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GERIATRIC DISORDERS (W MCDONALD, SECTION EDITOR)

Ethical, Legal and Forensic Issues in Geriatric Psychiatry

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Abstract
Purpose of the Review To evaluate the ethical, legal and forensic issues that is faced by the older adult population.
Recent Findings Many older individuals will face a host of ethical, medical and legal issues associated with their care. Most prominent among these issues are the maintenance of autonomy while ensuring their safety and the safety of individuals who care for them. Decisions regarding end of life including the formulation of advance directives add to the complexity of care for these older adults. A significant portion of individuals in the criminal justice system are aging and many of these individuals have psychiatric disorders. Their care is compromised due to the lack of appropriate services within criminal justice system for providing care for these individuals.
Conclusions Ethical, legal and forensic issues among older are not uncommon and complicate the care of these vulnerable individuals.

Keywords Decisional capacity · Competence · Power of attorney · Guardianship · Living wills · Competence to stand trial

Introduction

The population of older adults in the USA is growing at the significant rate [1]. The number of individuals aged 45 to 64 years in this country increased from 20 to 25% between 1980 and 2007. It is predicted that by 2050 the population of individuals aged 65 to 74 years will increase from 6 to 9% and those who are ≥ 75 years in age will increase from 6 to 11%.

Many older adults face a multitude of medical, psychological, and social issues that impair their activities of daily living and worsen their quality of life [2]. A considerable number of older adults also lose their independence and autonomy due to presence of chronic medical and/or psychiatric disorders. Older individuals are also vulnerable to exploitation and abuse given their cognitive and physical impairments.

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Ethical Issues

There are different ethical models that are available to help us develop a schema from which we can evaluate the various ethical issues faced by the aging population, although no one framework is universally accepted [3]. The Belmont Report identifies four ethical principles that are important in healthcare which include autonomy, beneficence, non-maleficence, and justice [4]. The Charter on Medical Professionalism identifies three ethical principles that are fundamental to healthcare: patient autonomy, patient welfare, and social justice [5]. The ethical principles discussed in these healthcare documents describe basically the same framework, and we will be using these principles in our discussion of ethical issues faced by the elderly.

Autonomy and Decision-Making Capacity

Autonomy describes as an individual's fundamental right to make independent choices about their own life [5]. In healthcare, autonomy describes the individual's ability to

make healthcare decisions through the process of informed consent [2]. An individual's ability to give informed consent is based on the availability of the relevant information, an individual's capacity to make an informed decision and their ability to make a free choice [6•]. An individual's decisional capacity depends on their ability to understand the relevant information, their ability to process the available information, the ability to personalize the context in which the decision is being made and their ability to state their preference or choice [2].

Voluntarism describes an individual's ability to make choices by their own free will without coercion or manipulation from external sources [6•]. Developmental factors, illness-related considerations, psychological issues, cultural and religious values and external pressures tend to influence voluntarism. Older adults with impaired cognitive functioning may be pressured by external sources and make uninformed or incorrect decisions. Many elderly individuals with apathy may appear to consent to procedures or interventions without really having the capacity to make appropriate and/or informed decisions. Many older adults are pressured by their caregivers to make decisions that could result in their abuse and/or exploitation. Often, many older individuals living at long term care facilities have limited input into making personal choices with regard to their care needs [2].

Available evidence indicates that ethnicity, culture, and spirituality affect decision-making capacity, but currently, there is no evidence to indicate that age and gender play any role in determining decision-making capacity [2, 7•]. Decision-making capacity is often limited for individuals who live at institutional settings or at hospice care [8]. Older adults with cognitive disorders also have impaired decision-making capacity [9, 10].

Older adults who are diagnosed with psychiatric illnesses may have limited decisional capacity [11, 12]. Individuals with depressed mood and other medical illnesses are more likely to consider physician-assisted suicide and euthanasia in hypothetical situations when compared to non-depressed individuals [13]. The strongest correlates of impaired decision-making capacity among older individuals with schizophrenia are the cognitive assessment scores. Among the elderly, it has been noted that the understanding of information relevant to the consent process appears to improve with repeated presentation of the relevant information [14].

Assessment of Capacity to Make Decisions

Clinicians who provide care for older individuals may be asked to evaluate the capacity of their patient's to either to consent to or to refuse a specific treatment or procedure [2]. Additionally, they may be consulted to assess an individual's capacity to make healthcare or financial decisions. Many older adults with cognitive impairment, psychiatric disorders or neurologic disorders may not have the capacity to make certain healthcare or financial decisions but no one disorder confirms the lack of decision-making capacity [15].

