderly Patients with Behavioural Disturbances* (April 2005)

<<http://www.fda.gov/Drugs/DrugSafety/PublicHealthAdvisories/UCM053171>> (date accessed: 02 July 2010). >

²⁵ *Supra* note 20.

²⁶ National Health Information and Quality Authority, *National Quality Standards for Residential Care Settings for Older People in Ireland* (February 2009) at 37-38 (Standard 21)

<http://www.hiqa.ie/media/pdfs/Residential_Care_Report_Older_People_20090309.pdf> (date accessed: 30 June 2010).

must be unresponsive to non-pharmacological interventions, and pose a risk of harm to the patient or others. It should not be used for more than six weeks.²⁷ There is no monitoring of the use of antipsychotics in the over - 65 age group in Ireland. There has been a slight overall reduction in the prescribing of risperidone since a peak in early 2004,²⁸ but the prescription of quetiapine and olanzepine rose between 2004 and January 2006.²⁹ Despite the warnings, antipsychotics continue to be used as a first line, long term treatment for B.P.S.D..

II - Informed consent

The issue of informed consent to medical treatment is central to the idea of autonomy. The administration of medical treatment without the informed consent of the patient is regarded as an assault³⁰ and/or negligent behaviour by the treating clinician,³¹ except in cases of emergency or necessity, or where another person or the courts have lawfully consented on the patient's behalf, or the clinician has a statutory power to administer treatment without the person's consent, for example under mental health legislation. In Ireland, the *Mental Health Act 2001* has been used to treat medical as well as psychiatric conditions in persons with dementia. In *McN. v. Health Services Executive*,³² patients with dementia who had become violent toward their carers were detained under the *Mental Health Act 2001*. They received treatment for both physical and mental illness and continued to reside in the ward even after the order for their detention had been revoked.

A. Treatment without consent

A person who is unconscious after a serious injury is unable to consent to medical treatment but may urgently require treatment to save his life or prevent

²⁷ *Ibid.* at 1.

²⁸ National Centre for Pharmacoeconomics, *Utilisation and Expenditure on Antipsychotic Drugs under the G.M.S. Scheme Between January 2001 and September 2005* (January 2006) <http://www.ncpe.ie/u_docs/doc_107.pdf> (date accessed: 02 July 2010).

²⁹ *Ibid.*

³⁰ This principle was most famously enunciated by Cardozo J. in *Schloendorff v. Society of New York Hospital* (1914) 211 N.Y. 125 at 126: "Every human being of adult years has the right to determine what shall be done with his own body; and a surgeon who performs an operation without...consent commits an assault."

³¹ In the Australian case of *Rogers v. Whittaker* (1992) 67 A.J.L.R. 47 it was held that failure to fully inform the patient of the risks of surgery was negligent.

³² [2009] I.E.H.C. 236.

further damage to his health. Under these emergency circumstances, a clinician may lawfully treat the patient, as to delay would cause harm to the patient. The doctrine of emergency was discussed in Canada in *Mohr v. Williams*³³ where it was held that the patient's consent could be implied where he had suffered a serious injury and was unable to consent. In England in *Re. F. (Mental Patient: Sterilisation)*,³⁴ the Court of Appeal discussed the doctrine of emergency treatment without consent, and the doctrine of necessity in relation to the mentally incompetent. A person who is unable to give consent may lawfully be given medical treatment if it is in their best interests to receive it. In the House of Lords decision of *F. v. West Berkshire Health Authority and another*, Jauncy L.J. held that those who lacked the capacity to consent had a common law right to receive necessary medical treatment, and should not be deprived of such care by their lack of competence.³⁵ Such treatment might include dental care and the administration of medication to lower blood pressure to reduce the risk of stroke, or the immunisation of the person against infectious diseases to which he would otherwise be vulnerable. The concept of best interests includes medical best interests but other welfare interests may also be considered. In Ireland in *Re. A Ward of Court (withholding medical treatment) (No. 2)*³⁶, which concerned the withdrawal of medical treatment from an incompetent adult, the Supreme Court held that the best interests of the ward were of paramount importance when making a decision concerning medical treatment.³⁷

There are two aspects to the administration of treatment to a person who is unable to consent: the treatment must be necessary and it must be in the person's best interests to receive it. If the treatment is not necessary and does not contribute to the well being, welfare or best interests of the patient, its administration may be both unlawful and unethical. The use of antipsychotics to control B.P.S.D. is a treatment of last resort unless the person is in danger of harming themselves or others. In this situation, an emergency would have arisen and a drug which is known to have serious side effects may be administered if the person would be harmed if it were not administered. Consideration should be given to alternative approaches. The routine and long term use of typical and atypical antipsychotics has not been shown

³³ (1905) 104 N.W. 12.

³⁴ [1990] 2 A.C. 1.

³⁵ [1989] 2 All E.R. 525 at 571.

³⁶ [1996] 2 I.R. 79 [hereinafter *A Ward of Court*].

³⁷ *Ibid.* at 106.

to help B.P.S.D., and may well harm the patient both in the short term because of the dangers of sedation, and in the long term by increasing the risk of stroke and death.

