

UNIVERSITY OF LONDON

**GUARDIANSHIP FOR PEOPLE WITH
MENTAL ILLNESS:
SOCIAL WORKERS' PERSPECTIVES AND DECISIONS**

**A DISSERTATION SUBMITTED TO
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By

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LIST OF ABBREVIATIONS

Approved Social Worker	-	ASW
British Association of Social Workers	-	BASW
Chronically Sick and Disabled Persons	-	CSDP
Community Psychiatric Nurse	-	CPN
Community Care Order	-	CCO
Community Supervision Order	-	CSO
Community Treatment Order	-	CTO
Diploma in Social Work	-	DSW
Mental Health Act Commission	-	MHAC
Mental Health Review Tribunal	-	MHRT
National Institute for Social Work	-	NISW
Residential care provided by a local authority under Part III of the National Assistance Act, 1948	-	Part III (accommodation)
Social Services Research Group	-	SSRG

SUMMARY

This research examines how social workers view the use of guardianship to meet the needs of clients with mental illness. It is the first empirical study of social work perspectives on guardianship and of social workers' decisions to select particular clients as appropriately placed on guardianship.

An historical review confirms current relevance of 'tutor' and 'curator', forms of guardianship for this care group since Roman times, in contrast with the commonly held view that guardianship was introduced by the Mental Health Act, 1959. The nature of 'committee', as English equivalent to the Scottish tutors, is given particular attention.

The survey part of the research employed a standard questionnaire which explored key guardianship concepts, sought to compare the role of social worker with that of guardian, and looked to future possibilities for the development of guardianship. The fieldwork took place in two adjacent London local authority social services departments. The profile of guardianship clients indicated that guardianship was used mainly for clients living alone in socially isolated circumstances, particularly women. It was used to help to gain access to the client to provide care and services, or to enable the person to move into residential care, often direct from hospital. For the most part, the present research confirms previously available data on clients. However it contests the view that guardianship is mainly used for people suffering from dementia, as clients with schizophrenia were in the majority in the survey sample.

Different models of guardianship were used to assist in the analysis of data: the 'legal/substituted judgement' or 'advocacy' model; the 'parent/child' or 'social casework' model; and the 'therapeutic welfare' or 'case management' model. There was clear support for these and for core guardianship concepts, including authority, continuity, personalised care and surrogacy - irrespective of the model considered. Arguably, the idea of trust (as in trusteeship) was endorsed as being at the heart of guardianship.

The position of social services departments as 'host' agencies for providing guardianship was seen as equivocal in that directors of social services have few incentives (and a number of disincentives) for taking on the responsibility. If social workers themselves have to shoulder the responsibility in the new community care climate, the absence of management back-up could seriously undermine the care given to clients and limit possibilities for effective adaptation of the guardianship concept.

Social workers' 'verdict' on guardianship was that it has potential which so far has not been realised. There was general agreement that guardianship needs to change so as to be more adaptable and enforceable to meet clients' individual needs. It is anticipated that a revised guardianship formulation on this basis would be widely supported.

CHAPTER I

INTRODUCTION

THE NEED FOR THIS RESEARCH

Information on guardianship for mentally ill people is surprisingly sparse. Apart from a limited statistical profile annually assembled by the Department of Health from returns from local authorities, monitoring of actions under Section 7 of the Mental Health Act, 1983, is delegated to individual social services departments and the data might be assumed to reside alongside that of other cases assessed by approved social workers (ASWs). By definition, information on assessments which did not conclude with a decision to pursue guardianship will be difficult to access. The Mental Health Act Commission, (MHAC), often assumed to fulfil a monitoring role regarding use of guardianship, have less information than the individual local authorities they visit.

Lack of monitoring on differential use of guardianship, or on the factors which predispose social services/social workers to choose for and against guardianship, means that information is not available on some critical matters, for example, on whether the initial six months period of a guardianship order gives sufficient time for social services to provide the necessary care and treatment which would enable statutory guardianship to give way to more informal arrangements; or how often longer term statutory enforcement of guardianship is required in order to achieve given objectives. Indeed, there is lack of clarity about the objectives involved, who determines these and who decides whether (or when) they have been achieved. This vitally effects interpretation of the significance of lapsed (expired) cases when considering original need measured against achieved gains.

Some important areas where information is either unavailable or limited are indicated below. Such data that is available from previous research - mainly on characteristics of clients selected for guardianship - is contained in Appendix A.

Perhaps the most surprising gap in knowledge, problematic throughout any discussion of guardianship, is the empirical basis for the relevance of the three essential powers.

Changes brought about by the 1983 Act were introduced with the broad intention of bringing guardianship up-to-date and making it more relevant; and it was apparently assumed that the 'essential' powers conferred on guardians were the ones required and that others were either not required or were 'inessential'. In the absence of the evidence it is impossible to tell:

- (a) whether these powers taken together meet the needs of more or less people than would have applied under the 1959 Act;
- (b) whether one power (or a combination of powers) has proved more necessary than the others and, consequently;
- (c) whether more (or fewer) powers are required.

There is a dearth of information on why guardianship is or is not used, alongside frequent assertions of under-use. Studies focusing attention on existing guardianship cases help to clarify reasons for use but not for non-use. Conceivably, studies of social services departments to review their policy making, procedures for sanctioning decisions, culture and attitude towards guardianship, alongside the dependency needs of their clients with serious mental health difficulties, might shed further light on these questions yet remain speculative in its approach towards specific decisions on actual clients.

It is therefore argued below that to focus the investigation on social workers targets the key actors whose task it is to consider use and non-use within the realistic context of local authority social services departments, thereby taking account of the organisational milieu within which the statutory process unfolds.

PRELIMINARY CONSIDERATIONS AND ASSUMPTIONS

Social Workers' Professional Identity and Commitment

It is assumed in this research that the social worker subjects are drawn from a professional group with a sense of commitment and accountability towards clients who suffer from mental illness, and who accept and exercise a level of responsibility - both

as professionals and as employees of social services departments and local authorities. The acquisition of this disposition comes from social work training and/or experience of social work, particularly in social services departments. Thus social workers' perceptions of the value of guardianship for people with mental illness would not be expected to be limited by the terms of formal statements contained in the Mental Health Act, Memorandum of Guidance, or Codes of Practice. Social workers are also assumed to have formed a view of the most appropriate mode of care for this group of people as being psycho-social rather than medical, either in the broad (psycho-therapeutic) sense or narrower (chemo-therapeutic) sense.

Social workers are also seen to have acquired a professional value-base and ethos which predisposes them to value a certain kind of relationship with their clients as the most effective way of assisting them, whether or not clients also require help, including medical help, from other sources.

Received wisdom as to the efficacy of relationships with these clients may stem from generally accepted notions of what constitutes meaningful relationships - continuity, persistence, consistency - while others stem from a perception of the nature of mental illness and the most appropriate ways of reacting to people suffering from mental illness, i.e. attitudes of supportiveness, acceptance and practical encouragement. This research tends to the view that social work attitudes and values are often acquired through considerations of what constitutes 'appropriateness'; consequently the way in which social workers relate to people with mental illness in practice is more to do with whether this relationship is acceptable within the professional culture than whether it is effective in helping people with mental illness.

In particular, there is an apparent conflict between the guardianship relationship requirements as regards assertiveness and the social work preference for non-authoritative approaches. Also, the emphasis in social work on self-determination of clients appears to conflict with the restricting nature of a statutory relationship. However, the paper hopefully shows that this is more due to a confusion of intent than a real contradiction, in that all professionals in the field of mental health service provision acclaim the notion of self-determination as the ultimate goal for therapeutic

endeavour. The real question, therefore, is whether such self-determination has to be assumed to exist, albeit partially, from the outset or whether it is more realistic to admit to the fact that some people with mental illness at times (and in some cases most of the time) display clear inability to shape their lives or determine their futures.

Different Levels of Decision-Making in Social Services

Formally designated decision-makers within the terms of the Mental Health Act, 1983, are the prospective applicants, termed 'approved social workers', and directors of social services who have to agree such applications under Section 7(5) of the Act. Only the first group of decision-makers receives detailed attention in this research. However, as these are social workers employed by social services departments they are inevitably influenced by management perspectives and expectations. This is a two-way influence to the extent that directors of social services look to social workers to advise them as to the correct decision on professional grounds. It is therefore necessary to consider social work decision-making in the organisational and cultural context of social services as well as that of their professional values and ethos.

The Significance of Decision-Making

Subject to the qualifications spelt out in the preceding paragraph, social workers deciding for and against guardianship are seen as accepting or declining an enhanced level of responsibility on behalf of their agency for an individual person with mental illness, which in turn relates to certain assumptions about mental illness and the degree and extent of justifiable surrogacy, i.e. the level of responsibility which other people should accept on such a person's behalf. In other words, guardianship and surrogacy are seen as inextricably linked even though no definition of surrogacy is offered in law or practice guidance. The issues discussed, based on different interpretations of the law and of different legal expressions of the guardianship concept in recent history, are described as centring on whether it is necessary for surrogacy to be complete, i.e. total, or whether it is more appropriate to address degrees of, and limits to, the surrogate function.

The Nature of Guardianship Responsibility

The nature of the surrogate responsibility towards people with mental illness is described as having a historical root in the trust relationship exercised by the Crown over infants and certain elderly people, as well as mentally handicapped/mentally ill people where they are unable to look after themselves. In other words, trusteeship and guardianship are seen as having a very close relationship, with clear implications in the nature of that relationship, i.e. that the guardian exercises care in a continuing, consistent and above all individualised way appropriate to people in these circumstances. Therefore, help offered to these people which is sporadic, inconsistent and impersonal (e.g. through excessive delegation) is seen as a contradiction in terms.

It is furthermore argued that the surrogate trust relationship is the most appropriate way to describe the nature of guardianship. Arguably, the foundation of guardianship on trusteeship is the basis for evaluating the models considered, i.e. substituted judgement, therapeutic or parental, so that provided each contains a trust element they remain valid and useful analytical tools.

Recent Empirical Basis for the Efficacy of the Trust Relationship

References to contemporary research on the components of effective mental health services,^(1/2) show a consistent pattern advocating that relationships of service providers to people with mental illness in the community should contain the elements of continuity and consistency linked with the individualisation of care. A further finding consistent with the guardianship idea is that such relationships should be as assertively offered as is necessary to engage the person with mental illness in care programmes appropriate for their need. Such people should not be left to decide for themselves whether to 'opt in' to such services, since this is a denial of our knowledge of problems of motivation among people with mental illness. It also vitally affects take up and maintenance of services, even when these have been carefully assessed between the client and the professionals involved before hand.

Recent research in this area has not generally linked these requirements with the legal/social institutional framework referred to as guardianship, and it is a vital argument of this thesis that provision of services in the most appropriate way should also be linked with the authority and accountability base of the person with key responsibility in this area. A conceptual link is identified between guardianship and case management, raising the question of whether the latter is to be seen as an updated version of guardianship or a separate strand of service providing activity.