Capacity Versus Competence

The evaluation of an individual's capacity to make any decision is distinct from the determination of a person's overall competence to manage one's affairs [2]. The assessment of capacity is done through a clinical evaluation that utilizes all available information to make a determination on the individual's capacity to make a decision [16••]. The determination of an individual's overall competence involves a formal judicial process including the selection of a guardian or conservator [2]. Available evidence indicates that there is significant variability in assessment of capacity between different clinicians [17]. Often there is a low level of agreement among assessors of capacity but the level of agreement can be improved by providing specific legal standards to the clinicians [18]. Information regarding the individual's ability to understand the available choices in a particular-situation, appreciating the consequences of making a choice, providing rational reasons for making a choice and stating the final choice made would improve the level of agreement between the assessors of capacity [18]. Table 1 highlights the major difference between capacity and competence.

The Use of Cognitive Scales and Standardized Assessment Tools

Although standardized cognitive assessment scales like the Folstein Mini Mental State Examination (MMSE) and the Montreal Cognitive Assessment (MoCA) have been used to assist in the assessment of decisional capacity, the use of cut-off scores on these scales to determine capacity have not been found to be helpful [19–21]. The use of standardized tools that have been developed for the assessment of capacity include the MacArthur Competence Assessment Tool for Treatment (MacCAT-T), the Hopemont Capacity Assessment Interview (HCAI), and the Competency to Consent to Treatment Interview (CCTI) [2]. These tools may be helpful in the assessment of capacity but their use in clinical situations is often limited by copyright issues for the tools and the training and time required in completing these tools. The MacCAT-T is based on the individual's understanding of their actual clinical situation and the reasons for their treatment choices whereas the HCAI and CCTI use hypothetical vignettes to assess an individual's decisional capacity [2]. A review by Dunn et al.

Table 1 Capacity versus competence [2, 16]

Capacity	Competence
Clinical term	Legal term
Decided by a clinical assessment	Decided by a probate court hearing
Completed by a clinician	Declared by the judge
Time limited and situation specific	Declared for either personal or financial decisions or for both decisions
No significant financial implications for the patient or their estate	Financial implications for the patient and for their estate

found that The MacCAT-T had the most empirical support in the assessment of capacity although other instruments may be equally or better suited in certain situations [22•]. The currently accepted standard is to use these specific instruments as adjuncts to the clinical assessment and not as a substitute for a comprehensive psychiatric evaluation.

Improving Capacity Evaluations

Karlawish has proposed a model for the evaluation of capacity among older adults, and it has gained widespread acceptance among clinicians [16••]. This model proposes asking a series of questions to assess the individual's ability to understand and appreciate the situation, to make a choice, and to provide reasons for the choice that is being made [16••]. The answers provided by the individual are then rated as being either adequate or inadequate. These questions can be further supplemented by standardized cognitive scales and/or capacity assessment tools. The individual's capacity to consent to or to refuse an intervention can be determined by the assessment of their decision-making ability with supporting data available from these standardized assessment tools. For intervention with higher risk, the standard required to consent to or refuse a specific intervention is also higher [23, 24].

Once it has been determined that the individual lacks decisional capacity, the reversible etiologies that result in the incapacity should be identified and treated appropriately [2]. These include the treatment of nutritional deficiencies, depression, delirium, and/or drug effects. Additional strategies that have been shown to improve the individual's ability to provide informed consent include the use of verbal re-explanation, enhanced written consent procedures, slideshow presentations, the use of multimedia educational aids, and additional one to one time spend with a neutral educator [25, 26].

Power of Attorney (POA) and Guardianships

When the decision-making capacity of an individual cannot be restored for any reason, the appointment of a surrogate decision-maker (healthcare proxy) must be considered [2]. In situations where there is a documented health care power of attorney (POA), these proxy-decision-makers are expected to take over the healthcare decisions for the individual, once the presence of incapacity to making decisions has been determined. Available evidence indicates that only a limited number of individuals have designated a healthcare proxy. In one study, only a third of older adults had designated documented healthcare preferences and less than half of these individuals had appointed a surrogate decision-maker [27].

In event that there is no appointed surrogate decision-maker in place prior to the determination of lack of capacity, then for all emergency decisions, the spouse or children are considered as the surrogate decision-makers until a legal representative has been appointed [28]. If there is no available family member, then clinicians assume the responsibility of surrogate decision-making until a legal representative is appointed [2].