B. Who may consent on behalf of an incapacitated adult?

In Ireland, a person cannot lawfully consent to medical treatment on behalf of another adult unless he or she has been empowered to do so. At present, the donee of an enduring power of attorney cannot consent to medical treatment on behalf of the donor although s/he can consent to the person being admitted to a nursing home, and administer their property.³⁸ An advance healthcare directive cannot, at present, bestow the power to consent to medical treatment on another person. Clinicians who consult with family members on the medical treatment to be received by an incapacitated adult are behaving in accordance with best clinical practice, but the only person lawfully able to consent to medical treatment on behalf of an incapacitated adult is the committee of an adult who is a ward of court (or the High Court itself). The committee cannot authorise withdrawal of life sustaining medical treatment: the power to make such serious decisions lies with the Court. In *A Ward of Court*, the ward's family contended that they had an inalienable and imprescriptible right to make a *bona fide* decision to withdraw treatment from the ward, a contention rejected by the High Court. Lynch J. held that the Court was vested with the power to make the decision, and although the family's views carried weight, they were not determinative.³⁹ The *parens patriae* jurisdiction of the Court was held to extend beyond wards to any person incapable of making their own decisions.⁴⁰ Presumably a committee could not consent to the administration of an antipsychotic unless it could be shown that there was a good clinical reason for doing so and it was in the person's best interests to receive it.

Older people with cognitive impairment are usually admitted informally to nursing homes and relatively few are wards of court or detained under mental health legislation. (Those detained under mental health legislation must be admitted to an approved centre, which is usually a hospital or? occasionally a private approved centre has an attached nursing home.) The cognitively impaired are unable to give

³⁸ *Power of Attorney Act 1996, Part II.*

³⁹ *Supra* note 36 at 92-93.

⁴⁰ *Ibid.* at 105.

informed consent to admission or to treatment. Legal justification for the administration of medical treatment is based on the doctrine of necessity⁴¹ and is sometimes justifiable as an emergency. The administration of medical treatment of any kind to an incompetent adult must be based on their best interests and the person should experience some benefit from the treatment. It is hard to see how the long term administration of antipsychotics to the elderly with B.P.S.D. can be justified as a necessity when there are well known side effects which may lead to death or further disability, when such drugs are of little use in the treatment of B.P.S.D. and when non-pharmacological interventions are the first line treatments recommended internationally.

C. Elements of consent

Patients must have the capacity to give consent, they must give consent voluntarily, and the consent must be based on sufficient information.⁴²

(i) Capacity

Patients with dementia may be unable to give informed consent to the administration of medication to control challenging behaviour because they are so severely cognitively impaired that they lack the mental capacity to do so. Capacity was discussed extensively by Laffoy J. in *FitzPatrick and Ryan v. FK and Attorney General (no. 2)*⁴³, which concerned a woman who claimed to be a Jehovah's witness and who had been given a blood transfusion against her wishes after haemorrhaging during childbirth. It was held that she lacked capacity to refuse the transfusion because she did not understand and retain the information given to her, did not believe the information and did not properly weigh the information given to her by medical staff.

Those suffering from dementia tend to have poor short term memories and difficulty processing new information: they cannot understand or retain the information given to them. If they are unable to understand or retain the

⁴¹ See C. Murray, "Safeguarding the Right to Liberty of Incapable Compliant Patients with Mental Disorder in Ireland" (2007) 29(1) D.U.L.J. 279. (This is the volume no. given in legal periodicals for this.)

⁴² See S. Mills, *Clinical Practice and the Law*, 2nd ed. (Haywards Heath: Tottell, 2007) at chap. 4.

⁴³ [2008] I.E.H.C. 104.

information given to them they cannot properly weigh and evaluate it. The cognitive abilities of those suffering from B.P.S.D. may be further impaired by the administration of neuroleptics which have a sedative effect and may undermine both understanding of information and the ability to retain it.

(ii) Voluntariness

In 1944, Scott L.J. described voluntariness in the following way:

A man cannot be said to be truly willing unless he is in a position to choose freely, and freedom of choice predicates, not only full knowledge of the circumstances on which the exercise of choice is conditioned, so that he may be able to choose wisely, but the absence from his mind of any feeling of constraint so that nothing will interfere with his will.⁴⁴

Being in an institution such as a prison, a hospital or a nursing home may influence the voluntariness of consent: the person cannot leave and is surrounded by others in a position of authority over him. This was recognised in relation to prison doctors and inmates in *Freeman v. Home Office (No. 2)*⁴⁵, which concerned consent to the administration of stelazine, an antipsychotic. In this case it was stated that “...where, in a prison setting, a doctor has power to influence a prisoner’s situation and prospects, a court must be alive to the risk that what may appear, on the face of it, to be real consent is not in fact so.”⁴⁶

Those in nursing homes, whether voluntarily or involuntarily, are physically frail and may also be cognitively impaired. They are dependent on medical and nursing staff for all or much of their care and may not wish to antagonise the staff by refusing medication offered. Even if the person has capacity and is in possession of the requisite information, there may be some doubt about the voluntariness of their acceptance of the medication offered.

(iii) Information

⁴⁴ *Bowater v. Rowley Regis Corporation*, [1944] K.B. 476 at 479.

⁴⁵ [1984] Q.B. 524.