Accountability

In parallel with the issue of responsibility for people with mental illness referred to above, is the question of which persons and agencies are obligated to exercise that responsibility. The key legal provision in this area, the Mental Health Act, 1983, clearly indicates that social services departments of local authorities are the ones obligated to both decide for or against guardianship and generally to provide the guardianship function themselves. Social workers at the centre of this study operate in a context which is at the same time organisational/legal/political. No decision in this area is 'neutral' from these points of view and in particular in the commitment of the agencies' resources to sustain a guardianship arrangement. The question of the extent and cost of resources which are inevitably linked to the guardianship commitment is a contentious area and one which receives specific discussion.

Perspective Limitations of Care Group and Legal Framework

Guardianship is both a general and a generic concept with a long, historical pedigree. In some ways it is artificial to discuss guardianship only in relation to a certain group of clients: people with mental illness. It is nevertheless essential for the research in hand for limitations of focus to be identified. Besides being concerned with one particular care group, the research is also concerned essentially with only one legal system, that applying in England and Wales, and, unless otherwise stated, with the contemporary law applying in England and Wales, the Mental Health Act, 1983. References to laws applying elsewhere and at different times, which will be found at various points in the study, usually illustrate differences of approach or alternative ways of operating guardianship

arrangements. They therefore mainly receive attention where suggestions for possible future developments and changes in guardianship law and practice are discussed. A comparative study of guardianship arrangements in other countries is not attempted.

In practice the research focus is confined to adults since guardianship for children is based on different assumptions and legislative requirements. Guardianships for mentally ill offenders provided for under other sections of the Mental Health Act, 1983, are not considered.

The Legal View of Guardianship and Possible Alternatives

The legal view of guardianship conveys the idea that guardianship is linked totally with legal provision: the rights of individual people with mental illness and the powers of people functioning as guardians. Whilst this aspect of guardianship requires considerable attention, the argument in this paper is that to focus on clients' rights and guardians' powers by reference to legal provision and terminology, is to fail to appreciate the wider social role and significance of guardianship.

Viewed as a social rather than purely legal institution, guardianship is open to criticism as being overdue for reformulation in tune with modern concepts and views as to the needs of people with mental illness. The question at issue in this thesis, however, is less to do with whether change is appropriate to bring guardianship in line with current thinking on the nature of relationships in society and the power base of such relationships, than whether the problems associated with people with mental illness require fundamentally different approaches now than in the past.

One illustration of this latter viewpoint will suffice. It could be said that a 'power relationship' is at the heart of guardianship where the options open to the mentally ill client are few and unattractive, i.e. where the exercise of volition and choice by that client provides the client with very little scope in achieving a satisfactory lifestyle at least approximating to a normal life. If, on the other hand, the services and facilities which can be made available to such people are attractive and efficient, and were offered without stigma or deterrent, would this tend to reduce the need for the exercise of

authority by guardians? Arguably, the need for such authority would not disappear since there will remain some people with mental illness who would seem to be unable to appreciate the nature of services available to them and may not therefore be in a position to exercise informed or rational choice.

Guardianship, Compulsion and Restrictiveness

This paper does not set out to provide a thorough discussion of the philosophical, political or practical issues involved in the use of compulsion in psychiatry or in the provision of mental health services. Although guardianship provided for under the Mental Health Act, 1983, is a compulsory measure in the technical sense of being imposed on clients whether they wish it or not, this does not inevitably involve coercion. And it certainly does not mean using guardianship against the client. There are informal forms of guardianship which, though seldom regarded as such, are equally valid in expressing the essential nature of guardianship in its focus on a relationship in which the key ingredients are trust and care, and which is neither coercive nor imposed.

It is acknowledged nevertheless that there is an aspect of statutory guardianship concerned with the use of the law to impose care arrangements on clients which, even though it has clients' best interests at heart, may be in conflict with clients' wishes. Mention will be made, in passing, of commentators who feel this is justified and others who feel fundamentally opposed to this use of the law. This writer's position is best summarised by Katz as follows:

"It is always easier to cut than untie Gordian Knots. Without coercion, society will abandon many people to their self-destruction and uncared-for state. Such an approach is as insensitive as the abuse of power that leads to indefinite incarceration without treatment..."⁽³⁾

Cavadino, re-examining the issues in the context of current proposals to introduce compulsory treatment in the community, argues, *inter alia*, that: "Most psychiatrists have succeeded in managing well enough without [this form of compulsion] until now - by using persuasion and negotiation..."⁽⁴⁾ However, relying for success on persuasion and negotiation can present considerable difficulties in working successfully with all

groups of people in society who require help. How much more problematic to depend entirely on persuasion and negotiation in assisting people with mental illness? If mental illness could satisfactorily be treated or managed by these means, there would be very little need for hospitals, community mental health centres or any of the other 'institutionalised' forms of care which form the bulk of the nation's expenditure on this care group. Even less would it then be necessary to resort to the use of compulsion and the law.

The debate on the introduction of compulsory treatment in the community proceeds in parallel with suggestions for expanding the use of guardianship, and some of the research findings shed light on the connection. The main thrust of the argument most favoured by the research subjects is that compulsory treatment in the community is necessary and would be most appropriately introduced within a revised and extended guardianship framework.

For those who regard guardianship as actually or potentially a 'least restrictive alternative' to hospital (which, by implication, is also less coercive) it is comparatively easy to locate guardianship within social policies connected with de-institutionalisation and the development of community care strategies for people with mental health problems. For this writer, guardianship does not fit easily into these descriptions and therefore cannot be likened to any other strand of social policy development, actual or hoped-for. The relationship of guardianship to movements and changes in psychiatry and the development of community mental health services hopefully emerges during the discussion. Suffice it to say that the relationship is complex.

APPROACHES TO LITERATURE REVIEW, THE HISTORICAL ACCOUNT AND TO DEFINITION OF SUBJECT AREAS

Approach to Literature Review

The whole of this dissertation contains elements of literature review, and references to written material related to the subject of the research are shown in the usual way. There is no single chapter reviewing the literature for the reason that each section and chapter

is supported by its own literature review. In short, literature review is applied as a method for assembling the dissertation rather than as a separate element in its own right.

Approach to Guardianship History

Apart from demonstrating long-standing concern for the welfare of those suffering from mental illness with particular attention to the trust relationship, Chapter III examines the influence of the Roman concepts of 'tutor' and 'curator' on modern solutions to dilemmas arising from the need for total guardianship to provide complete surrogate powers. The chapter also includes an outline of the historical development of guardianship for people with mental illness sufficiently detailed to demonstrate a continuity of concept and intent behind the various laws operating from Roman to present times.

This view is in direct contrast to the traditional approach to the history of guardianship within the field of mental health and mental disorder which often suggests that guardianship originated with statutory measures applicable to people with learning disability (Mental Deficiency Act, 1913) or that the Mental Health Acts of 1959 and 1983 were the only legal bases for providing guardianship for people with mental illness. Indeed, Gunn suggests that guardianship for mentally ill people was 'born' with the 1959 Act.⁽⁵⁾ A further purpose of this dissertation therefore is to demonstrate that this proposition stems from a misreading of guardianship history.

In addition, this thesis seeks to show a separate and discrete history of the legal and social institution of guardianship. In particular, it is argued that guardianship is quite distinct from the Poor Law arrangements instituted in the 17th century for the indigent and from commitment arrangements for dangerous and/or offender patients.

The Approach to Definition

This section commencing on the following page deals with the nature of definition and looks at different types of definition.

The Defining Task

The Oxford English Dictionary* highlights two aspects of the defining task:

1. stating precisely or exactly what something is; setting forth to explain the central nature of something;
2. setting bounds to; limiting, restricting, confining; determining; i.e. fixing or deciding; laying down definitely.

These interrelated tasks are thus concerned with determining the nature of something and how the nature of that thing is distinguished or distinguishable from other things - i.e. to convey boundaries of differentiation.

A similar distinction is conveyed by Quinton in his explanation of the notion of essence,** as:

1. "The set of properties or instances of a kind of a thing which that thing must possess if it is to be of that particular thing, or instances of that particular kind...which can be said to be the *defining properties* of a thing.
2. This is distinguished from the *contingent properties* of the thing which are accidental, i.e. not peculiar to or essential to the nature of the thing being defined, and, by implication, could be shared by a number of other related items."⁽⁶⁾

Definition thus provides us with:

- (1) a concise description of the nature of something; and
- (2) a way of enabling us to distinguish this 'something' from others whose features may be similar.

* The 1989 Oxford English Dictionary is used throughout as a reference for dictionary definitions.

** The term 'essence' confusingly coincides with a description from the official literature of guardianship powers as being 'essential' in the sense of the 'minimum necessary' operationally, rather than in reference to the basic nature of guardianship.

Types of Definition

1. *Formal Definition:* dictionary, statute, etc
2. *Operational Definition:* how the subject defined actually operates; its impact or consequences and general effect on key parties; what would happen if it did not operate in that way or did not exist.
3. *Definition by Perspective:* i.e. considering whose view of the definition is being taken into account, asking who the key parties are and how they perceive the thing being defined. There are clear relationships with other types of definition: for example, the historical definition refers to a variety of perspectives at given points in time.

Two particular perspectives are involved in this research, i.e.:

- (1) that of social workers, upon which the **empirical research** is based.
 - (2) the researcher's own perspective - referred to below as a **working definition**.
4. *Definition by Comparison and Context:* i.e. how the thing being defined compares with similar subjects or areas and how guardianship is seen in context. Thus guardianship can be defined in relationship to advocacy, in its most general or in its specifically legal sense, or could be defined by its relationship to social work - using social work to represent an area overlapping with guardianship or overlapping with advocacy. Guardianship can also be compared with other statutory measures related to the care, protection and control of people with mental illness. A particularly contentious area is the comparison between guardianship and hospital, discussed on pages 48 to 54, which needs to be seen in this context as well as in broader social policy contexts.
 5. *Definition by Typology:* i.e. by the various categories and differences of form or type. This approach to definition would assume that the differences overlay core similarities of the essential nature of the item. The dictionary definition of guardianship,

for example, uses a typological approach to clarify the legal definition of guardianship but succeeds only in portraying it as an out-moded and obsolete concept. Currently applicable typologies could have been used instead.

6. *Historical Definition:* i.e. how the subject being defined evolved or developed over a given period, possibly changing emphasis from one characteristic to another, updating and adapting (or not, as the case may be) to other changes (social/legal/political/economic) and eventually producing the current version or variation on the item. Obviously this form of definition will be more important when the term in question has a long historical pedigree, and may be less important where it is of more recent origin.

7. *Definition by Concept Analysis:* i.e. consideration of theories, models, etc.

8. *Working Definition:* i.e. a particular category of a perspective definition, namely the perspective of the researcher, or more generally the point of view brought to bear on the subject by the writer. This also includes a selective interpretation of underlying concepts, summarised to enable the definition to serve as a reference point or bench mark throughout the research.

SUBJECT AREAS DEFINED

The subjects of definition are confined to **guardianship** (Chapters II, III and IV) and **social work** (Chapter IV). The task of defining 'mental illness' is not undertaken.