When an individual is determined to lack the capacity to make health and other important life care decisions and there is no designated surrogate decision-maker, then a guardian or conservator has to be appointed by the legal system [29]. The appointment of a guardian or conservator involves a legal hearing at the local probate court. Limitations of guardianship include the loss of privacy and autonomy for the individual, possible limited legal representation for the individual concerned, legal costs and the possibility for hasty institutionalization [2, 29]. Table 2 identifies the essential differences between POA and guardianship.

The Living Will

The living will is the legal document in which individuals note their advance directives with respect to life-sustaining treatments [30]. Usually, the advance directives also document the individual's choice for a surrogate decision-maker. The choice for the surrogate decision-maker is noted on the durable POA for health care. The "living will" was created in order to provide individuals who lose their capacity to make decisions to receive the care they want if they had

Table 2 Differences between a POA and guardianship [2, 28, 29]

Items	Power of attorney	Guardianship
Definition	It is a legal document that identifies the appointment of an individual (Agent) to act and perform certain functions on behalf of another individual (Principal).	The process by which a substituted (surrogate) decision-maker is appointed by the court of law for personal and/or for financial reasons.
Application	Self-initiated, private process where one voluntarily confers decision-making authority on a designee.	Decision-making authority is given to a designee by court of law
Initiated by	Self (Principle)	Families, friends, healthcare professionals, attorneys or government agencies
Physician's opinion	Not required	Required
Capacity	Present	Absent

documented their wishes and their choice of a surrogate decision-maker in advance.

All Medicare-certified institutions are mandated to provide written information regarding the individual's right to formulate advance directives as part of the Patient Self-Determination Act [31]. It is expected that all health care institutions will provide the clinicians with the necessary support to be able to discuss and develop an appropriate end of life care plan with their patients as evidence indicates that patients most often want their clinicians to initiate the advance care planning early in their care and while the patient is in good health [32–34]. One strategy that is ineffective for advance care planning and completion is the provision of written educational materials to the patients without direct counseling, whereas the incorporation of direct patient–healthcare professional interactions over multiple visits maximizes success [35]. The Centers for Medicare & Medicaid Services (CMS) now reimburse physicians or other qualified health care professionals for the face-to-face time that is spent with a patient, family member or surrogate decision-maker in advance care planning (ACP) for the traditional Medicare beneficiaries [36].

Forensic Issues

The aging crisis in the U.S. Criminal Justice System appears to be worsening [37]. The older prisoners often present with chronic medical conditions, untreated mental illness, and unmet psychosocial needs [38]. As the population in the criminal justice system ages, there is an elevated risk for poor health outcomes for most-older prisoners. The annual cost of caring for an older inmate is approximately $70,000 which is about three times the cost of keeping a younger inmate in prison. In addition, the healthcare costs for older prisoners are approximately 3.5 times that of the costs for younger prisoners. This significant disparity in the cost of housing older inmates and providing them with medical care makes this an important public health concern.

The U.S. Department of Justice reported that the number of older prisoners sentenced to ≥ 1 year in state prisons has increased 400% (from 26,300 to 131,500) between 1993 and 2013 [39]. They also reported that 66% of state prisoners ≥ 55 years in age were serving time for a violent offense, when compared to 58% across other age groups. In addition, the number of sentenced federal and state prisoners ≥ 65 years in age increased 94 times faster than the total prisoner population between 2007 and 2010 with the total prison population only growing by 0.7% during the same time period.

Older inmates (≥50 years in age) tend to have a substantially higher number of chronic illnesses like hypertension, asthma, arthritis, cancer, and hepatitis when compared to the younger inmates. In addition, older prisoners also have a greater probability of having untreated mental illnesses or unmet psychosocial needs [37]. A special report of the Bureau of Justice Statistics, the largest national census on the burden of mental illness in the criminal justice system to date, reported that the highest percentage of mental illness was found among older adults in county jails (52.4%), followed by state prisons (39.6%), and then by federal prisons (36.1%) [40].

Although information regarding the epidemiology of psychiatric illnesses among incarcerated older adults is limited, available data indicates that older inmates are more likely to be have psychiatric disorders. Barry et al. reported the prevalence of depression to be approximately 25% among older prison inmates which is significantly higher than among the community dwelling older adults [41]. This group also identified older incarcerated adults as being particularly susceptible to attempting suicide. One study found that approximately 40% of older inmates in a county jail in the USA were found to have psychotic disorders [42]. Data from a state prison showed that the prevalence of schizophrenia and bipolar disorder to be 25 and 18% respectively among elderly prisoners [43]. Studies conducted in other western countries, specifically England and Wales, demonstrated varying rates of depression and suicide among elderly inmates: 30% [44] and 83.3%, respectively [45••]. Additionally, it was

not the length of the prison sentence that determined the severity of the depression, but rather poor vision, overall poor health, chronic pain, and disability [41, 45••].