⁴⁶ *Ibid.* at 556.

In order to decide whether or not to accept the medical treatment offered, the person has to be provided with relevant information including the risks and benefits of the proposed treatment. Adequate disclosure of the risks is especially important and the degree of disclosure required is based on the amount of information a reasonable patient would expect to receive.⁴⁷ A truthful doctor would have to disclose the warnings by the Irish Medicines Board regarding the use of antipsychotics together with information on their limited efficacy for B.P.S.D.. Alternative treatments should also be discussed. Imparting this knowledge to a competent adult, or the representatives of an incompetent adult may well result in refusal of the proffered treatment. In practice, there is probably very little discussion of the risks and benefits of antipsychotics or any other category of sedative drugs, as the families of the Leas Cross residents discovered.

III - The Rights

The rights of older adults are not extinguished by age or infirmity. Being cognitively impaired, however severely, does not deprive a person of rights under the European Convention on Human Rights (E.C.H.R.). The E.C.H.R. generally regards the rights of vulnerable people such as children,⁴⁸ the physically⁴⁹ and mentally incapacitated, prisoners,⁵⁰ and those detained in institutions⁵¹ as especially deserving of protection. The State has an obligation to protect the rights of vulnerable persons in its care and also has an obligation to ensure that private individuals do not violate vulnerable people's rights.⁵² In Ireland, the Health Service Executive (H.S.E.), which may be regarded as an organ of the State, has an obligation under section 3 of the *European Convention on Human Rights Act 2003* to perform its functions in a manner compatible with the State's obligations under the

⁴⁷ *Fitzpatrick v. White*, [2007] I.E.S.C. 51.

⁴⁸ *Z. v. United Kingdom*, (2002) 29 E.H.R.R. 97. This case concerned a group of children who were being neglected and abused by their carers. No action to remove the children was taken by social workers even though they were aware of the situation. The Court held that the State had a duty to protect them and that duty extended to other vulnerable persons which would presumably include the frail elderly.

⁴⁹ *Price v. United Kingdom*, (2002) 34 E.H.R.R. 1285 which concerned a woman with severe physical disabilities who was imprisoned in unsuitable conditions where she could not go to the toilet, clean herself or keep warm.

⁵⁰ *Keenan v. United Kingdom*, (2001) 33 E.H.R.R. 903 which concerned a prisoner with mental illness.

⁵¹ *Herczegfalvy v. Austria*, (1993) 15 E.H.R.R. 437 which concerned the forced administration of medication to an individual detained in hospital.

⁵² See M. Donnelly, "Legislating for Incapacity: Developing a Rights-Based Framework" (2008) 30 D.U.L.J. 395. (No space on either side of hyphen in Rights-Based)

Convention. Nursing homes are licensed by the H.S.E. after inspection, so the State is responsible for the standard of care in both private and publicly funded nursing homes. It is clear that older adults residing in nursing homes, who may be suffering from cognitive impairment and physical disability, are an especially vulnerable group. The rights to be discussed in this article are the related rights to liberty, the right not to be subjected to inhuman or degrading treatment and the right to privacy and family life.

A. Article 5: Right to liberty and security

In some circumstances, admission to a nursing home may amount to a deprivation of liberty under Article 5 of the E.C.H.R... Those who are deprived of liberty are effectively in the care of others, and their rights to privacy, as well as their rights not to be subjected to inhuman or degrading treatment, may all be threatened as a result. The jurisprudence of the European Court of Human Rights places special emphasis on the protection of those who are deprived of liberty.

Some older adults may enter residential care voluntarily with varying degrees of reluctance, because they can no longer safely live in their homes. Some older people lack the capacity to decide on admission to long term care, but are nevertheless admitted to nursing homes. They may be compliant or protest. The legal justification for their admission may be because the decision has been made by their Committee or by a donee of an enduring power of attorney, or in the vast majority of cases, the doctrine of necessity.

Article 5 of the E.C.H.R. states that:

Everyone has a right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law...

5(1)(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics, drug addicts, or vagrants...

5(4) Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be

decided speedily by a court and his release ordered if the detention is not lawful.

Article 5 contains two concepts relevant to older adults: the deprivation of liberty and the procedure required by law for detention of those of unsound mind.

(i) Deprivation of liberty

The European Court of Human Rights discussed the concept of deprivation of liberty in relation to adults who lack capacity in *H.L. v. United Kingdom*⁵³ (the *Bournewood* case). The case concerned a severely autistic man who normally lived with carers. He was detained informally on a psychiatric ward despite attempts by his carers to obtain his release. The Court reasoned that the starting point was the concrete situation of the individual, together with factors such as the type, duration, effects and manner of implementation of the measure in question. There was a difference in degree, not substance between the deprivation of liberty and the restriction of liberty. H.L. lacked the capacity to consent to psychiatric admission and did not protest his deprivation of liberty, but was compliant. The court held that, "... the right to liberty is too important in a democratic society for a person to lose the benefit of Convention protection because he may have given himself up to be taken into detention, especially when the person was legally incapable of consenting ... to the proposed action."⁵⁴

The key issue in relation to H.L.'s situation was whether the ward staff exercised complete and effective control over his care and movements for over three months. It was irrelevant whether the doors to the ward were locked or not because of the nature of the control over him. The Court held that he had been deprived of liberty.