Definition of mental illness is a complex area and arguably one which would not throw additional light on this particular use of guardianship. Mental illness is not defined in the key legislation up to and including the Mental Health Act, 1983, though possibly a medical model is implicit in the statutory framework. Clearly, perspectives on mental illness will be one of the factors influencing the approach to guardianship and vice versa, but rather than discussing mental illness in general, the particular mental illness problems of actual clients are the main focus of attention. Additionally some questions about the definition of and attitudes towards mental illness in history are referred to in Chapter III, particularly those concerning differences and apparent similarities between mental illness

and learning disability. Also some attention is given to the difference between generic guardianship and guardianship which is particularly geared to the needs of mentally ill people. The former term refers to forms of guardianship applying in other countries, such as the USA, where criteria for use are sometimes on the broader basis of social vulnerability, i.e. applicable to other sorts of disabilities and problems as well as mental illness.

Different perspectives on mental illness are discussed as applying to the different models of guardianship (see page 61 for an outline of these three different approaches). These influenced the researcher's working definition of guardianship as well as interpretation of findings. The idea of the need for a trust relationship as a foundation for any model or approach to mental illness and the use of guardianship is also discussed.

TERMINOLOGY

Client/Ward/Patient/Case

Patients subject to guardianship are referred to as 'patients' in the Mental Health Act, 1983, whereas the historically more accurate term for such a person is a 'ward'. Classical writings have always referred to the person being looked after by a guardian as a ward. The historical link between wardship and guardianship is discussed in Appendix D, pages 375/6.

Users of mental health services who receive help from social workers are often referred to as clients, especially when it is necessary to convey that the user has a particular relationship with a social worker. (See definitions of 'social worker' and 'client' on page 164).

Four terms are used in this dissertation, depending on circumstances. Where a person with mental illness is being assessed by or cared for by a social worker, the term 'client' is generally used. However, for a social worker's client who becomes part of the research sample, the term 'case', is used. It is accepted that many people with mental illness resent being referred to as a 'case' and no pejorative implication is intended. It

is the configuration of social worker and client in the guardianship relationship within these research populations which justifies the use of the term 'case' for this particular purpose.

Mental Illness and the Reference to Clients

During the time that this research has been undertaken, the researcher has been made aware that people with mental illness prefer to be referred to as 'people with mental illness' rather than 'the mentally ill' or 'mentally ill people'. In response to this sensitivity, the researcher generally uses the term 'people with mental illness'; however, in headings and when the use of the term 'people with mental illness' tends to render the discussion cumbersome or verbose, the phrase 'mentally ill people' is used.

The main legislation distinguishes only between the following categories of 'patient': the mentally ill, mentally impaired and severely mentally impaired, in addition to those suffering from psychopathy. Only people described as 'mentally ill' are the subject of this dissertation though it is accepted that some of the discussion, and indeed some of the key arguments, have been rehearsed in the context of care and treatment of people suffering from mental impairment. A note on the connection between mental impairment and mental illness, is contained at the beginning of the historical chapter (Chapter III).

Pre-1959 legislation referred to mental illness as 'lunacy' or 'insanity' and these terms are used where appropriate.

The Terms 'Order' and 'Application'

The terminology of the 1983 Act would suggest that the term 'order' is technically only applicable to guardianships under Section 37 of the Act, i.e. court orders. However, the alternative term, 'application', is unhelpful in reference to guardianships that have been formally agreed by a social services department, since reference to an application suggests a stage in the process prior to acceptance by the authority. Consequently 'order' is used throughout this dissertation to refer to guardianships in force.

Use/Under-Use/Usage

The operational definition of guardianship discusses the term 'usage' in reference to factors which cause directors of social services to endorse actual guardianships, to maintain cases in force under given conditions, and to create policy and practice guidance understanding as to how social workers should view the need to submit guardianship applications.

On the other hand, the term 'under-use' refers to the frequently asserted position that guardianship is not sufficiently used. The whole question of the amount of guardianship use is discussed at pages 216 to 218 and again on pages 351 to 352.

It is questionable, nevertheless, whether the terms 'use' or 'usage' are appropriate for a concept such as guardianship, and it may be that the terms are more applicable when considering the narrower question of resort to use of certain sections of the Mental Health Act. In other words, 'use' and 'usage' refer to the resort to statutory guardianship rather than to the idea of guardianship in the wider sense. It is also arguable that guardianship is not something one uses but is a description of certain conditions and assumptions applying to the individual care of people with mental illness.

Legal/Formal-Informal/Personal/Statutory Guardianship

The term 'legal guardianship' is unsatisfactory in that it could convey the sense of guardianship being legal as distinct from illegal, or even unlawful. All guardianships discussed in this dissertation are lawful in the sense of being recognised and upheld by the legal system, directly or indirectly, and no questions of illegality arise. A better term, but one which is seldom used, is '**formal guardianship**' as distinct from informal arrangements which are not the subject of legal rulings or of statutory requirements.

The term '**informal guardianship**' is used to cover the latter situation as distinct both from '**statutory guardianship**', as laid down in the relevant legislation and '**personal guardianship**'; which is the term used by Ward⁽⁷⁾ to describe legally constituted guardianship in Scotland, based on civil (Roman) law concepts rather than statute.

Guardian Social Workers

At any one time some social workers will be acting as guardians for mentally ill people while others will not be undertaking this task. The dissertation sometimes refers to 'guardian social workers' to distinguish those social workers who have assumed guardianship responsibilities for individual clients, either formally or informally, though in the empirical research formal guardianship is the usual criterion. Occasionally, the untidy term 'non-guardian social worker' is used to indicate social workers who were not assuming (formal or informal) guardianship responsibilities at the time of the research fieldwork.

Mental Deficiency/Subnormality/Handicap/Impairment/Learning Disability

Official sanction for a change of terminology from 'mental impairment' to 'learning disability' occurred during the period of this research, but the term 'mental impairment' has generally been retained. There is some justification for continuing this usage where references are explicitly concerned with statutory definition, as this is the term adopted in the Mental Health Act, 1983.

Prior to the 1983 Act, the terms 'mental handicap' and 'mental subnormality' were used. Occasionally these terms are used where referring to definitions applicable to previous legislation, and likewise to the term 'mental deficiency' used in pre 1959 legislation, and 'idiocy' when referring to pre-1913 legislation.

In addition to the revised term 'learning disability', the expression 'learning difficulties' has gained favour, particularly in educational circles, but this term is not used in this dissertation.

ARRANGEMENTS FOR CONDUCTING THE SURVEY AND EFFECT ON RESEARCH DESIGN

Chapter V details the survey of social workers' views and guardianship cases and interprets the findings. The following outlines some of the practical arrangements and difficulties associated with a survey of this kind.

The researcher was faced with a substantial lack of information on guardianship usage across the social services departments in England and Wales and a survey of all social workers involved in guardianship was impracticable. Selecting agencies within which to undertake this survey therefore posed considerable problems with the only confident assumption that those agencies that use guardianship most are probably demonstrating some enthusiasm for its use.

Of more practical and telling concern was the question of which agencies would provide ready access to social workers involved with guardianship cases, as well as access to the management viewpoint, practice and policy guidelines, and ready availability of clients' records.

These considerations combined enabled the researcher to gain access to: the Isle of Wight Social Services Department, whose known enthusiasm for the use of guardianship is measured in an unusually high number of guardianships per head of population, and who agreed to allow the researcher to pilot the documentation and field work in that agency; to Kensington and Chelsea Social Services Department (as an average agency in terms of guardianship numbers); and Westminster Social Services Department (slightly above average of guardianship numbers). The latter two agencies agreed to be parties to the research field work proper and to provide the required data.

Kensington and Chelsea and Westminster share borough boundaries near the centre of London and are Conservative controlled authorities with some similarities in terms of demographic profile. In other respects, they are in considerable contrast: a different style of Conservative administration prevails, with Kensington and Chelsea being in the traditional Conservative mode and Westminster moving much closer towards a pragmatic and business-orientated approach.

The researcher had no control over choice of social workers and the guardianship cases were self selected as being on the case loads of social workers involved in guardianship. Managers of the agencies chose these social workers as the means of identifying the cases and representative managers to speak for the agencies' views of guardianship, as well as

to participate in the survey. Information on agency policies about guardianship made available to the researcher was uneven and piecemeal; this proved so inconsistent as to be best discounted from inclusion in the research data.

Research of this kind is inevitably faced with a very wide range of variables over which the researcher has no control. For example, social workers' motivation and interest in guardianship varies considerably and their attitudes to their cases likewise. Some social workers see their position as an independent professional advocating use of guardianship as an important factor in its own right whereas others wait for 'green lights' from management before even giving consideration to guardianship for a given client. Also, as is discussed later in the analysis of findings, the relationship and influence as between practitioners and management is different in the two agencies which has important effects on the decision-making process.

Finally, no adequate account is taken of the different level of resources that could be made available by managers to practitioners to carry through guardianship decisions in the respective agencies. In theory this could have been measured and described but, in practice, new developments in budgeting and purchasing of services mean that an agency could decide to purchase the necessary services to make guardianship viable whether or not these resources were readily available or easily accessed. It has to be acknowledged, however, that consideration of guardianship by most social workers was often in practice dominated by the last two factors, i.e. whether a given resource is readily available and whether access will be endorsed by management.

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CHAPTER II

DEFINITIONS OF GUARDIANSHIP

AREAS OF DEFINITION ATTEMPTED

This chapter covers *formal definition*, most aspects of *operational*, *perspective*, *comparative/contextual* and *typology* definitions, and the researcher's own *working definition*.

The next chapter deals with *historical definition*, i.e. how the concept of guardianship has evolved. Historical and history-related typologies are outlined in the typology definitions and discussed in Appendix D.

The chapter on **Guardianship and Social Work** is essentially *comparative* both in relationship to the definition of guardianship and in the definition of social work. That chapter also contains discussion of guardianship definition by *concept analysis* in the form of the review of models of guardianship and their relationship to social work.

Finally, the empirical study is itself concerned very closely with definition, i.e. that of guardianship and *social workers' perspectives*. It is also definitional in a developmental sense in that social workers deciding for or against the use of guardianship can be said through this process to be taking opportunities (or failing to take opportunities) to develop the guardianship concept through use.

FORMAL DEFINITIONS

The Dictionary Definition

The dictionary definition of guardianship is:

"The condition or fact of being a guardian; the office or position of guardian".

This is seen as having a specialist legal meaning referred to as 'tutelage' and a general meaning of "keeping, protecting, guarding".

The term 'guardian' is defined (again referring both to a specialist legal meaning and to a more general sense) as:

"One who has or is by law entitled to the custody of the person or property (or both) of an infant, an idiot, or other person legally incapable of managing his own affairs; a tutor. (The correlative of ward)".

"One who guards, protects, or preserves; a keeper, defender."

The dictionary definition of guardianship does not include reference to the alternative term 'mund'. The dictionary definition of 'mund' equates the term with guardianship and protection, indicates that the term is of ancient origin, and cites references from 1064 and 1205.

The dictionary definition of guardianship does not, in this writer's submission, give adequate recognition to guardianship as implying a relationship, other than an oblique reference to the correlative position of the ward.* The fact that the relationship is transparently an 'unequal' one, being based on the dominant or power position of the guardian towards the person being protected, should not be cause for minimising the reciprocity components. The relationship aspect of guardianship forms a major part of the researcher's working definition discussed on pages 64 to 67.

