**IPA and WPA-SOAP position statement on deprivation of liberty of**

**older persons with mental health conditions**

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Older persons with mental health conditions may experience deprivation of their liberty due to multiple intersecting vulnerabilities, often enduring lack of autonomy, independence, and free decision-making1. Hence, liberty and dignity based mental healthcare and policies are crucial as part of an ethical framework to better support older people against stigma and discrimination, and protect them from neglect, elder abuse, and violence2,3. In recognition of the challenges faced by older persons deprived of their liberty, a call was made for input into the 2022 report to the Human Rights Council (HRC) on older persons. In response to the HRC call, this Position Statement outlines the views of two global organizations, the International Psychogeriatric Association (IPA) and the World Psychiatric Association Section of Old Age Psychiatry (WPA-SOAP), working to provide rights and dignity-based mental health services to older persons. Two special contexts of deprivation of liberty are considered, namely within care settings and detention facilities, outlining ‘Actionable areas to ensure liberty in older persons with mental health’ in both settings (Table 1).

Deprivation of liberty in care settings

About 20% of older persons experience some kind of mental health condition. However, neither old age nor a diagnosis of a mental disorder is sufficient in itself to determine the lack of capacity to make meaningful decisions4. Moreover, capacity might change over time and might vary depending on the issues at hand. Key components of capacity include understanding, appreciation, reasoning, retention and the ability to express preference with consistency4. Older persons who are capable of making decisions have the right to refuse treatment which they believe would compromise their quality of life4.

The impairment of decision capacity leaves older persons with mental health conditions vulnerable to loss of liberty and exploitation5. They are less likely to be able to advocate for themselves and protect their own interests5. Responding to this reality, most states have established mechanisms for the determination of capacity and for decisions to be made on behalf of persons found to lack capacity. Those decisions may cover areas such as finances, living situations, medical treatment, hospitalization and institutionalization in long care facilities. These decisions are vital to preserve liberty and are based on promoting wellbeing, autonomy, independence, safety, privacy, respect and access to all forms of healthcare4.

A substitute decision maker (SDM) may be appointed, or lawful advance directives put in place, in order to protect the personal, health and or financial interests of older persons who experiences impaired decisional capacity4. People with limited capacity should be allowed to make those decisions, which they remain capable of making for themselves. An SDM must only be invoked as a last resort and be limited to areas over which an individual is proven to lack capacity4. In these situations, appropriate measures should be taken to ensure and maintain discretion, respect, privacy, and protect the older person’s dignity4. A SDM must be considered as a complementary alternative to optimize the person’s liberty, and not as a substitute for it.

Recognizing that some older persons with severe mental health conditions may pose a substantial risk of harm to themselves or others, legal mechanisms must be followed to permit hospitalization to ensure their safety and wellbeing4, 5. The laws that permit non-consensual hospitalization of older persons with mental health conditions must be strictly abided by permitting time-limited periods of hospitalization followed by mandatory re-evaluation and reassessment for the need of continued hospitalization. Similarly, if non-consensual institutionalization is required in a long-term care facility, mechanisms to ensure appropriate clinical and legal indications and regular review processes are in place, as well as mechanisms to assure the presence of impaired capacity4, 5.

Non-consensual hospitalization and treatment as well as the use of SDMs have an appropriate role in protecting the interests of persons with severe mental conditions but require very careful oversight and procedural protections. All efforts should be made to assist persons with decisional impairment, to recover capacity and to ensure that their desires, wishes and decisions are respected4, 5.

Individuals living with dementia, particularly those who reside in sheltered housing, assisted living facilities and in nursing homes need higher levels of specialized care, which must be made available. Those individuals who require specialized care sometimes face a threat to their liberty in the form of restraints, chemical or physical, often consequences of limited resources. These are a consequence of limited available staff to provide care to older persons as well as limited training in working with older people with substantial mental health conditions. Moreover, elder abuse and neglect is a common occurrence especially in the case of older people with mental health conditions and therefore, monitoring and guidance are essential to ensure the safety and wellbeing of those who require long term care6. Quality of life, dignity, safety, and comfort are of critical importance to the treatment and delivery of care to persons with dementia. Meaningful attention should be paid to the activities of daily living, the choice of treatments offered and the involvement and engagement of the individual and their family to enhance and maintain the individual’s liberty.

Deprivation of liberty in detention facilities

All governments should be clear about the purpose of their prisons to ensure that all imprisonment is human, decent, reasonable and proportionate1. The mental and physical health conditions of older persons should not deteriorate or be exacerbated just because of the custodial environment1. Mental health professionals in working in prisons should be supported in the event of any untoward or inappropriate discrimination, or any prevention of the ability to practice ethics-based medicine, or the need to speak out about any significant shortcomings1.