By contrast in *H.M. v. Switzerland*,⁵⁵ the Court held that the right to liberty had not been violated in the case of an elderly woman with dementia who was compulsorily admitted to a nursing home after she was found to be unwell and living

⁵³ (2005) 40 E.H.R.R. 95.

⁵⁴ (2005) 40 E.H.R.R. 95 at para. 90.

⁵⁵ No. 39187/98, §48, E.C.H.R. 2002.

in unhygienic conditions. She was able to receive visitors, use the telephone and go outside and was said to have consented to admission. The Court did not consider her capacity to consent. As she was not locked in, enjoyed a degree of liberty and could not care for herself in the community, the Court held that her circumstances were not a violation of Article 5. The legal process for compulsory admission had been followed. By contrast, in the *Bournewood* case, no formal compulsory admission process had been invoked, and H.L. was detained on the ward without access to a court which could review the lawfulness of his detention.

(ii) Procedure required by law

The second strand of Article 5 violation in relation to older adults is the procedure required by law. Article 5(1)(e) recognises that those who are of unsound mind may be lawfully detained. Those who are admitted to nursing homes or hospitals with the consent of their Committee, or the donee of an enduring power of attorney, or under the *Mental Health Act 2001* are lawfully detained, but those who are admitted under the common law doctrine of necessity are less likely to be seen as being lawfully detained. In the *Bournewood* case, the Court held that Article 5(4), the right to review of the lawfulness of detention, was violated because informal detention under the doctrine of necessity offered insufficient safeguards - there was no right to review of detention, and release was dependent on the discretion of H.L.'s doctors, rather than any statutory procedure. As a result of this ruling, the *Mental Capacity Act 2005* of England and Wales was amended by the *Mental Health Act 2007*. The new sections provide for the appointment of supervisory bodies to oversee admissions which involve the curtailment of liberty and allow the appointment of advocates to act on behalf of those who lack capacity and whose liberty is curtailed. In Ireland, these safeguards do not yet exist. Those with dementia cannot consent to their admission and cannot consent to the administration of sedatives which may well be administered in an attempt to make them more manageable if they exhibit B.P.S.D..

In Ireland, in *E.H. v. Clinical Director of St. Vincent's Hospital*,⁵⁶ a woman suffering from dementia and bipolar disorder was lawfully detained in a psychiatric ward under the *Mental Health Act 2001*, but had continued to reside in the hospital

⁵⁶ *Ibid.* at para.18.

for a period of 12 days without the necessary order. She claimed that her detention was unlawful and violated her rights under Article 5 of the E.C.H.R.. Similarly, in *McN. and Anor. v. Health Service Executive*,⁵⁷ the two patients had both been lawfully detained under the *Mental Health Act 2001* but continued to reside in the ward after the order had been revoked. They were not allowed to leave unless a family member took care of them, and an attempt to leave resulted in a further application for detention under the *Mental Health Act 2001*. None of the patients was held to be unlawfully detained and it was noted that if it were safe to allow them to leave, they were free to go. The facts of these cases were different to those in the *Bournewood* case because the patients had been admitted into hospital and detained there under the *Mental Health Act 2001*. Like the woman in *H.M.*, they were unable to care for themselves and there was a risk to their life and health if allowed to return to the community. Unlike H.L. who had carers ready and willing to look after him, they had no one to care for them. When they sought to leave they were again detained under section 23 of the *Mental Health Act 2001*; H.L. was compliant and never sought to leave. In both of the Irish cases, the Court used reasoning similar to that of the European Court of Human Rights in *H.M.*, where the safety and health of the patient was as important as considerations of liberty.

The vast majority of elderly patients who lack the capacity to consent to admission to nursing homes are not detained under the *Mental Health Act 2001* and the facilities to which they are admitted are not approved centres for the care of the mentally ill. Their situation is different from that of *E.H. and McN.* because they are admitted informally and there is no specific statutory procedure which allows for their detention or confers protection upon them.

The use of sedatives such as antipsychotics may help staff exert effective control over patients in their care. A sedated person may be more docile and less mobile, making them unable to abscond from the ward. In considering whether older adults in long stay care are detained, it is important to consider the physical as well as cognitive abilities of the person:

- (a) Older adults with dementia may be confined to locked units because they are physically able to walk out, but could not safely be allowed to do so

⁵⁷ [2009] I.E.H.C. 236.

unattended. The staff exert effective control over their movements and care and they can be considered to be detained. The use of sedation may enhance the ability to exert effective control over their movements.

- (b) Those who are suffering from dementia and are compliant and do not normally seek to leave may or may not be sedated to aid compliance. If they were to leave, a search would be organised and they would be returned to the ward. Even though they are not locked in, their situation is like H.L.'s as they lack the capacity to decide to leave and the staff exert effective control over them in the sense that the staff may administer sedative drugs, and would seek to restrain the person suffering from dementia if s/he tried to leave.
- (c) Those who suffer from disabilities but who are helped to leave for visits to family, to go outside to the garden, are not sedated unnecessarily, and not confined to bed or chair or ward, could not reasonably be regarded as suffering loss of liberty.

