

The use of guardianship in mental handicap services

Helen Whitworth and Shashi Singhal

There has been little published on the use of Guardianship Orders in mental handicap (the term 'mental handicap' is used rather than 'people with learning disability' to avoid ambiguity). Its use in the mental handicap services in four health districts in the Mersey region was surveyed. The study was retrospective, covering a five year period ending August 1994. Guardianship was used on ten occasions. Health professionals have been divided over the interpretation of the definition of "mental impairment" in the Mental Health Act (MHA) 1983. They have tended to exclude many mentally handicapped adults who do not, in their opinion, exhibit "abnormally aggressive or seriously irresponsible conduct". It is clearly shown by our study that some health professionals are willing to classify self-neglect and vulnerability as "seriously irresponsible conduct", therefore allowing wider usage of the order.

To date there has been no literature purely examining the use of Guardianship Orders (GOs) in mental handicap services. The Mental Health Act (MHA) 1983 section 8(1) states that the guardian has the power to require:

- (a) the patient to reside in a specified place
- (b) the patient to attend for medical treatment, occupation, education or training
- (c) access to the patient to be given to specified professionals.

Much has been written about GOs "lacking teeth" (Craig, 1988). A recent review criticised the order, particularly in its failure to include the power to transfer a patient to the required residence (Grant, 1992) and this may well, in part, account for its low rate of use both in general and in our survey. These points have been thoroughly discussed in the literature (Craig, 1988; Dooher, 1989; Wattis, 1990; Grant, 1992) and are not considered further. There has, however, been much debate among health professionals (Craig, 1988; Cooke, 1990) about the use of the GO in the mentally handicapped population. Under the Act, guardianship can offer a measure of control and support in the community to people suffering

from one of four forms of 'mental disorder': mental illness, psychopathic disorder, mental impairment and severe mental impairment. It also has to be stated that the order is in the "interests of the welfare of the patient" (MHA, S7(1)).

Our survey attempts to assess the current use of GOs by mental handicap services.

The study

Patients placed under a GO by one of five consultant psychiatrists in four randomly selected mental handicap services in Mersey region were identified by circulating a questionnaire to the respective consultants, and in one area a social services register helped to confirm our findings. The survey was retrospective, covering mixed urban and rural areas.

Case-notes and section forms were scrutinised to obtain data on demography, degree of mental handicap, diagnosis, any coexisting psychiatric disorder, who initiated the process, and where patients resided at the time of initiation. The outcome of any Mental Health Review Tribunal (MHRT) was noted, and an objective judgement on the overall success of the order was made. No statistical analysis was attempted – the study was descriptive in nature.

Findings

Ten patients were placed on a GO during this five year period (nine on section 7, one on section 37) five in Wirral, four in Warrington, one in Southport and none in Chester. They ranged in age from 18 to 56 years; six were single and four were divorcees; six were female and four male; eight had mild learning disabilities and two severe learning disabilities (IQ<35). Seven patients were living in private accommodation prior to the application for reception into guardianship (three of these

lived alone), one patient was in hospital (on section 3, MHA), and one was in custody. In one case the mother was displaced as the nearest relative by a court hearing.

Initiation of proceedings was by a psychiatrist on three occasions, by social services on two occasions, jointly on four occasions and by the court in one case (section 37).

In each instance, district social services were appointed as guardians.

Powers required by the GO were:

- (a) to facilitate transfer to residential accommodation, and to require access in all cases
- (b) to require attendance at day centres etc in seven cases.

The diagnoses in terms of the Act were:

- (a) mental impairment in seven cases (two with co-existing schizophrenia, and three who had a history of firesetting or paedophilia)
- (b) severe mental impairment in two cases (one of whom was subject to section 37) and
- (c) mental illness (schizophrenia) in one case.

A detailed analysis of the notes and section 7 forms revealed that three of the seven patients with a diagnosis of mental impairment in terms of the Act displayed no history of "abnormally aggressive" behaviour or the usual concept of "seriously irresponsible conduct". These cases are briefly discussed.

Case 1: a 26-year-old divorced female patient with mild mental handicap and a spastic paraparesis. She lived alone and was subject to exploitation and physical abuse by local teenagers. Her insight was poor and she was resistant to attempts to help her. She had no history of aggression.