Incarcerated older adults are more also likely to develop post-traumatic stress disorder due to a higher prevalence for early childhood trauma, ongoing exposure to violence and psychosocial stress, concern over ailing physical health [46], and the fear of dying in prison [38]. Flatt et al. examined older adults in a county jail and reported that approximately 40% of their sample screened positive for PTSD [47]. Older inmates with mental health problems are also at higher risk for facing physical abuse [48] and sexual victimization [49, 50]. Furthermore, the prevalence for substance use disorders is high in this population with 68 to 70% of the incarcerated older adults meeting the criteria for a diagnosable substance use disorder.

Older prisoners also often suffer from cognitive impairment. This issue is a major concern as these individuals with cognitive impairment must be protected from predatory prisoners. Additionally, the presence of dementia makes older inmates confused which can lead to fights initiated by their actions. The increasing health burdens of chronic illnesses, exposure to trauma, brain injury, poor living conditions, and mental illnesses further predisposes these old inmates to dementia [51, 52]. Although there is no national consensus on the prevalence of dementia among older inmates, it has been estimated in 2010 that there were approximately 125,220 prisoners with dementia [52]. This number is expected to double by 2030 and triple by 2050. The process of diagnosing dementia in the prison population is challenging because of the absence of reliable informants who can described in detail the cognitive deficits and their consequences. In addition, there is lack of utility for the standard definitions of activities of daily living (ADLs) and instrumental activities of daily living (IADLs) in prisons. To overcome this deficit, Williams et al. developed the prison activities of daily living (PADLs) criteria that has the potential to aid in diagnosis of cognitive impairment among inmates [53]. The PADLs assesses the following activities: dropping to the floor for alarms, standing for head counts, ambulating to the dining hall for meals, hearing orders from staff and climbing up and down from the top bunk.

Dementia also impacts the quality of life of these elderly prisoners as they are often unable to follow rules set in place by the prison's management due to impairments in memory, reasoning, executive functioning, and personality changes. These deficits make inmates with dementia vulnerable to receive institutional charges such as solitary confinement [52, 54]. Additionally, these older inmates are at a higher risk of becoming victims of violence due to their wandering behavior resulting from visuospatial impairment, therefore disrupting living areas [49, 52].

Competence to Stand Trial

Competence is defined as the legally determined capacity of a criminal defendant to proceed with criminal adjudication [55]. The Dusky Standard mandates that a defendant must be able to understand the objectives of the legal proceedings and be able to assist his counsel in his defense in order to be deemed competent to stand trial. The rates of incompetence to stand trial varies among older criminal offenders between 32.3 to 50% [55].

Among younger adults, it is not uncommon for functional psychiatric impairments due to serious mental illness like schizophrenia to be associated with incompetence to stand trial [56]. Among older adults, cognitive disorders rather than psychotic disorders are the most common reason for incompetence to stand trial [56, 57]. Defendants unable to comprehend a basic sense of person and place, or struggle with retaining important information about the case will be unable to assist their counsel in their own defense. The lack of abstraction, which is required to appreciate the right to legal representation and the right against self-incrimination, may affect the competence of individuals even in the early stages of dementia [57].

Restoration of competence, however, is possible, despite the strong association of dementia with incompetence to stand trial [57]. Morris et al. recommended that these individuals with dementia have a thorough cognitive assessment to determine the extent of their cognitive defects and to also treat these cognitive deficits. The other factors that are essential in restoring competence include the assessment and treatment of reversible causes of cognitive impairment, management of medical comorbidities, and the optimal treatment of co-morbid psychiatric disorders [58].

Conclusions

Multiple ethical issues often complicate the care of older adults. These include the loss of autonomy and voluntarism and the impairment in decisional capacity. Additionally, issues associated with the end of life care add another layer of complexity to the care of the elderly. Often clinicians caring for the elderly are expected to resolve ethical conflicts, evaluate safety concerns and provide comprehensive treatment recommendations. While evaluating complex ethical issues, the clinician must be aware of competing interests and the acuteness of the situation. The clinician should use all available resources to ensure the safety of the older individual in addition to providing comprehensive assessment and treatment recommendations. The forensic issues among older adults and the psychiatric care of the elderly in the criminal justice system are becoming a major public health concern. A major overhaul of all the systems that care for these vulnerable individuals is needed now.

Compliance with Ethical Standards

Conflict of Interest Juan Young, Silpa Balachandran, Dhweeja Dasarathy and Deena Tampi declare that they have no conflict of interest.

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