Those whose movements and care are effectively controlled by the ward staff may be deprived of liberty with or without the use of sedatives.

B. Inhuman and degrading treatment

(i) Article 3: Prohibition of torture and the right not to be subjected to inhuman or degrading treatment

Article 3 of the E.C.H.R. prohibits torture and says that no one shall be subjected to torture or to inhuman or degrading treatment or punishment. The issue of torture will not be considered here. Cases involving inhuman or degrading treatment or punishment usually involve those detained in prisons, but there is some case law involving those detained in hospitals where the treatment administered may be regarded as inhuman or degrading.

The boundary between treatment which is inhuman or degrading, and that which violates the right to privacy and family life (Article 8), is fluid. Some forms of treatment are therapeutically necessary and are not seen as violating either Article 3 or Article 8. Concepts of inhuman or degrading treatment vary according to the individual's age, sex and state of health, and the circumstances of the impugned

treatment, such as its duration and its physical and mental effects on the person.⁵⁸ The Court's views of such treatment have varied over time: treatment which did not previously reach the required threshold has more recently been regarded as constituting torture, inhuman or degrading treatment.⁵⁹

(ii) *Inhuman treatment and degrading treatment*

Although the terms inhuman and degrading treatment are often not distinguished by the Court,⁶⁰ they have been defined separately on some occasions. In *T. v. United Kingdom*,⁶¹ the Court discussed both inhuman and degrading treatment in relation to the public trial of two ten year old boys charged with the murder of a two year old child. Inhuman treatment has been defined as treatment which is premeditated, is applied for hours at a time and causes either actual bodily injury or intense physical and mental suffering or both.⁶² Such treatment may differ from torture only in its severity. In *T. v United Kingdom (Joined with V. v. United Kingdom)*⁶³ the Court held that the trial did not amount to inhuman or degrading treatment. In some cases, there is no requirement for premeditation or intent. In *D. v. United Kingdom*,⁶⁴ which concerned the deportation of a prisoner suffering from A.I.D.S. to a country where there was no hospital capable of treating him, it was held that although the British government acted lawfully and there was no evidence of malicious intent, Article 3 was violated.

Degrading treatment need not be premeditated but it must arouse in the victim feelings of fear, anguish and inferiority capable of humiliating and debasing them, and possibly breaking their physical and moral resistance.⁶⁵ An intention to humiliate and debase could be taken into account, but Article 3 could still be violated in the absence of such intent. Treatment could be degrading even if others did not witness it. In *Tyrer v. United Kingdom*,⁶⁶ the Court considered whether corporal punishment administered to a teenage boy could be considered degrading and held

⁵⁸ *Ireland v. United Kingdom*, (1979-80) 2 E.H.R.R. 25.

⁵⁹ A point acknowledged in *Selmouni v. France* (2002) E.H.R.R. 97.

⁶⁰ See e.g. *Il v. Bulgaria*, no. 44082/98, §86, E.C.H.R. 2005.

⁶¹ (2000) 30 E.H.R.R. 121.

⁶² (2000) 30 E.H.R.R. 121 at 69.

⁶³ No. 24724/94, §84, E.C.H.R. 1999.

⁶⁴ (1997) 24 E.H.R.R. 423.

⁶⁵ *Ibid.* at 69.

⁶⁶ (1979-80) 2 E.H.R.R. 1.

that, "...it may well suffice that the victim was humiliated in his own eyes, even if not in the eyes of others."⁶⁷

The consequences of the treatment should, in most, but not all circumstances, adversely affect the personality of the victim in order to be considered degrading. The treatment of mentally ill individuals is an exception to this. In *Keenan v. United Kingdom*,⁶⁸ it was held that:

There are circumstances where proof of an actual effect on a person may not be a major factor...Treatment of a mentally ill person may be incompatible with the standards imposed by Article 3 in the protection of fundamental human dignity, even though the person may not be able, or capable of, pointing to any specific ill effects.⁶⁹

The ability to suffer degradation is an important consideration in relation to the incapacitated elderly who may be severely cognitively impaired. The question of whether a severely mentally or physically incapacitated person can be humiliated, debased or degraded has been considered in relation to the E.C.H.R. by the English courts. In (*R.*) *Burke v. General Medical Council (Official Solicitor intervening)*,⁷⁰ Oliver Burke, a man with progressive neurological disease which would result in his death, sought a declaration that the General Medical Council's guidance on withdrawal of artificial nutrition and hydration violated his rights under Articles 2, 3 and 8. Although the judgment was overturned on appeal, Munby J. made an *obiter* comment on degrading treatment:

In my judgement treatment is capable of being degrading, whether or not it arouses feelings of fear, anguish and inferiority in the victim. It is enough if it is judged by the standard of right thinking bystanders - human rights violations obviously cannot be judged by the standards of the perpetrators - it would be viewed as humiliating and debasing for the victim, showing lack of respect for, or diminishing his human dignity.⁷¹

⁶⁷ *Ibid.* at para. 32.

⁶⁸ (2001) 33 E.H.R.R. 903.

⁶⁹ *Ibid.* at para. 113.

⁷⁰ [2005] Q.B. 424 [hereinafter *Burke v. G.M.C.*].

