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Personal columns

The use of Guardianship Orders

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Guardianship Orders (GOs) are being applied more often in care of people suffering from mental illness (Hughes, 1991) and the elderly may have problems particularly suited to their use. Since many individual psychiatrists have little experience of GOs, we decided to examine our use of them. One of us had been involved in six orders over seven years working as a full-time consultant in the psychiatry of old age.

Case histories

Case 1: Mr D, aged 74 years, had been known to the old age psychiatry service for two years, with a severe relapsing depressive illness which was precipitated by conflict with his sister with whom he lived. She did not want him to return to her house, but proved unable to say this to him, despite family meetings. He was unable to consider living elsewhere, and had always been cared for by a sister since the breakdown of a short-lived marriage. A prolonged period of negotiation with the family was terminated when social services and health service staff caring for Mr D on a psychiatric ward decided that a GO would offer a solution. It was not in Mr D's interests to remain long-term on an acute psychiatric ward and the order was applied for.

Mr D was discharged to a social services home while the order was being organised. It was not finalised for about six weeks and just over two months post-discharge he relapsed, became actively suicidal and was readmitted to hospital. The severity of his illness necessitated a Section 3 for treatment.

Case 2: B W, an 83-year-old single woman with a long history of paraphrenia and early dementia, had been treated in hospital on short admissions, when she would improve substantially, but would return to live alone in the community where she would soon neglect herself, fail to eat or tend to her personal hygiene, refuse to use any heating in winter, deny access to home helps, nurses and other staff and fail to comply with her medication. Rapid deterioration would follow discharge, leading to increasingly disturbed behaviour and a floridly psychotic mental state. Her ability to care for herself was worsening as her memory function declined, but she would not consider a move to an elderly persons' home. A GO presented a way out of the cycle of recovery followed by neglect, distress, relapse and readmission. An application was made while she was at home in the early stages of relapse. Before the order was ratified she was found wandering and taken to a home. The GO was invoked to require her to remain there under supervision, despite her initial insistence on leaving.

She continued to ask to return home for some months, but, when renewal of the Order was considered, she had accepted the move, had gained weight and was enjoying the home's social life. The GO was allowed to lapse and she remained in the home.

Case 3: E R was an 83-year-old recently widowed man with multi-infarct dementia, who was placed in a social services home on a guardianship order after an alleged assault on a neighbour, which resulted from delusions that the neighbour was stealing things from his home. He was awaiting court appearance and was barred from returning home, but was assessed on an old age psychiatry assessment ward as being unable to manage at home without considerable support. A home was seen as more appropriate than attempting to place him alone in a new and unfamiliar home. A GO would offer some control over him in that he could live under supervision in a home, and attend day hospital regularly while the legal compexities were sorted out. The order has since been renewed.

Case 4: V J, an 80-year-old man, was referred following a stroke with aggression. He had a severe receptive and expressive dysphasia and an underlying argumentative quick-tempered personality with poor impulse control. Both factors exacerbated his poor tolerance of frustration and led to outbursts of violence towards his carers. He and his wife had been estranged for many years, but had continued to live separately in the marital home. Seeing the deterioration in her husband, his wife took out an injunction to exclude him from the marital home. Mr J was unable to express his views on the matter because of his dysphasia, and his understanding of events was unclear. He remained aggressive and irritable, but could be managed by calm sympathetic nursing staff, prepared to allow him independence and space.

A GO offered a framework for decisions to be made about his future and was implemented. He was placed in a small nursing home with known psychiatric expertise where the staff were tolerant of his difficulties and managed him well. The GO was allowed to lapse after six months as he had settled happily in his new home.

Case 5: A S was a single woman of 87 with senile dementia Alzheimer type who lived alone and was known to the old age psychiatry service for about six months before a multidisciplinary review meeting was held. She had resisted offers of day care, and had limited the domiciliary services which she would accept. She was wandering, locking care staff out, refusing to change her clothes or wash, burning pans frequently and burning her legs in front of the fire. A package of care was agreed by those present, and an approach

to attempting to implement it. She continued to prove implacable, and an 'at risk' conference was convened two months later, as the situation continued to deteriorate. A S was now urinating into bowls and then using them for washing up, and was repeatedly burning her legs severely by sitting close to the fire all night. It was agreed that a further attempt should be made to put in extra support at home, but that, if this failed, a GO would be appropriate. She was admitted to an elderly person's home as an emergency two weeks later and a guardianship order invoked to detain her there.

Case 6: D E W was an 81-year-old schizophrenic man who had been travelling around the country staying briefly in hostels and homes until he was admitted on Section 2 after being verbally and physically aggressive, irritable and expressing strange ideas on a medical ward, where he had been admitted because of chest disease. Following detailed assessment, he received treatment on a Section 3 and improved markedly, although he remained irritable. He was discharged to live in a rest home on a GO, to break the cycle of his continued meanderings around the country, and has continued to comply with depot neuroleptic injections to date.

Comment

The recent Law Commission Consultation Paper (1991) has highlighted a number of difficulties in using guardianship, and puts forward ways in which it might be revised and extended. It is therefore important to consider whether GOs are presently useful.

The ASW involved in Case 1 perceived the GO as having failed because the patient relapsed and was readmitted soon after the order was finalised. However, it allowed him to leave his sister's home and to move to a less emotionally volatile environment. Subsequently he has always returned to live in social services home and he and his sister have kept in touch by visiting each other. In this respect the Order might be regarded as having succeeded in that it allowed Mr D to return to the community to live in an appropriate and supervised setting. The main difficulty in using the order was the time delay between the decision to make an application and its implementation.

Case 2 also suffered a delay in ratification of the GO, but this did not prejudice its successful use. The outcome was regarded as satisfactory by all staff involved and the patient herself. Since her admission to a home she has not required readmission to a psychiatric ward and her health has improved, physically and mentally.

The third GO allowed an aggressive irritable man to be placed back in the community after a period of in-patient assessment with close co-operation between all those involved in his care. This case illustrates the use of GO as a framework to allow decisions to be made on behalf of a patient who was unable to make decisions for himself and had no relative to act in his best interests. There was an argument for renewing the order, to allow the guardian to carry on taking responsibility for Mr J and acting in his best interests. The patient had an ongoing need for care and protection and in the light of the Code of Practice (1990) the Order should probably have been renewed.

Wattis *et al* (1990) have drawn attention to the use of GOs to maintain older patients, mostly with dementia, in the community. Of our six cases, four had dementia syndromes. In all, the Order was used to facilitate a suitable residential placement, rather than to support someone in their own home. The uncertainty over whether an order gives the power to convey a person to a placement needs to be resolved, but, in practice, all these patients were moved without difficulty.

The Mental Health Act Commission Third Biennial Report (1989) encourages active consideration of GOs and the literature suggests that they do have a limited but useful role in managing the elderly mentally ill. Their use depends on close cooperation between health and social services, and, at present, this may constitute a problem in some areas.

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