

Guardianship in Oxfordshire: hits and misses

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This is a follow-up of 24 cases of guardianship orders, and demonstrates how they can be used in practice for complex cases and highlights practical problems with the process of guardianship. Results showed that orders were generally applied to elderly females with dementing illness living alone. Many orders resulted in a move to residential care where the orders were often left to lapse within six months. Occasionally orders needed continuous renewal and here the process was often haphazard and disorganised. However, guardianship was used to coordinate and facilitate multi-disciplinary care. Difficulties have since been identified and improvements in organisation are discussed.

Guardianship (Mental Health Act 1983, Section 7) is a way of providing community care within a legal framework where it cannot be provided without the use of compulsory powers. It provides three main powers: to specify a place of residence, to attend for treatment and to require access to that residence. It is rarely used in comparison with other sections of the Mental Health Act (Department of Health, 1995) as the Code of Practice stipulates that the patient has to "understand and consent" to the authority of the guardian, and any access to a residence under the Act cannot be done "forcibly". It has been argued that these powers are unenforceable (Gunn, 1986). In addition guardianship orders do not release any funds to provide a more concerted and coordinated package of care for those with mental health needs in the community. These factors may account for its relatively low usage.

The study

Cases accepted by Oxfordshire Social Services for guardianship which were held on file in March 1996 were analysed. Cases less than six months old were excluded. Basic demographic data were extracted from scrutiny of guardianship applications. Retrospective analysis of psychiatric and general practitioner notes was carried out in conjunction with informal interviews with the relevant social worker, doctor or carer (usually staff from a nursing home) to

determine whether there were difficulties once the guardianship order was in place, and to determine the perceived effectiveness and suitability of the order.

Findings

Twenty-four cases were found with a male to female ratio of 1:11. Twenty-two had a diagnosis of dementia with one case of schizophrenia and one of manic-depressive psychoses. All cases but one were over the age of 65 when the order was made. The mean age was 81 (range 58–96) and only five (21%) were married or living with relatives.

Renewals

In 17 (72%) of cases, guardianship lasted only six months. Four cases had died during this six months but the remaining 13 had no recorded follow up with respect to guardianship. Five (21%) were renewed for a year and then lapsed after 18 months and the remaining two continue to be renewed and are ongoing.

Reasons for guardianship

When the 24 guardianship papers were scrutinised, 20 (83%) of the cases had recorded place of residence as part of the order although in seven cases this was the sole use of guardianship specified. Fourteen (58%) moved directly to residential care, eight cases were moved from their homes, the remaining six were transferred from psychiatric hospital. Two had been admitted under other sections of the Mental Health Act.

Patients placed on guardianship as in-patients were associated with a higher mortality than those living at home. Five of the six admitted to hospital were deceased within one year compared with one death in the home population. There was no significant difference in their mean ages so presumably they differed in the severity of dementia and frailty.

Of the six cases living at home, all lived alone and guardianship was used to allow access for formal carers as part of their care plan. In

seven (29%) cases the power to return the patient to the stated place of residence was specified. These all concerned residents of homes. Only three cases specifically mentioned to attend for treatment, generally a day centre.

How these powers were used in practice

In five (21%) of the cases an elderly person with dementia was at considerable risk. One case represented physical abuse (bruising and human bite marks), in another case an elderly spouse was unable to provide the level of care needed at home but not consenting to care packages or nursing home placement, and three cases of siblings in fierce disagreement over the most suitable placement for their parent, causing constant unplanned changes of residence for the patient. In all cases the powers of guardianship allowed a framework to be negotiated successfully around which families and social services could work. For people living at home, access was considered by formal carers to be facilitated. Carers felt more authorised knowing they were within the law to gain access to a residence and in some instances keys could be cut to allow easier access. Carers reported that residents seemed more accepting of this routine once in place.

Guardianship also allowed residential staff to have greater authorisation to bring back persistently wandering people. In addition relatives who disagreed with the placement were prevented (by guardianship) from removing the patient, and staff felt they could have police assistance if the situation required it as the patient was subject to the Mental Health Act.

Difficulties with guardianship

To attend treatment was a rarely used part of guardianship, possibly as most people were in residential care or moved to care as a result of the order. Guardianship was unsuccessful initially in a lady with milder cognitive impairment as she became confused and distressed as to the nature and process of the Act, believing to have filled in a financial form incorrectly. The order was not renewed at 18 months.

Two of the seven cases needed multiple renewals. In both cases these renewals were missed due to lack of awareness that the section had expired. Subsequent renewals were also missed. In one case renewal forms were also accepted and then found to be unsigned, while another was thought to have expired, but was in force for a further six months. Lack of knowledge concerning the legal processes associated with guardianship created further complications in sections expiring in error. Consent of the nearest relative is a necessity for guardianship but in

three cases relatives had disagreed with all or part of the proposed plan and objected to the guardianship. These cases concerned families objecting to residential placement. However, it is possible to displace the nearest relative to allow the order to proceed, and this happened in these three cases. However, when two of the orders lapsed in error, the powers of the displaced relatives were unclear. In one case information provided by the legal department of social services was at odds with the Mental Health Review Tribunal, resulting in an application having to be made on a different basis to the original application.

Comment

Since March 1996 local guidelines for the use of guardianship have been published and distributed to mental health staff in Oxfordshire (Oxfordshire County Council & Oxfordshire Mental Healthcare NHS Trust, 1996). Ongoing education by means of half-day conferences have provided a forum for lectures and case discussions and given staff the opportunity to discuss difficult management problems and to consider the appropriateness of guardianship.

A centralised case-load of current cases is now kept at social services with a named approved social worker responsible for renewals and a 'trigger mechanism' in place two months prior to renewal date. A solicitor with a special interest in guardianship has recently formed close links with the department and applications are now scrutinised by the assistant director of social services, the mental health services manager as well as the approved social worker. All applications must be accompanied by a care plan.

Conclusion

This small study reflects the findings of Wattis *et al* (1990) and Benbow & Germany (1992). Guardianship is used primarily for elderly ladies with dementia who may be at risk of self-neglect or emotional abuse. The Act seems more effective for a relatively small subgroup of patients who are severely impaired and have complex needs where care is provided for their own protection. The powers afforded by the Act are very similar to those of supervised discharge, providing a highly structured care plan around individuals at risk where compulsory powers cannot be used. Although the actual powers seem inadequate, in practice this paper demonstrated that even in complex family disputes the order can be used effectively to provide care.

However, it can be a complicated and time consuming process if it is not well-organised. One could argue that as no control population for

comparison was used these patients may have had similar outcomes without the formal powers of guardianship.

Whether or not guardianship will be retained in a new Mental Health Act remains to be seen. This study suggests that guardianship can be a useful method to direct and coordinate care if well organised and considered as part of a detailed care plan.

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