There are other fairly obvious limitations to the dictionary definition related to comprehensiveness, especially as no contemporary references, legal or otherwise, are

* *Dictionary Definition of 'Ward'*

The definition of ward referred to implicitly provides three basic contexts:

1. General ("guardianship, keeping control");
2. Specialist ("guardianship of a person legally incapable of conducting his affairs");
3. Feudal Law ("The control and use of the land of a deceased tenant by knight-service, and the guardianship of the infant heir, which belong to the superior until the heir attained his majority").

The dictionary reference to wards links this with the role of the Court of Wards and Liveries discussed in the historical chapter.

cited to support the meanings conveyed. . There are no references to contemporary statutory guardianship for children, or for people with mental disorder (learning disabilities or mental illness).

The fact that the dictionary definition goes on to use outdated legal terminology (the use of the word 'idiot', for example) and its disposition towards considering legal guardianship only in historical language, must give rise to questions about its contemporary relevance. On the other hand, the dictionary definition distinguishes between 'legal' and 'general' meanings of guardianship. Although not especially helpful at first sight, the omnibus title 'general' is a useful base-point for considering non-legal definitions of guardianship, especially the institutional (socio-psychological) view. In short, the fact that the dictionary definition avoids portraying the subject as purely a legal entity is a strength in itself, and clearly indicative of alternative ways of seeing the subject.

The Statutory Definition

The contemporary legislation applying to England and Wales, the Mental Health Act, 1983, provides no explicit definition of guardianship. The accompanying Memorandum of Guidance to some extent makes up for this and the two need to be considered together. The relevant statutory requirements are outlined in detail below. Basically, statutory guardianship consists of a limited range of 'powers', of questionable enforceability, acquired through procedures laid down in the Act, known as a guardianship application, made by an ASW and supported by medical recommendations. The operational definition (see page 31) describes how this works. The background to the Act is discussed in the historical chapter (pages 115 onwards) while comparisons between this Act and other measures related to provision of protective care or services will be found in the section on comparative definitions, commencing on page 44, in which other sections of the 1983 Act are discussed.

The relationship between the statutory basis for guardianship and a wider view of the concept is discussed in the sections below on **statutory and non-statutory guardianship** and **personal guardianship and committee**.

THE MENTAL HEALTH ACT, 1983

The relevant clauses of the 1983 Act are outlined below. These follow the interim changes brought about by the Mental Health (Amendment) Act, 1982.

- "7 (2) A guardianship application may be made in respect of a patient on the grounds that -
- (a) he is suffering from mental disorder, being mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which warrants his reception into guardianship under this section; and
 - (b) it is necessary in the interests of the welfare of the patient or for the protection of other persons that the patient should be so received.
- (3) A guardianship application shall be founded on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in subsection (2) above are complied with; and each such recommendation shall include -
- (a) such particulars as may be prescribed of the grounds for that opinion so far as it relates to the conditions set out in paragraph (a) of that subsection; and
 - (b) a statement of the reasons for that opinion in so far as it relates to the conditions set out in paragraph (b) of that subsection.
- (5) The person named as guardian in a guardianship application may be either a local social services authority or any other person (including the applicant himself); but a guardianship application in which a person other than a local social services authority is named as guardian shall be of no effect unless it is accepted on behalf of that person by the local social services authority for the area in which he resides, and shall be accompanied by a statement in writing by that person that he is willing to act as guardian.
8. (1) ...the application...shall confer on the authority or person named in the application as guardian, to the exclusion of any other person -
- (a) the power to require the patient to reside at a place specified by the authority or person named as guardian;

- (b) the power to require the patient to attend at places and times so specified for the purpose of medical treatment, occupation, education or training;
- (c) the power to require access to the patient to be given at any place where the patient is residing, to any registered medical practitioner, approved social worker or other person so specified."

THE MEMORANDUM OF GUIDANCE TO PARTS I TO VI, VIII AND X OF THE MENTAL HEALTH ACT, 1983

The Memorandum contains brief but explicit indications of a statutory definition of guardianship providing a fuller account than the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations, 1983.

The following sections of the Memorandum justify quoting in full as main reference points for social workers making key decisions:

"43. Placing a mentally disordered person under guardianship enables the guardian to exercise certain powers which are set out in Section 8. The guardian may be the local social services authority, or an individual approved by the local social services authority, such as a relative of the patient. In almost all cases it should be possible for patients for whom care in the community is appropriate to receive that care without being subjected to the control of guardianship. However, in a small minority of cases guardianship enables a relative or social worker to help a mentally disordered person to manage in his own home or a hostel, where the alternative would be admission to hospital.

45. The grounds for guardianship are that the patient is suffering from mental illness, mental impairment, severe mental impairment or psychopathic disorder and guardianship must be necessary **in the interests of the welfare of the patient or for the protection of other persons**. The purpose of guardianship is therefore primarily to ensure that the patient receives care and protection **rather than** medical treatment, although the guardian does have powers to require the patient to attend for medical treatment (but not to make him accept treatment)." (This writer's emphasis)

A guardianship application must be founded on two medical recommendations, the procedure being similar to an application for admission to hospital for treatment. As to guardians' powers, section 46 provides:

46. The effect of a guardianship application ... is to give the guardian three specific powers....The first power is to require the patient to live at the place specified by the guardian. This may be used to discourage the patient from sleeping rough or living with people who may exploit or mistreat him, or to ensure that he resides in a particular hostel or other facility. The second power enables the guardian to require the patient to attend specified places at specified times for medical treatment, occupation, education or training. These might include local authority day centres, an adult training centre, or a hospital, surgery or clinic. The third power enables the guardian to require access to the patient to be given at the place where the patient is living, to any doctor, approved social worker, or other person specified by the guardian. This power could be used, for example, to ensure that the patient did not neglect himself...[I]f without his guardian's consent, a patient leaves the place where he is required by his guardian to live, he may be taken into custody and returned within 28 days of leaving. A patient under guardianship may also be transferred to hospital..."

Sections 47 and 48 of the Memorandum lay down procedures regarding applications and recommendations for the appointment of **private guardians**, and Section 47 says that social services authorities retain "duties of visiting and supervision under Regulation 13". It also mentions that "...it will no doubt be usual for the patient to live with or near to [the private guardian]".

Section 48 includes the fullest description of the expected role and credentials of guardians:

"....Any guardian should be a person who can appreciate the special disabilities and needs of a mentally disordered person and who will look after the patient in an appropriate and sympathetic way. The guardian should display an interest in promoting the patient's physical and mental health and in providing for his occupation, training, employment, recreation and general welfare in a suitable way. The local social services authority must satisfy itself that the proposed guardian is capable of carrying out his functions and should assist the guardian with advice and other facilities. Regulation 12 provides that they can call for reports and information from the guardian, as they may require; the Guardian also has a duty to inform them of his address, the address of the patient and of the nominated medical attendant, and if the patient should die."

Responsibilities of Social Services Departments Towards Guardianship Clients

Supervision

The word 'supervision' is not to be found in the 1983 Act itself, and the nearest connection with supervision is the requirement to visit clients. Section 9(2) of the Act says only that "regulations...may...make provision for requiring the patients to be visited, on such occasions or at such intervals as may be prescribed...." while Section 250 of the Memorandum explains that "local authorities continue to have a duty to arrange visits to certain patients in hospital or nursing homes...[including those] subject to guardianship...." The definitive statement is left to the Regulations, Section 13 of which says that:

"The responsible local social services authority shall arrange for every patient receiving guardianship under Part II of the Act to be visited at such intervals as the authority may decide, but in any case at intervals not more than 3 months...."

Confusingly, Section 47 of the Memorandum refers to duties of private guardians as including "visiting *and* supervision". (This writer's emphasis)

Provision of Services

The 1983 Act is silent on the question of obligations to provide services specifically to guardianship clients, but the 1960 Memorandum states clearly that:

"Placing a patient under guardianship does not confer extra powers to provide [community health or social] services..." (Section 75)

Nothing in the 1983 Act, Memorandum or Regulations countermands this, and the presumption must be that the guidance still applies.

OPERATIONAL DEFINITION

A BRIEF OVERVIEW OF OPERATIONAL AND RELATED POLICY ISSUES

Introduction

This section discusses contemporary guardianship 'usage' (as defined below) and related issues. It is not possible to treat these entirely objectively since perspectives of key actors are inevitably influencing experience and developments. Nevertheless, an attempt is made to describe the situation rather than to comment on it and to provide 'signposts' to the wider subject area, including the basis for this research.

The following material asks: 'How does guardianship operate?' and suggests a framework for dividing the question into more manageable components so as to present an operational profile. This profile, or pen picture, looks at: why guardianship is used, by whom and for whom; its social policy and legal basis (including regulation and monitoring); the pattern and quality of usage; and the key areas of decision-making involved, including a preliminary consideration of main problem areas.

Guardianship Usage and Objective

The term 'usage' is used here to refer to three interrelated aspects of guardianship use:

Extent of Use

This is the quantitative measure from which we are able to judge whether guardianship is used too little, too much or at an optimum level, *provided* we also have a basis for comparison - i.e. a reference point.

Functions of Use

These are the various means by which guardianship attempts to fulfil its objective - e.g. by promoting clients' welfare.

Type of Client Use

This refers to clients with various kinds and degrees of mental illness and identifies how such differences render them more or less suitable for guardianship. Demographic differences are also considered under this heading, as are social factors such as family circumstances.

Relationship Between Object of Guardianship and Extent of Use

The official literature from 1954 (Section 399, Royal Commission Report) to 1983 is consistent in indicating that the object of guardianship for mentally ill people is to provide an alternative to inappropriate compulsory admission to or detention in hospital. The changes brought about by the 1983 Act are thus seen as an update in the application of the concept to make it more effective, rather than a fundamental revision of intention.

The official literature has also consistently advocated and/or anticipated small scale use of guardianship for mentally ill people. The implication would seem to be that the number should remain constant compared with the numbers of compulsory hospital admissions.

The relationship between extent and type of use is not clear. Possibly the underlying assumption is that those suitable for guardianship will always be a small minority. The Royal Commission's view that guardianship use would increase as community services expanded, may imply that more people would become suitable for guardianship as and when tangible and clearly identifiable means existed to provide comparable levels of care outside hospital.

Those who advocate greater use for guardianship may have a wider objective in mind than that stated in the official literature, namely the intention to make community services available to mentally ill people who are unwilling to receive them. Although these services could stave off compulsory admission to hospital in some cases, there may also be the implication that the clients concerned would not meet the criteria for compulsory admission into hospital.

As yet no scale of measurement exists for quantifying the types of service provision that could serve as alternatives to hospital. If the scale existed, there would be a case for judging the extent of guardianship use against this quotient. Arguably, this task should have been undertaken in 'Better Services',⁽¹⁾ which discussed the need for growth in services but referred to an impending review of the legislation without comment on guardianship.

Official numbers of guardianships and observed trends are shown in the Department of Health Statistical Bulletin, the first official account of guardianship usage.⁽²⁾ A Dorset-based survey of 18 shire counties in the south of England and one in Wales⁽³⁾ confirms the national picture of an increasing number of guardianships for mentally ill people overall and an increasing percentage of guardianships for mentally ill people over other guardianships under the Mental Health Act.