Given the high risk of mortality and morbidity levels and abuse in prisons, reception health screening should be universally provided, effective mental health assessment and treatment should readily be available7. The roles of health and justice can have a potential conflict. Health care provision practitioners should ideally function independently of the Criminal Justice System and be supported through the Health Care System. An ideal scenario will be to ensure age-friendly detention environment and training the staff in respectful communication and informed decision-making1.

Older persons in prison have the same rights to access appropriate health care as those in the community. States are responsible for ensuring that older prisoners receive appropriate clinical care and that general prison conditions promote their wellbeing, and the welfare of staff1, 8.

Timely medical interventions should be provided when older persons in prisons are in need of clinical attention. Access to preventive and rehabilitative services are also needed, particularly for suicide prevention and the management of older people in segregation1. Care should be made available to an optimum professional standard and equate with that in the community, accessed free of charge. Informed consent is essential for all clinical interventions, and prisoners have like all other citizens the right to refuse treatment without any consequence for their security or punishment1.

Clinical decisions should only be made by health-care professionals, and they should not be overruled or ignored by non-medical prison staff1. There must be prompt access to medical attention. The relationship between clinician and patient should be governed by the same ethical and professional standards as in the community, especially regarding the confidentiality of medical information. Appropriate standards of medical care in detention facilities need periodic supervision1. A healthy collaboration between all stakeholders involved can promote person liberty for older persons in such settings.

There is an absolute prohibition on all healthcare professionals to engage in acts that may constitute torture or other cruel, inhuman or degrading treatment or punishment1. This includes the administration of lethal injections as part of a death sentence1. Healthcare professionals who become aware of any signs of torture or other cruel, abuse, inhuman or degrading treatment or punishment should document and report such cases. Healthcare personnel do not have any role in imposing disciplinary sanctions and must visit older prisoners daily when they are held in seclusion to effectively monitor mental and physical health needs, to provide prompt medical assistance and treatment. Any adverse physical or mental effects arising from disciplinary sanctions should be reported, with advice provided regarding necessary termination or alteration of conditions of detention as required1.

Solitary confinement can have severe and sustained adverse health effects. Guidelines should be in place so that health professionals access prisoners before they are secluded, and regularly after that. Particular attention should be paid to any pre-existing vulnerabilities, such as acute mental or physical illness, physical disability, intellectual disabilities, neurodegenerative disorders, or the ongoing management of drug or alcohol disorders, and to any exacerbation or deterioration in mental or physical health. The use of solitary confinement should be kept to an absolute minimum1.

Health information is considered confidential, unless disclosure is justified in the public interest. However, some information sharing between practitioners and prison staff may be essential to safeguard and promote the welfare of people in prison, such as awareness of medical conditions requiring potential emergency intervention or at risk of exacerbation or deterioration by the prison environment1.

Multidisciplinary systems and procedures should be in place for the early identification and management of vulnerability to self-harm or suicide. A custodial multidisciplinary coordinated system should be in place for the safe and effective management and observation of older persons who have been identified as presenting with any such risks. Systems should be in place to investigate death by suicide1.

Without access to effective rehabilitation, the containment of older persons who are socially, physically, intellectually and mentally disadvantaged can be damaging. It serves no humanitarian purpose, and it may foster further criminal activity on eventual release from prison. Poor education, illiteracy, lack of numeracy, low self-esteem, physical and mental ill-health equip can poorly equip people for participating to a community life, with consequences for themselves and their families. Untreated significant mental illness can lead to repeat criminality and additionally may place the individual or the public at risk. Improving social skills should be part of any general rehabilitation program, alongside educational opportunities. Minimum standards for meaningful daytime activity should be developed that include the amount and range of these activities1, 7.

Optimization of the individuals’ capacity, autonomy, respect and dignity should be integrated in all healthcare plan which apply to older persons with mental health conditions. The IPA and WPA-SOAP strongly advocate for the same.

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Table 1: Actionable areas to ensure liberty in older persons with mental health conditions

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| * Addressing social stigma through public awareness campaigns
* Advocacy for human rights and personal liberty
* Combatting ageism
* Personal security in sheltered homes and dementia facilities
* Ensure privacy, confidentiality and sexual/reproductive rights
* Optimizing psychotropics to focus on functional recovery
* Assisted (and informed) decision making
* Improve digital literacy in older persons in care settings and detention facilities
* Respectful communication and social recognition
* Optimal pain management and nutrition
* Age-friendly environment in care settings and detention facilities
* Healthy and respectful staff communication
* Research into liberty-promoting strategies in older persons in vulnerable situations
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