⁷¹ [2005] Q.B. 424 at para. 149.

He recalled the comments of Hoffman L.J. in the Court of Appeal in *Airedale N.H.S. Trust v. Bland*⁷² that, "...our belief that quite irrespective of what the person concerned may think about it, it is wrong for someone to be humiliated or treated without respect for his value as a person."⁷³ This point of view was shared by Hale L.J. in *R. (on the application of Wilkinson) v. Responsible Medical Officer Broadmoor Special Hospital Authority and Another*,⁷⁴ which concerned the forcible administration of drugs to a patient deemed incompetent to give consent where it was stated that, "... the degradation of an incapacitated patient shames us all even if that person is unable to appreciate it ..." ⁷⁵

In another judgment concerning the withdrawal of treatment from two patients in a persistent vegetative state (P.V.S.),⁷⁶ Butler-Sloss L.J. took the view that withdrawal did not violate Article 3 because the patients were incapable of experiencing suffering. Perhaps withdrawal of life sustaining treatment should be regarded as a special case, as mutilation or medical experimentation would doubtless be regarded as degrading and inhuman regardless of the person's level of awareness. Few elderly patients are so severely incapacitated as to be regarded as being in a P.V.S.; few would be as physically disabled as Oliver Burke in *Burke v. G.M.C.* while retaining mental capacity. The majority of those in institutions suffer a mixture of physical and mental disabilities, which make them uniquely vulnerable and able to experience suffering with varying abilities to communicate their distress.

(iii) Medical treatment

The leading case on the violation of Article 3 and medical treatment is still *Herczegfalvy v. Austria*.⁷⁷ The complainant alleged he had been handcuffed to a bed and forcibly fed and administered drugs while detained in a psychiatric hospital and declared incompetent owing to his mental illness. The Court did not find that Article 3 was violated in this case, but held that:

The Court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for

⁷² [1993] A.C. 789.

⁷³ *Ibid.* at 826.

⁷⁴ [2001] All E.R. (D.) 294.

⁷⁵ *Ibid.* at para. 79.

⁷⁶ *N.H.S. Trust A. v. M. and N.H.S. Trust B. v. H.* [2001] 4 L.R.C. 1.

⁷⁷ *Supra* note 51.

increased vigilance in reviewing whether the Convention has been complied with. While it is for medical authorities to decide, on the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the ... health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible, such patients nevertheless remain under the protection of art 3, whose requirements permit of no derogation ...

... [A]s a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist.⁷⁸

The Court was satisfied that at that time the measures used were therapeutically necessary. Ideas about therapeutic necessity change over time as new drugs and treatments become available and research affirms or discredits the efficacy of treatments previously regarded as therapeutically necessary. International research has shown that the use of antipsychotics in the treatment of B.P.S.D. has only very limited efficacy and raises the risk of death and stroke in this group of patients. The use of sedative drugs may be justified in an emergency, in the short term, but is not usually justifiable as a long term measure, as a substitute for non-pharmacological measures which include adequate numbers of adequately trained staff with knowledge and experience of treating B.P.S.D.. In Leas Cross there were too few staff to care for the numbers of demented residents, and their level of knowledge about the needs of such patients was inadequate. Relatives complained about the over use of sedative drugs, which may have been a response to the difficulties faced by too few staff struggling to deal with large numbers of patients with B.P.S.D.. Therapeutic necessity was replaced by expediency. Benefit to the patient was replaced by benefit to the inadequate numbers of staff.

The long term and routine use of antipsychotics in nursing homes may constitute inhuman and degrading treatment, and does not appear to protect fundamental human dignity for the cognitively impaired.

⁷⁸ *Ibid.* at para. 82.

C. Article 8 Right to respect for private and family life

The right to respect for private and family life, especially private life, encompasses a wide range of issues⁷⁹ including those relating to healthcare. The concept of private life is a broad term which includes mental health, consent to medical treatment, sexual life and orientation, and gender identification.⁸⁰ The Court has acknowledged that some alleged violations of Article 3 do not meet the requisite standard of severity, but might nevertheless amount to a violation of the right to respect for private life under Article 8.⁸¹ In general terms, in relation to medical treatment, a failure by the State to provide the required medical care and treatment to those in its custody meets the standard for a violation of Article 3, for example *Nevmerzhitky v. Ukraine*,⁸² *Keenan v. United Kingdom*,⁸³ *Testa v. Croatia*.⁸⁴ Issues surrounding confidentiality of medical notes, access to medical records, and issues of informed consent are sometimes regarded as violations of Article 8 rather than Article 3.

Article 8 was held to have been violated in the case of *Storck v. Germany*,⁸⁵ which concerned a young woman who was detained in a psychiatric ward and given medication without her consent. She had initially been admitted at the behest of her father, but during her detention she reached the age of 18 and her consent or an order of the court should have been sought.