From 1975 to 1992 (the last year for which official figures are available) there was a 10-fold increase (from 24 to 248) in continuing guardianships for mentally ill people and a 25-fold increase (from 8 to 198) in new cases. Over the same period, continuing guardianship cases for other clients subject to the Mental Health Act declined by nearly a half (from 144 to 78). Numbers of new cases for these groups have fluctuated around 30 and stand at 35 for 1992. (See Appendix B)

The Social Science Research Group (SSRG) have analysed figures up to 1978 and, due to the unavailability (to them) of data for later years, estimated 1990 numbers of guardianships for all groups as 200. The actual figure was 286 and the 1992 figure was 332. SSRG relate their total of 200 to numbers of compulsory hospital admissions, expressed as a ratio of 1:100. Quantification of community service availability is not brought into the SSRG equation while the view of guardianship as an alternative to hospital is forcefully challenged. Wide variation of numbers between authorities is commented upon by the SSRG.⁽⁴⁾

Only one study⁽⁵⁾ discusses the relationship between the kinds of clients social workers consider for guardianship and those finally approved by social services management.

This study indicates a ratio of 11:2 between cases considered to those agreed, which compares with 7:1 in one of this research subject agencies.

Functions of Guardianship

Guardianship functions are frequently equated with guardianship powers, as for example when referring to arranging residential care placements.⁽⁶⁾ However at least three specific functions (not dependent on the powers) are referred to in the literature: supervision; promoting welfare; and surrogacy. They apply to non-statutory guardianship as well as statutory; and to guardianship for other care groups as well as those provided for under mental health legislation.

Supervision

Though not favoured by the Royal Commission (because of the association with previous arrangements for 'statutory supervision') this function has clearly featured in the official literature with the declared purpose "of protect[ing] the person from exploitation and harm."*

The statutory requirement to visit the client on guardianship clearly links with the supervision function, which some practitioners refer to as monitoring, maintaining surveillance, or by other euphemisms.

Promoting Welfare

Taking the promotion of 'welfare' to embrace meeting both 'care needs' and 'developmental needs', ** the 'welfare criteria' for use of guardianship (to quote the Scottish terminology) was possibly brought into sharper focus in the 1983 Act than in the 1959 Act. Specific examples in the official literature descriptions concentrate on encouraging 'activities' (such as helping with employment) but, by implication at least,

* 1978 White Paper, 'Review of the Mental Health Act 1959', P. 40, Para.4.14.

** Section 48, 1983 Memorandum of Guidance.

promoting the client's welfare in his/her own home is clearly part of guardianship. Though the wider literature does not dwell on these functions, there are suggestions that helping clients to continue living at home places guardianship within some social workers' 'normalisation' strategies. Promoting clients' welfare through advocacy is seen by some social workers as more effectively undertaken within statutory guardianship for certain clients.

Surrogacy

Surrogacy refers to the idea of one person deciding and/or acting for another person who is unable to decide or act for him/herself. Under the 1959 Act, guardians' quasi-parental powers implied a paternalistic approach to surrogacy in the application of the 'best interests' criterion; the 'welfare approach' of the 1983 Act conveys a more service-specific 'best interests' basis for surrogacy.

The residential/attendance/access requirements (using convenient shorthand) could also be viewed as services for the client, i.e. promotion of welfare through surrogacy in these areas. From this standpoint, the 1983 Act provides fewer opportunities for guardians to serve their clients.

Much of the literature dwells on the exercise of guardians' power to determine placement in residential care, and comments on the link between this and attempts to facilitate discharges from hospital. It is suggested that sometimes there may be less concern for best interests or welfare criteria than administrative convenience, especially regarding elderly people placed in old people's homes. However, the following section considers other views of this situation.

Type of Client Use

The Royal Commission approved the use of guardianship for people with "mild or chronic forms of mental illness or infirmity",⁽⁷⁾ and the Mental Health Act Commission (MHAC) have suggested that, among other groups, guardianship is particularly useful for

elderly people in order to enable them to live outside hospital,⁽⁸⁾ a sentiment following closely that expressed by the Royal Commission.

The MHAC also commend use of guardianship for "young people leaving care who are at risk of becoming homeless, exploited or a danger to themselves"; but there is no evidence of this usage being pursued. Age range of clients on guardianship gives a variable picture but most available data shows that people over 60 comprise more than 50% of the total. Approximately two-thirds of guardianship clients are women.

Some studies show that guardianships are mostly used for people suffering from dementia*. For example, the Social Services Research Group Survey found that dementia is the single most common diagnosis of those referred for guardianship (38% of referrals, compared with 11% of all referrals under the Act), followed by mental handicap (27% of referrals compared with 6% of all referrals) and schizophrenia (11% of referrals, compared with 40% of all referrals).⁽¹⁰⁾ Other studies, including this research, show that most people referred for guardianship are people suffering from schizophrenia. Actual balance of numbers from local authorities' returns to Department of Health bears out this latter finding.

A general picture of social isolation and lack of family support applies in most guardianship cases. Circumstances of guardianship clients living in the community before guardianship commenced indicate severe management problems and health hazards.

More information on guardianship clients from research findings is provided in Appendix A.

* This writer has resisted the tendency to see guardianship as applicable to two different groups: younger people suffering with schizophrenia and older people diagnosed as having dementia. Although the research data discussed in Chapter V could be viewed to some extent as justifying such a formulation, it must be borne in mind that such data is only a 'snapshot' of peoples' situations and the nature of their mental distress. In reality, people with schizophrenia grow older and there are now a number of forms of 'pre-senile' dementia, including Alzheimer's Disease and AIDS-related dementia. Furthermore a blurring of symptom differences between schizophrenia and dementia apparently often accompanies the aging process.⁽⁹⁾

Problematic Policy Issues Associated with Guardianship Usage

Use of Compulsion

Misgivings persist about the place of compulsion in the care and treatment of mentally ill people. Particular expressions of these concerns in relationship to guardianship are indicated below. Compulsion is sometimes seen as less appropriate or acceptable when used in a community care context and the view is still expressed that different 'ground rules' should apply to control mentally ill people while in hospital than outside.

This has been most recently expressed by Fisher who asserts that the concept of compulsory powers in the community is fundamentally flawed since "the use of compulsion cannot be divorced from its institutional base; the compulsorily detained hospital patient cannot be translated into the compulsorily controlled community resident".⁽¹¹⁾ Similar arguments were advanced during the inter-departmental review of the 1959 Act and led to the rejection of the BASW proposals for a community care order.

A further concern arises from the prospect of 'net-widening',⁽¹²⁾ i.e. more people being brought within the ambit of statutory control than would otherwise be the case. From this viewpoint, use of guardianship would take the place of voluntary care or informal admission to hospital, but there is no evidence from the UK of a trend in this direction.

From the social services' point of view, the compulsory element in individual guardianships may be seen as more of a continuing concern than in arranging admissions to hospital under Sections 2, 3 or 4 of the Act. However it is an open question as to whether, in practice, the compulsory element in guardianship is applied on a continuing basis during the currency of the order. There may be a tendency to use initial placements arranged through guardianship to demonstrate, for example, that the experience of residential care is both viable and acceptable to certain clients.

Concern can nevertheless arise where residential care staff are uncertain as to whether they are being called upon to apply a dual standard of restraint in preventing people

leaving care - and to exercise this on a continuing rather than a 'one-off' basis - between residents on guardianship and other residents.

Credibility

There are two main aspects to the credibility of guardianship measures: the resource aspect and the question of guardians' powers.

This writer's assumption is that guardianship presupposes a sufficient level of *resource availability* to give guardians access to appropriate services for their clients. Nevertheless discussion proceeds as to whether clients on guardianship should have priority access⁽¹³⁾ to these services and whether social services should be legally responsible for providing specific services for these individuals; the absence of a specific resource requirement clause in guardianship orders to link powers needed by the guardian with services required by the client is widely missed.⁽¹⁴⁾

Despite the lack of a clear link between guardianship and provision of social services, and the absence of a mandatory responsibility upon social services to accept guardianship orders, there is persistent reference to guardianship as, at root, a social services order.⁽¹⁵⁾ Even without the requirements mentioned, there are suggestions that social services should specifically budget for guardianship and, at the very least, underwrite individual guardianship orders which carry a clear resource assumption. There is an interesting debate as to whether guardianship itself should be regarded as a service,⁽¹⁶⁾ (needing itself to be financed) or is more appropriately viewed as an enabling arrangement, i.e. a means of providing access to services - but even the latter view is not without its own cost implications.

Most commentators agree with the Royal Commission assumption that the numbers of guardianships cannot reach a realistic and appropriate level until services have grown commensurately. Against this view, is the argument that the wider the range of good quality alternative services in the community, the less likely would be a need to use authority, legal or professional, to seek to ensure that a person takes advantage of these services.

One or two commentators observe that use of guardianship arises from pre-agreement between social services and health services about the appropriate use of community facilities and this appears to link with the MHAC assumption that wider use of guardianship will result from, or be an expression of, greater degrees of co-operation between social services and health authorities. Certainly a good working relationship between social services and the health service is seen as pre-condition of appropriate guardianship usage.⁽¹⁷⁾

There is a debate concerning whether a private guardian would, other things being equal, have the same level of access to services to meet the needs of a client as would a social services social worker. Clearly, the latter could be expected to be more 'tuned in' to the local authority systems of resource allocation, though may be more influenced by management pressures and from demands of other clients. The private guardian, on the other hand, may know less about appropriate services but be better motivated to establish what is available, possibly via the client's social worker, and could then be in a more independent position to advocate for the client and press social services management to deliver the particular services required. Lack of empirical evidence on how these differences apply in practice is noted.

There are resource questions linked to the specific guardianship powers, and these are discussed below.

The *problems of guardians in enforcing the three powers* vested in them under the 1983 Act is widely discussed and the legal limitations on the enforceability of the three 'essential' powers are widely noted. These are briefly summarised below:

The Residential Requirement clauses in the Act are silent on whether the person can be compelled to enter the desired place of residence or on whether he or she can be detained on these premises, though most authorities advise that such instrumental powers do not exist. The inconsistency arising from the guardian's legal power to return an absconding client to the place of residency is widely mentioned and frequently implies a credibility issue.

The Attendance Requirement of the Act is likewise silent on whether, for example, clients can be taken to day centres against their wishes and, likewise, whether care and control can be imposed on the person whilst at that place. The absence of the power to compel treatment, e.g. at an out-patient clinic, under this requirement is widely missed.

The Access Requirement lacks clarity as to whether it extends to include any one who the guardian social worker asks to gain access - e.g. home help. There is also uncertainty about how the access condition can be enforced against clients' wishes, though forceful entry is generally proscribed. Nevertheless there remains doubt as to whether the guardian social worker would need to use other sections of the Mental Health Act to gain physical entry (e.g. Section 135) or whether guardianship powers include this authority.

Lack of 'sanctions' to enforce guardianship orders is widely commented upon, but sometimes resort to the 'more restrictive' option of detention in hospital is portrayed as an ultimate sanction, thereby giving a punitive connotation both to sanctions and to hospitalization.