Case 2: a 20-year-old single male with mild mental handicap and epilepsy. He was the subject of emotional and physical neglect and lived with his mother who fed and medicated him inconsistently. He had no history of aggression but was incapable of making and adhering to a decision independent of his mother who sabotaged his treatment.

Case 3: a 42-year-old divorced female patient with mild mental handicap (and coexisting schizophrenia). She lived alone, refused care, was self-neglected and was subject to abuse by neighbours. Again there was no personal history of aggression.

Of the ten cases, three patients appealed to the MHRT (including case 1) – on each occasion the order was upheld. Eight patients continue to be subject to a GO; in five cases patients remain in residential care with a good social and psychological outcome. One has been re-admitted to hospital following failure of her residential placement because of challenging behaviour. One continues to express dissatisfaction with the GO but has complied with its requirements. One patient is awaiting transfer to residential care. The two remaining GOs were allowed to lapse after a successful placement and compliance with a care programme.

Comment

As mentioned above, several authors have expressed reservations about using section 7 of the Act for vulnerable or neglected patients (Craig, 1988; Cooke, 1989; Doohar, 1989) because it includes in 'mental disorder', the term 'mental impairment' but not 'mental handicap'. The definition of mental impairment in terms of the Act is "a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct". Difficulties have arisen because the majority of mentally handicapped adults do not display abnormally aggressive conduct and are hence excluded from the Act on that criterion. Indeed many correspondents replying to a questionnaire circulated by Cooke (1990) felt unable to use guardianship – because of this wording – to protect mentally handicapped adults from abuse. It was proposed that "appropriate legislation... be passed before more tragedies occur" (Cooke, 1989).

Similar reservations about the wording of the Act, and as a consequence the potential under-use of GO "in cases where the legal requirement is strict adherence to these criteria", were expressed soon after the introduction of the Act. In Scottish law, the term mental handicap has been retained, enabling the continued use of guardianship in its more traditional sense.

Craig (1988) cited two cases of adults with mental handicap who were subject to similar kinds of neglect as our cases 1 and 2. In those cases it was considered that Guardianship was "desirable from a practical viewpoint, but

legally impossible". Practice appears to vary. Our survey has identified the use of GO in a wider sense "in the interest of welfare of the patient". Those mentally handicapped patients who are vulnerable, and subject to abuse and neglect, while not necessarily being "abnormally aggressive" may be interpreted as displaying "seriously irresponsible conduct" because of their failure to protect themselves from abuse. This is an opinion supported by the 1989 Legal Director of MIND – William Bingley (Craig, 1988). This interpretation of the Act has been supported by mental health professionals in two of our cases.

Case 1: the MHRT upheld the GO

Case 2: the consultant psychiatrist sought the opinion of the Mental Health Commission before making the application for the patient to be received into GO – on the basis of his doubts about whether the patient fulfilled the legal definition of mental impairment.

We recognise that the small numbers of GOs described in our survey represents its major downfall. Our paper may, however, stimulate further research on this topic and, in due course, a larger study.

In conclusion, although our survey is small and retrospective, the findings appear to echo results of other studies in terms of the wide variations in the consideration/use of GOs by local authorities (Fisher, 1988), psychiatrists (Wattis, 1990) and by social workers (Craig, 1988). Its decline in use by mental handicap services, whose patients represented 73% of those on a GO in the 1970s to 21% in the period 1983–87 (Grant, 1992) may in part be a

result of division between health professionals over the wording of the Act. This needs to be clarified to allow the protection of the MHA to be afforded to other vulnerable mentally handicapped individuals.

Acknowledgements

We would like to express our thanks to Barry Morris for his assistance in collating some of the data and to Sandra Cross for her help.

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*H. E. Whitworth, *Registrar in Psychiatry, Ashton House Hospital, Columbia Road, Oxtou, Birkenhead L43 6TU*; and S. Singhal, *Consultant Psychiatrist in Learning Disability, Ashton House Hospital, Columbia Road, Oxtou, Birkenhead L43 6TU*

*Correspondence