In *Glass v. United Kingdom*⁸⁶ (*Glass*), the Court considered the case of the administration of diamorphine to a child with respiratory and other illnesses without the consent of the child's mother. The treating clinicians did not wish to resuscitate the child should he suffer a respiratory arrest, and made a do not resuscitate (D.N.R.) order, without the mother's knowledge or consent. The Court held that there had been opportunity for the clinicians and hospital to seek the ruling of the domestic courts in relation to the administration of diamorphine, and its administration was not, as a result, an emergency as the hospital had contended. The matter of

⁷⁹ C. Ovey & R. White, *Jacobs & White - The European Convention on Human Rights*, 4th ed. (Oxford: Oxford University Press, 2006) at chap. 11.

⁸⁰ *Bensaid v. United Kingdom* (2001) 33 E.H.R.R. 205 at para. 47.

⁸¹ *Ibid.* at para. 46.

⁸² No. 54825/00, §54, E.C.H.R. 2005.

⁸³ *Supra* note 68.

⁸⁴ No. 20877/04, §37, E.C.H.R. 2007.

⁸⁵ No. 61603/00, §139, E.C.H.R. 2005.

⁸⁶ (2004) 39 E.H.R.R. 341.

administering narcotics to the child had been discussed in the past and one of the clinicians had noted that it might become necessary to seek an order from the courts. The Court held that this failure to obtain the mother's consent, or the consent of the High Court violated Article 8. The majority did not further consider the D.N.R. order, but Casadevall J., in a separate judgment annexed to the main judgement was of the opinion that the D.N.R. order was an aggravating factor, and that the decision to make a D.N.R. order without consent was "difficult to accept."⁸⁷

It is difficult to compare the decision in *Glass* where a parent of the child could clearly consent to, or refuse medical treatment on behalf of the child, with that of an incapacitated adult normally treated under the doctrine of necessity. However, *Glass* suggests that administering treatment without consent, when there is controversy over whether it is in the patient's best interests may violate Article 8. The use of a sedative such as an antipsychotic which has major short term and long term side effects and which may not be effective, would require informed consent. In Ireland, such drugs are administered without the informed consent of the patient, their representatives, or the courts. In some circumstances, their use may violate Article 8 because of the lack of convincing benefit and the lack of consent.

IV - Possible solutions

The inappropriate use of sedating medication as well as the other failures noted by the Leas Cross Commission, reflect the low status accorded to the elderly in Ireland and other countries. Treatment which would be regarded as intolerable for prisoners or children or younger mentally ill people has been tolerated with regard to the elderly, who have committed no crimes, but are at the end of their lives and may have no one to advocate on their behalf. To achieve a change in the status of older adults requires a major change in the perceptions of both the public and professional groups in relation to older people. Such a change could be brought about by education and campaigning on the part of groups which advocate on behalf older adults.

⁸⁷ *Ibid.* Separate Opinion of Judge Casadevall, at para. 2.

Changes in the law relating to older adults who lack capacity, and changes in practice relating to their care would also contribute to the protection of the rights of older adults.

A. Current practice

H.I.Q.A. was established by the *Health Act 2007* (the *Health Act*). The *Health Act* is to provide for a scheme of registration and inspection of residential services for older people, those with disabilities, and for children in need of care and protection. Failure to comply with its standards may, in some circumstances, lead to loss of registration or refusal of registration for residential homes. There are thirty-two standards for residential care for older adults,⁸⁸ but the status of each standard differs. Those based on regulations which give effect to legislation relating to care standards in residential homes can be enforced because failure to comply may result in loss or denial of registration. Failure to comply with other standards which are not linked to regulations does not result in loss of registration. Standard 21 relates to B.P.S.D. and is entitled “Responding to behaviour that is challenging,”⁸⁹ but it can be regarded as aspirational rather than prescriptive as no formal regulations exist to enforce it. It states that non-restrictive, non-pharmacological interventions are the preferred method of supporting residents experiencing behavioural disturbances, that the home should have a policy setting out the response to challenging behaviour, that a care plan should be drawn up for the individual and that it be reviewed regularly, that staff be properly educated in relation to challenging behaviour, that the person be properly assessed and the interventions be documented and reviewed, and that if psychotropic medication is used, it is used in the least restrictive fashion. The person should be assessed for drug related hypotension, falls, discomfort and cognitive impairment. The need for such drugs should be reviewed regularly, and their use implemented in relation to standards relating to medication management and monitoring.

⁸⁸ National Health Information and Quality Authority, *National Quality Standards for Residential Care Settings for Older People in Ireland* (February 2009) <http://www.hiqa.ie/media/pdfs/Residential_Care_Report_Older_People_20090309.pdf> (date accessed: 02 July 2010).

⁸⁹ *Ibid.* at 37-38.

The regulations set out in the *Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009*,⁹⁰ do not specifically mention B.P.S.D.. Regulation 6 deals with general welfare and protection and provides that the registered provider shall ensure that all reasonable measures are taken to protect the residents from all forms of abuse and that policies and procedures are in place to prevent, detect or respond to abuse. The long term and indiscriminate use of sedatives is regarded as abuse by some organisations such as the Alzheimer's Society, but whether it would be regarded as a form of institutional abuse by the Minister is debatable. There is no regulation which specifically enforces Standard 21, which is at present voluntary, although desirable. The standard contains international best practice guidelines and is generally respectful of the rights of older adults. If it were to be enforced by regulation, it would contribute to the promotion and protection of the rights of older adults in residential care. Amendment of the Regulations to enforce Standard 21 would provide an effective intermediate measure pending the enactment of Mental Capacity legislation.