The argument is frequently advanced that if guardianship is only 'workable' for people for whom such 'fall back' sanctions are not required, the guardianship concept is thereby demonstrated as redundant. Comparison with a probation order which enables the probationer to be brought back to court should he/she fail to comply with the terms of the order has often been made.⁽¹⁸⁾

Not all references to the sanctions issue are problematic. Examples are given of clients who accept the authority of the guardian to fulfil surrogate roles, having previously conveyed to the social worker that this acceptability stems from the officer's legal standing rather than his or her professional capabilities as a social worker, whose authority no longer needs to be 'tested out'.⁽¹⁹⁾

There are also examples of guardianships being satisfactorily used to 're-negotiate' the terms under which social services, such as home help and meals on wheels, are provided for the client. This is sometimes explained as a quasi-contractual arrangement by which

the client's objections are legally recognised and the social worker's (and/or others') need to over-rule them accepted. Added to this is the view that arriving at these 'understandings' is preferable on all counts to situations in which social services are simply imposed on clients without any legal safeguards - on ethical and professional, as well as legal grounds.⁽²⁰⁾

LOGISTICAL PROBLEMS

A number of practical difficulties are referred to in discussions of the management of guardianship and these are summarised below:

Supply of Guardians

Clearly guardianship cannot operate without people appropriately disposed to fulfil guardianship functions. The absence of private guardians (however qualified or pre-disposed) is frequently mentioned, often alongside the point that no training or professional background is presumed for private guardians, making it more difficult to approach recruitment questions realistically. The supply of social workers willing to fulfil this role is an unknown quantity, but it is known not to be an area of work regarded as attractive or of high prestige.

Training of Guardians

With regard to social work guardians, there are noted examples of specific training requirements which may or may not be met in practice and of some fairly obvious gaps in the knowledge of some social workers which would be likely to make them consider guardianship only as the last possible way forward. The Mental Health Act Commission particularly note that social workers need to understand the "subtle mixture of compulsion, persuasion and fully agreed co-operation" involved in guardianship work.⁽²¹⁾

Administration and Procedural Problems

Particular mention is made of delays in processing guardianship applications within social services departments, with the implication that social services are more cautious in considering guardianship proposals than the health service is in considering compulsory admissions to hospital for treatment. In other words, there is a built-in administrative 'inertia' militating against the prompt and appropriate use of guardianship. Gunn spells out this inertia factor as including lack of understanding of guardianship by social services management due to the absence of any training prescription on their part.⁽²²⁾

Clearly, a social worker considering a guardianship proposal remains in a state of uncertainty coping with the problem of the client in the community while awaiting some form of service provision or enhanced care; with a hospital order, on the other hand, the client is usually precipitately moved into a situation where care and treatment are readily made available.

SOCIAL WORKERS' ATTITUDES

Some of the problems associated with the use of compulsion (see above) are particularly the concern of social workers. In addition, some commentators feel that the degree or kind of authority they are expected to exercise, still referred to occasionally as 'quasi-parental control',⁽²³⁾ clashes with social work values related to respect for client self-determination. On the other hand, social workers who view guardianship as a form of 're-negotiation' of the terms under which social services are provided to clients, point to the fact that assumptions about mentally ill people remaining fully autonomous, self-directing adults need to be periodically tested by way of objective assessment.

Some social workers nevertheless argue that use of guardianship is tantamount to an admission of a 'failure' or of a limitation of skills on their part within the social worker-client relationship, and have this idea linked in their minds with a moral imperative only to use guardianship as a last resort.

THE GUARDIANSHIP PROCESS: CASE STUDIES AND INSIGHTS FROM PRACTICE EXPERIENCE

Case material provided to the researcher in the course of the survey is offered in Chapter V, pages 300 to 313. The limited amount of background information available on clients was frequently an issue and the cases are presented in the form of illustrative outline notes.

Appendix C is therefore set aside to present five cases in a fuller and more complete form. Two are 'fictionalised' accounts from the researcher seeking to show the thinking and actions one might expect to occur when looking at the changing course of care for people suffering from schizophrenia and dementia. The three other cases are profiles of actual cases brought to the researcher's attention during the pilot study.

PERSPECTIVE DEFINITIONS

The main perspective definition to receive attention in this dissertation is that of social workers and to a lesser extent social work managers. The researcher's own perspective, or working definition, will also be presented.

Two perspectives on guardianship are not taken into account in this research, namely the perspective of the client on guardianship and that of the person's family or nearest relative. The views of non social worker guardians are similarly poorly represented.

No attempt to reference these perspectives would be adequate in the context of the objectives of this research. It is, however, pertinent to refer to the descriptive approach of Moore, who provides a forceful personal account of her position as guardian, advocate and 'supporter' of her own mentally ill brother. She describes how she protects his interests while defending her right to make demands on professionals and statutory agencies on her brother's behalf and to ensure they fulfil their obligations towards him.⁽²⁴⁾

COMPARATIVE AND CONTEXTUAL DEFINITIONS

GUARDIANSHIP AND OTHER STATUTORY CARE RESPONSIBILITIES TOWARDS PEOPLE WITH MENTAL ILLNESS

Slater has argued that it is misleading to equate 'mental health law' with specific mental health legislation since local authorities have a wide range of powers to provide what are sometimes referred to as 'protective services' for a range of vulnerable adult care groups, including those suffering from mental illness ⁽²⁵⁾.

Arguably, it is reasonable to assume that social workers considering the use of guardianship for people with mental illness will be aware of the range of services available to their clients, whether or not on guardianship, and of the statutory basis for such provision. They might therefore be expected to know that the main reference point is a **Local Authority Circular 19/74**⁽²⁶⁾ which identified local authorities' requirements to provide services as being:-

- "the provision...of residential accommodation (including residential homes, hostels, group homes, minimum support facilities etc) for persons [living within that local authority's boundary or who are homeless] and the care of those persons;
- "[similar provision for people coming from other areas] following discharge from hospital;
- "[provision of day care centres] for training or occupation of persons suffering from or who have been suffering from mental disorder, [including meals, remuneration and other] facilities for social and recreational activities;
- "the appointment of officers (normally social workers) to act as mental welfare officers for the purposes of the Mental Health Act 1959 - [now superseded by arrangements to appoint Approved Social Workers under the Mental Health Act, 1983];
- "the provision of social work and related services to help in the identification, diagnosis, assessment and social treatment of mental disorder and to provide social work support and other domiciliary and care services to people living in their homes and elsewhere."

The Circular went on to confirm that local authorities could provide residential, day and social work services to people suffering from mental illness.

Another important reference is the National Health Service Act, 1977, in which Section 2(1) of Schedule 8 provides that: "the local authority social services authority may... make arrangements for the purposes of the prevention of illness and for the care of the person suffering from illness and for the aftercare of persons who have been so suffering".

In addition to the sections on guardianship, the Mental Health Act, 1983 made important statements as to obligations to provide: a sufficient number of ASWs (Section 114(1)); statutory aftercare, but not applicable to those on Guardianship (Section 117); and to provide authority for ASWs to obtain access to a person's home when they believe that a person suffering from mental illness is being seriously neglected (Section 135) - see also under 'Compulsory removal from Home', page 46.

The Disabled Persons (Services, Consultation and Representation) Act, 1986, sought to improve coordination, effectiveness and access to services for people with mental illness (among others) and to establish the principle of an 'authorised representative' who could speak for the person's needs as an advocate, but this latter section has yet to be implemented.

Also still to be implemented is Section 7 of the Act which would have strengthened local authority responsibility for providing after-care to psychiatric patients who had been in hospital longer than six months. The Social Services Select Committee Report for Session 1989/90⁽²⁷⁾ argued that this section of the Act should be implemented as soon as possible (Recommendation 23), to which the Government's response has been that the Care Programme Approach, as promoted in Circular HC(90)22/LASSL(90)11, "operationalises good practice" in this area, so that statutory obligations will only need to be imposed on health and social services authorities "in the event of failure to meet voluntarily the required standards".⁽²⁸⁾

National Health Service and Community Care Act, 1990

The Government's response to the **Griffith's Report**,⁽²⁹⁾ the White Paper, **Caring for People**,⁽³⁰⁾ is implemented within Sections 46 and 47 of this Act, viz.:

- Section 46 requires each local authority to "prepare and publish a plan for the provision of community care services in their area"; to keep this plan under review; and to prepare and publish modifications of the plan, or to prepare a new plan, as and when required.
- Section 46(2) requires local authorities to consult District Health Authorities, Family Health Service Authorities, housing authorities and voluntary organisations in the construction of this plan.
- Section 46(3) defines 'community care services' as those "which a local authority may provide or arrange to be provided under any of the following provisions:
 - a. Part III of the National Assistance Act, 1948;
 - b. Section 45 of the Health Services and Public Health Act, 1968;
 - c. Section 21 and Schedule 8 of the National Health Service Act, 1977; and
 - d. Section 117 of the Mental Health Act, 1983."
- Section 47(1) requires local authorities to carry out assessments of those who appear to be in need of these services to decide whether these call for provision of the services.

COMPULSORY REMOVAL FROM HOME, AND IMPOSITION OF CARE AND TREATMENT

Alongside powers under statutory guardianship, two other sets of compulsory powers need to be taken into account:

National Assistance Act, 1948, Section 47

This Act provides for the removal from home of persons thought to be living in unacceptably unhealthy conditions, whether due to mental illness or other reasons. For

example, a recluse who has shut him/herself away and avoided contact with the outside world over a long period may be neglecting themselves and their dwelling to a point where they become a health hazard. In these circumstances (with elderly people mainly in mind) arrangements can be made to enforce access to the premises and remove the person to a suitable care situation - normally a home for the elderly but not necessarily so.

Although the emphasis has tended to be on a set of circumstances which gives rise to public concern, together with an unacceptable health risk, there is also the implication that the alternative arrangement for the person concerned must be appropriate to their needs and this does not necessarily signal the end of independent living. Sometimes it results in arrangements being made to clear and clean the premises to make them more comfortable and acceptable for the person and their immediate neighbours. From a civil rights point of view, it has to be borne in mind that neighbours and would-be helpers will be greatly deterred from assisting a person if the health hazard element cannot be tackled by official sanction and effective intervention. Obviously, this has particular relevance for people in multi-occupied premises.

This section of the National Assistance Act is rarely used, yet has generated controversy over the years.^(31/32) In comparison with guardianship, the missing link is obviously an individual representative of care agencies to take necessary steps to advocate for the client as well as to intervene. The quid pro quo principle is also poorly developed - though possibly implicit.

The Law Commission have recently expressed views (not supported by clearly referenced evidence) which, they suggest, apply both to these arrangements and to those pertaining to Section 135 of the Mental Health Act, 1983 (see above) to the effect that they provide powers which:

"are generally regarded as draconian and stigmatising and are rarely used...[It is difficult] to achieve the correct balance between the individual's right to live as he (sic) wishes, even if such wishes are delusionary or in most people's view extremely eccentric, and the need for protection from unnecessary suffering or danger." ⁽³³⁾

Mental Health Act, 1983, Sections 2, 3, 4

The 1983 Act is largely concerned with the terms and conditions for the removal of a person from a dwelling or public place, and their admission to a psychiatric hospital, detention there, and possibly subject to compulsory treatment. Although the relevant criteria relate both to the needs of the person and to the needs of others, there are a number of elements missing from the point of view of a guardianship concept. Again, there is no individual professional to accept care responsibility for the client as part of the compulsory admission arrangement other than the ASW. Legally, responsibilities of ASWs cease at the time the person enters hospital, unless he/she chooses as an individual professional to find means to stay in contact with the client and exercise *de facto* care responsibility.

On the other hand, a compulsory admission to hospital may be part of a long-term care programme with a designated social worker arranging for the admission to take place at a particular time. Arrangements would ideally be determined in conjunction with other professionals and agencies providing necessary care and treatment for this person as he/she becomes too psychiatrically ill to remain at home. In other words, the *manner* of the hospital admission may distinguish the effect of this procedure, from being a contingency dominated event to one which is a part of individual care and continuity of intention. In this latter sense, therefore, the procedures may carry a guardianship connotation, and indeed may be used in conjunction with existing guardianship arrangements.

GUARDIANSHIP AND HOSPITAL COMPARED

This section identifies the key distinctions between hospitalisation and guardianship, especially necessary since the official literature and other influential commentaries continually refer to guardianship and to care and treatment within hospitals as alternatives.

The historical definition in Chapter III will set out to demonstrate that guardianship has a history independent of the rise and fall of psychiatric hospitals, and that the only

dependent relationship between *guardianship and hospital* is when hospitals are viewed as social services to which guardianship clients gain access as and when appropriate. In other words, rather than these institutions being seen as alternatives, it would be more appropriate to see them as interdependent, interrelated, but essentially as separate and distinct, institutions with different legal, social and practical implications.

Dictionary Definition of 'Hospital'

A suitably adapted dictionary definition of a psychiatric hospital is "an institution for the receipt and containment of people with mental illness".

Clearly this definition does little justice to the wider functions of hospitals. For example, Bachrach describes the social function of psychiatric hospitals as providing or promoting:

- "Personal and social care
- Containment
- Independence (assisting in the development of individual and social functioning)
- Social relationships".⁽³⁴⁾

Aside from 'hotel' elements (food/heating/lighting/bed/shelter/physicalcomfort), hospitals could be said to provide the following:

1. ***Fixed Physical Boundaries*** - This is linked to the degree of security required, and in some cases internal and external boundaries will be firmly fixed by physical restraint.
2. ***Proximity and Location*** - Obviously, hospitals occupy a fixed physical position, either more or less integrated into the community or, as in the case of a number of the older psychiatric hospitals, some distance from centres of urban population. The implications of this factor, besides the physical distance of the patient from his community of origin, concerns

visiting and communication aspects of hospital life *vis-à-vis* the patient's family. Travelling time and expense for families of patients are very important factors, interrelated with both treatment and rehabilitation prospects and have a great affect on whether families to stay in contact with, and are sympathetic to, the treatment requirements of their family member.

3. ***Organisation and Staffing*** - Hospitals are run by medical and lay hierarchies and maintained by a range of different groups of staff, usually offering specialist skills and functions, and usually in a more or less fixed ratio to the number of patients in the hospital.
4. ***Regime*** - Most psychiatric hospitals provide a routine, including a programme of activity supporting the treatment programmes of individual patients. Sometimes the activity and treatment programmes coincide, as, for example, with arrangements for group psychotherapy or individual counselling.
5. ***Statutory Recognition and Authority for use of Compulsion*** - Clearly hospitals need to have a statutory basis for their lawful functions, especially when they are required to detain people and to impose compulsory treatment. The fact that hospitals have such legal status is often taken for granted, possibly because most medical care and treatment is seen as a service to the patient rather than an imposition. However, in the case of psychiatric patients who are resistant to care and treatment in hospital, the status and standing of a hospital as a lawful place to contain and detain patients is of critical importance. This in turn is linked with logistical factors related to physical capacity to detain and contain.

Key Distinctions

By contrast to hospital, guardianship could be seen as a freestanding framework for the care and control of mentally ill people independent of physical establishments or institutional care. On the other hand, many guardianship arrangements will depend for their maintenance on the availability of social services, including hospital care, all of which contain some degree of institutional restriction. Under guardianship, the guardian's role is to ensure that the patient/client/ward receives the most appropriate care and medical treatment, and this may include hospital or other institutional care.

Guardianship in itself presupposes no fixed physical situation within which care and protection are administered - this will depend on individual needs. Hospital care, on the other hand, assumes some containment or restriction within the hospital environment - although increasingly hospital care is also assumed to include long leave and rehabilitation periods in the community, as well as the confinement imposed through the physical constraints of secure units and fixed boundary wards.

Guardianship and hospital care are often viewed as fundamentally distinguished by their different authority and accountability bases as between local authority and the health service respectively. This might be seen to be the key reference point for understanding the respective roles and responsibilities of guardians and consultant psychiatrists. Nevertheless, few of the other hospital characteristics listed above apply to the institution of guardianship, in that the latter presupposes no fixed staff ratios, no predetermined daily routine or regime, and no fixed relationship to treatment arrangements, compulsory or otherwise. It might therefore be assumed that these are concepts which do not bear more than superficial comparison.

One way of testing this proposition is to consider the areas where the two concepts interrelate, namely in the situation of people on guardianship who are also patients in hospital. This could apply to informal psychiatric patients as well as to those admitted to hospital under Sections 2 and 3 of the Mental Health Act, 1983. It is assumed for the purposes of this discussion that the medical needs of these people are unexceptional and

that the hospital regime would thus be imposed in a similar way to other patients with comparable conditions. Given the position of a person for whom both statutory authorities share concurrent responsibility (while in hospital), how are the respective contributions to care, treatment and rehabilitation affected?

An initial pragmatic assumption might be that the authority position of the guardian would diminish on admission and be resumed progressively as discharge nears, since the authority of the medical hierarchy prevails over all hospital patients. The position of the guardian would not therefore be a central feature of hospital treatment arrangements, but would be expected to be brought into the clinical case conference to help determine the pattern of treatment as well as future rehabilitation arrangements.

The above does not, however, take into account the statutory authority of the guardian, and he/she should be recognised as a person with a statutory as well as a moral interest in the welfare of the client without necessarily directly influencing patterns of care and treatment within the hospital. The fact that the client was on guardianship could therefore critically affect preparation for rehabilitation and discharge timing because the support systems offered by the hospital would presumably be progressively withdrawn as a person moves from institutional care into normal community care. The assumption may well be that the guardian would be the formal means (as advocate and facilitator) through which alternative arrangements in the community would be arranged.

Realistically the position would seem to be that a guardian effectively delegates authority to medical staff during the period of hospital care. This compares with the situation of a person not under guardianship, where decisions about care and treatment will typically be a matter between social workers and general practitioners on the one hand and nurses and consultant psychiatrists on the other, who will share some degree of guardian-like responsibilities without the explicit obligation to safeguard the position of the individual in a social care sense. Conversely the situation would be reversed were it to become legal to administer compulsory treatment in the community with the consultant psychiatrist accountable to a guardian.

Finally, the most fundamental difference between guardianship and hospital is seen by Fisher as derived from different 'ground rules' regarding the use of compulsion, whereby detention and containment is logistically and morally acceptable in hospital but not elsewhere. Again, this does not recognise the situation of guardianship patients in hospital but Fisher has also pointed out that the SSRG survey results indicated that guardianship was not in fact being used as an alternative to hospital.⁽³⁵⁾

A key distinction between hospital and any form of non-hospital care is often assumed to lie in the extent to which hospitals inevitably restrict patients' freedom, whether or not this is needful for patients at any given time. Clearly, when a guardianship patient is in hospital the level of restrictiveness (other things being equal) would be the same as for other patients.

A guardianship patient who is outside hospital will obviously not be subject to the restrictiveness of hospital life, though this says nothing of other restrictions which may apply instead - i.e. those imposed by the patient him/herself, by his/her family, or by a highly restricted way of life, with family or in a residential care home.

It is nevertheless self-evidently true that all institutions impose their own rules and that residents have to comply with these rules whether they meet the needs of the individual or not. In this sense, institutional life is inevitably more restrictive overall than normal life in the community.

The doctrine (or principle) of the **least restrictive alternative** is discussed in Chapter IV in the context of the proposition that guardianship is better able to fulfil these less restrictive expectations than hospital care, or possibly other forms of care. (See pages 193 to 197).

This paper does not seek to enter the debate over whether hospitals are still needed to provide asylum or whether, as suggested by Renshaw,⁽³⁶⁾ following Bachrach⁽³⁷⁾ and the 1985 Social Services Select Committee Report,⁽³⁸⁾ asylum for certain people with mental illness can be provided for equally well in the community, given certain pre-conditions. However, guardianship may well be one of the less tangible means of creating and

maintaining such conditions as a possible alternative to hospital for particular individuals in certain circumstances.

GUARDIANSHIP TYPOLOGIES

KEY DISTINCTIONS AND GUIDE TO LATER REFERENCES

The sections below provides a resumé of the forms of guardianship applicable to people with mental illness which have current relevance to the situation in England and Wales, and clarifies key distinctions. This is followed by an outline guide to other guardianship categories discussed in more detail in Appendix D.

Guardianship of the Person and Guardianship of the Estate

Discussion in the historical chapter indicates that distinct concerns over the welfare of the person and the security of the person's estate have been differentially provided for throughout guardianship history. The current relevance of the divide is to be found in the 1983 Act where guardianship of the estate is clearly located within the province of the Court of Protection. This paper is essentially concerned with guardianship of the person, though some references to the role of the Court of Protection and the possibilities of bringing these two forms of guardianship together as a possible way forward for guardianship, are indicated at various stages.

It is interesting to note that Scotland has retained forms of guardianship which can cover both person and estate - i.e. tutors dative and tutors-at-law (see page 58). It is also of note that two North American terms for guardianship of the estate are 'trusteeship' and 'conservatorship', though this is subject to variations between different states and between the USA and Canada.

Generic and 'Specialist' Guardianship

The forms of guardianship referred to in this paper apply only to people with mental illness unless otherwise indicated. However a discussion is offered in Chapter IV on the connection between this form of 'specialist' guardianship and 'generic' guardianship

(i.e. Guardianship in legal systems which provides protective care on the same basis for people from different care groups), when considering the therapeutic model of guardianship. Generic guardianship has no current relevance under the legal system applying in England and Wales, but is referred to as an important development in the USA, Canada, Australia and New Zealand, where generic terms, such as 'dependent persons', have been coined to cover mentally ill people alongside other people with some apparently similar care and protection needs.

Limited and Total Guardianship

Guardianship for people with mental illness in England and Wales up to 1983 was usually thought of as 'total' guardianship, in that the powers of the guardian have been defined as those of a parent over a 14-year-old child and were not specifically limited, other than by the divide between person and estate. In some ways all guardianship which does not combine person and estate could be described as a form of limited guardianship, but this usage is not adopted in this paper.