B. Mental Capacity legislation

The full text of the *Mental Capacity Bill 2008* has not yet been published, but the Heads of the Bill are available. After publishing two consultation papers,⁹¹ the Law Reform Commission published a report⁹² which included a draft Mental Capacity Bill. The *Mental Capacity Bill 2008* closely resembles this and its "functional approach to capacity is informed by human rights values of dignity and autonomy."⁹³ It is intended to reform the law concerning mental capacity and establish a Guardianship Board which may appoint personal guardians to deal with the property, finances and welfare of adults who lack capacity. Section 4 of the *Mental Capacity Bill 2008* provides a set of guiding principles for those concerned in the implementation of the *Mental Capacity Act* or those making any decision or order under the *Mental Capacity Act*. The principles include intervening in the person's life

⁹⁰ Under S.I. No. 236 of 2009.

⁹¹ Law Reform Commission, L.R.C. CP37-2005, *Consultation Paper on Vulnerable Adults and the Law* (Dublin: Law Reform Commission, 2005); Law Reform Commission, L.R.C. CP23-2003, *Consultation Paper on Law and the Elderly* (Dublin: Law Reform Commission, 2003).

⁹² Law Reform Commission, L.R.C. 83-2006, *Report on Vulnerable Adults and the Law* (Dublin: Law Reform Commission, 2006).

⁹³ Irish Human Rights Commission, *Observations on the Scheme of the Mental Capacity Bill 2008* (November 2008) <<http://www.ihrc.ie/publications/list/observations-on-the-scheme-of-the-mental-capacity/>> (date accessed: 02 July 2010).

only when necessary, in a way which is least restrictive of the person's freedom, and the need to give due regard to the person's rights to dignity, bodily integrity, privacy and autonomy. The rights are couched in Constitutional terms but are reflected in the E.C.H.R.. The use of antipsychotic drugs for B.P.S.D. encroaches on rights to freedom, dignity, bodily integrity, privacy and autonomy, or in the language of the E.C.H.R.: liberty, the right not to be subject to inhuman or degrading treatment, and the right to respect for privacy and family life. Those providing care for older adults would have to consider these rights when administering or consenting to the administration of sedative drugs, particularly antipsychotics.

Part 2 of the *Mental Capacity Bill* deals with informal decision making which may well include the administration of drugs and other treatment for B.P.S.D. by staff in nursing homes. The person must take reasonable steps to establish whether the person in question lacks capacity before acting. The *Mental Capacity Bill* does not specifically state that an act, for example administration of a sedative, must be in the person's best interests, but says that the principles in section 4 should be applied. If the two requirements in section 8(2) are complied with, the person will not incur any liability that he or she would not have incurred if the other person had had the capacity to consent and had consented. In relation to the emergency administration of a sedative to an incapacitated adult, it may be possible to argue that the intervention was necessary in the circumstances, was the least restrictive intervention and due regard was given to privacy, dignity, bodily integrity and autonomy. It may be possible to argue that had the person the capacity to consent, they would have consented to an emergency treatment which would have prevented them from being harmed. It is not possible to argue, in light of current knowledge about antipsychotics, that their long term unreviewed use for B.P.S.D. would comply with section 8(2) and that any person with the capacity to consent would consent to their use in this manner. Part 2 would not justify the long term first line use of antipsychotics. A personal guardian, the Guardianship Board or the Court could consent if long term use could be shown to be necessary and no other alternative was available.

The *Mental Capacity Bill* provides for the establishment of a Guardianship Board able to make Guardianship Orders, appoint personal guardians to make

decisions for those who lack capacity, or make Intervention Orders directing a specified person to take an action or make a decision relating to the property, finances or personal welfare of an incapacitated adult. A personal guardian could consent to admission to a nursing home, and to medical treatment including the administration of medication.

The *Mental Capacity Bill* also provides for the establishment of an Office of the Public Guardian which would supervise personal guardians and attorneys, provide help and information about the performance of their duties, and provide suitable persons to act as personal guardians if no other person was available. The Public Guardian would be responsible for preparing and issuing a code of practice relating to issues such as the assessment of capacity, and the care and treatment of persons who lack capacity. It is to be hoped that such a code would include guidelines on the rights of older adults in relation to the use of sedative drugs, particularly atypical and typical antipsychotics. The code should acknowledge that nursing home care should provide an environment where the rights of older adults are respected and protected, not merely provide custody for those unable to care for themselves.

The *Mental Capacity Act*, when commenced, should provide protection to older adults in nursing homes, particularly in relation to the use of sedation. Personal guardians would be appointed to consent to the administration of medical treatment including the use of sedatives. Some people, including those suffering from mental illness such as schizophrenia, may still require antipsychotics either in the short or long term, but the decision to administer them would be subject to scrutiny by the personal guardian, and by the guardianship board in the event of disagreement between the guardian and the nursing home.

Mental Capacity legislation, in combination with an appropriately empowered inspection regime, is likely to provide protection to the rights of older adults in institutions, so long as there is adequate resourcing and a determination to enforce it. Until then, older adults are vulnerable to the inappropriate use of sedating medication which may violate their human rights.