Limited guardianship applies to systems operating with variations in the USA, Canada, Australia and New Zealand, whereby petitions are brought before a court asking for a guardian to be granted powers in relation to a ward, leaving the court to decide the nature and extent of such powers. No such system applies in England and Wales, where guardianship powers are predetermined by the legislation. However, in another sense of the term, the 1983 Act can be described as prescribing a form of limited guardianship in that it refers to the guardian having limited powers, i.e. the minimum essential, rather than a full range.

The possibility of semantic confusion in this explanation is compounded by the fact that 'total' powers is a misnomer. Equating total powers with the powers of a parent over a child is seriously misleading because of the strict limits which apply to the powers parents may exercise over children, depending on circumstances, age of child, etc.

Likelihood of confusion may be partly lessened by the following form of categorisation:

Plenary : This is a term to describe situations in which the guardian has 'total' powers, as defined in legislation or as prescribed by a court. It should be noted, however, that 'total' conveys a different concept to 'complete', and no legal system allows a guardian to have complete control over a ward, while few systems (none in England and Wales) allow a guardian to exercise power and control over both person and estate.

Limited/Fixed: This is the situation where guardians have specific powers assigned to them. In England and Wales this is defined by mental health legislation. In other words, the specific powers are statutorily defined and in this sense pre-empted.

Limited/Variable: This also refers to a guardian with specific powers assigned, but indicates a situation where a court can vary these powers and tailor them to the particular needs of the individual. This applies to a number of countries outside England and Wales, but has been put forward as a possible way forward in developing guardianship in this country.

Guardianship Authority and Agency

In England and Wales, the authority of the guardian stems from the legislation, but in practice this is enforced through the position of the director of social services and delegated to an employee, usually a social worker. In other countries guardians may be anyone that a court considers is suitable to exercise powers in relation to an individual mentally ill person. Sometimes the guardian may be individually chosen, possibly by the ward him/herself, and can represent any agency or profession. Alternatively, the guardian might be a representative of a specifically designated guardianship agency, especially applicable if the person is in the residential care of the prospective guardian. None of these considerations apply directly to the situation in

England and Wales,* though the idea of discrete guardianship agencies, recommended by the San Sebastian conference on guardianship in 1969,** is still discussed from time to time.

The above distinction remains important to understand because the social work background of guardians in England and Wales is defined by the authority base and legislative framework, whereas the professional background of guardians elsewhere is not so defined. Furthermore, the professional background of private guardians under the legislation applying in England and Wales has a similarly indefinite characteristic.

Guardianship and Institutional Care

A very broad definition of guardianship might convey that any form of formalised care could be described as guardianship, whether offered in hospitals, institutions or in the community and by whomsoever it was offered. Under the law applying in England and Wales, guardianship might be seen as a care arrangement operating outside institutions. However this view is by no means universal and is not historically true in Britain. Guardians in other countries continue to do what guardians were allowed to do under the law in England and Wales in earlier times, namely to provide for the care of their wards in institutions, including hospitals, when the situation requires this.

Two residual remnants of this situation currently apply in England and Wales: (i) in the statutory arrangements whereby guardianship powers can continue in certain circumstances while the mentally ill person is informally residing or compulsorily detained in hospital; and (ii) the residential placement aspect of guardianship powers which enables a residential care home to be the designated place of residence for a client under guardianship.

* An apparent exception is the Brighton Guardianship Society (renamed the Grace Eyre Foundation in 1988), which seeks to provide an environment to create learning and life experience opportunities for people with mental handicap placed by local authorities. Although the Society was particularly hoping to receive clients under guardianship as per the Mental Deficiency Act, 1913, it now concentrates on helping clients as a placement agency, whether or not they are under statutory guardianship.

** International League of Societies for the Mentally Handicapped, 'Symposium on Guardianship for the Mentally Retarded', at San Sebastian, Spain.

The connection between institutional and non-institutional care under guardianship is further pursued in the discussion of the therapeutic model of guardianship - apropos residential care, commencing page 188.

Statutory and Non-Statutory (Informal) Guardianship

Statutory guardianship in England and Wales is guardianship provided for under the terms of the Mental Health Act, 1983. 'Non-Statutory' guardianship could therefore be a term used to describe situations where social workers, for example, provide a relationship with a client which carries one or more guardianship characteristics (e.g a degree of surrogacy) but where the social worker has not sought statutory powers. A more apt term for these situations, and the one that is used in this paper is **informal guardianship**. However, another form of non-statutory guardianship, presently only applicable in Scotland, is described by Ward as **personal guardianship**⁽³⁹⁾ - see below.

Personal Guardianship and Committee

Ward's use of the term 'personal guardianship' describes the Scottish situation in which other forms of legally prescribed guardianship exist alongside a statutory version (which latter is very similar in effect to its English counterpart). These alternative forms of legal guardianship are tutors dative and tutors-at-law, derived from Roman (Scottish) civil law. Tutors are guardians who can be given total powers or a range of powers by the court.

There is clear likeness between this Scottish form of personal guardianship and the English counter-part, **committee**. Past and present significance of committee as an English form of personal guardianship is discussed in the chapter covering the history of guardianship, from page 90 onwards and further information on committee is contained in Appendix D.

Private and Public Guardianship

The Law Commission are currently proposing a range of supplements to statutory guardianship, which could formalise powers of family and carers to determine aspects of a mentally ill person's life, and provide a basis for the introduction of 'personal managers'. They also suggest, following Section 5(1) of the Children Act, 1989, provision for a range of specific orders to determine, for example, where a person shall reside. These are collectively referred to as 'private law bases for substituted judgement' and, if adopted, would entail removal of so-called 'private guardians' from the mental health legislation, i.e. the 'public' law provision in this area.^(40/41/42)

HISTORICAL TYPOLOGIES (See Appendix D for more detailed discussion)

In the historical account (Chapter III, page 96) reference is made to a review of guardianship arrangements undertaken by the *Royal Commission on the Care of the Feeble-minded, 1904/8*, the only official analysis of the scope and significance of types of guardianship. The Commission mainly considered and described:

Collective ('Colony') Guardianship, with special reference to the family colonies at Gheel, Belgium.

Boarding Out/Family Placements, i.e residential care arrangements arising from guardianships, especially associated with the Scottish system.

Curator Bonis, the Scottish equivalent of the Court of Protection, as distinct from Scottish guardianship of the person (tutors dative and tutors-at-law).

Council de Famille and Curatelle, i.e. guardianship arrangements operating in France and in the Channel Islands respectively.

Wardship; the Commission also provided an illuminating comparison between guardianship and wardship for children.

'Legal' Guardianship. Finally the Commission examined so-called 'legal guardianship', apparently looking for an equivalent to committee which would not require inquisition proceedings. The Commission made no reference to previously legislated guardianship fulfilling this role.

Also of historical relevance to people with mental illness can be noted:

Feudal Guardianship, a 'Generic' form of guardianship linked to land law up to 1660;

Chancery/Civil Law Guardianship, a 'shorthand' term for the pattern of guardianship from 1660 onwards, particularly expressed via the form of committee;

Canon Law and Borough Guardianship, obsolete forms of guardianship specifically intended to meet the needs of mentally ill people (but outside the 'mainstream' of historical development) which also illustrate 'derivative' forms arising from canon law and delegated Royal Prerogative powers respectively;

Quasi-Guardianship, arrangements arising from guardianship which could be referred to as quasi-or secondary guardianship. The former term (discussed in the section on the historical perspective of the Percy Commission, page 98) emphasises arrangements such as 'single care' which might have arisen from formal guardianship.

HISTORICAL DEFINITION

Historical perspectives on guardianship are contained in Chapter III and these include discussion of the context within which the history of guardianship needs to be seen.

DEFINITION BY CONCEPT ANALYSIS - THE USE OF MODELS

Models of Guardianship have been put forward in an attempt to define the subject by highlighting different, and sometimes contrasting, underlying assumptions. Detailed consideration of various models, and their relationship to social work is a main part of Chapter IV, page 173 onwards.

In anticipation of this discussion, reference can be made to the three model framework adopted by Frolick considering the:

1. *Substituted Judgment*, legalistic, or advocacy model;
2. *Parent/Child*, developmental or case-work model; and
3. *Therapeutic*, welfare or case management model.⁽⁴³⁾

An alternative formulation offered by McLaughlin⁽⁴³⁾ distinguishes the legalistic (broadly as above) from a 'social work-istic' model, which latter combines Frolick's models (2) and (3).

SUMMARY AND WORKING DEFINITION

SUMMARY OF DEFINITIONS

The following draws out the salient features of the definitions discussed above, identifies points of convergence and contrast and employs this framework as a basis for formulating the researcher's working definition.

The **Dictionary Definition** clearly distinguishes between the legal basis for guardianship and guardianship in the general sense. This is taken to be a distinction between the law of guardianship and the social institution of guardianship.

The **Perspective Definitions** considered are those of social workers - the main subject of this research - and that of the researcher - see working definition below.

The **Statutory Definition** emphasises guardian's powers and their limits, conveying that such powers should rarely be needed, so that guardianship itself will seldom be necessary. Although the purposes of guardianship are identified, e.g. to prevent neglect, actual obligations to clients in clearly identified duties and responsibilities are limited to stating that guardians must visit their clients, and that clients must have the services of a registered medical practitioner.

The **Operational Definition** commences from different qualitative and quantitative assumptions, being concerned with the actual pattern of 'usage' in terms of: 'supervision' (assuming that statutory visiting is the basis for supervision); promoting welfare; and exercising surrogacy, as an implied function.

The problematic side of guardianship usage identifies the limited enforceability of powers; ethical issues over the use of compulsion in the community; and the credibility of the institution overall, especially without statutory authority to provide guardianship clients with services by virtue of the guardianship order itself.

The **Process Definition** emphasises through presentation of case studies that guardianship is not primarily a measure which will induce radical and sudden change, but that it provides a basis for gradual renegotiation of positions between the authority base of the guardian/provider and that of the client. It presumes that the appropriate use of authority within guardianship is potentially of positive benefit and does not inherently contradict good professional practice.

The **Comparative/Context Definition** looked at guardianship in relationship to a range of service-providing obligations on local authorities - services which might be alternatives to or complementary to guardianship, and to which guardians could be in the best position to require access on behalf of clients. This definition also explores the link with other compulsory measures, mainly related to removal from home and hospital admission. The definition helps to establish that hospital and guardianship are not alternatives in the general sense as distinct from possible options for clients in certain circumstances.

Finally, this definition locates guardianship within the new community care policies in relation to:

Client choice, self-determination and needs assessment;

Case management;

The care programme approach and care management.

The **Typologies Definition** makes key distinctions particularly between limited and total guardianship and between informal and formal (personal/statutory) guardianship.

The **Historical Definition** defines guardianship in terms of the evolution of a particular form of trusteeship, seeing the ideas behind tutorship and curatorship as having a continuing influence on contemporary guardianship developments.

This view of the history of guardianship sees it as a claim for recognition of the need for enhanced levels of care and accountability towards individual people with mental illness - as distinct from collective, or care group responsibilities latterly defined within welfare legislation. No such individual recognition of need or accountability in meeting that need can be exercised without the presumption that the guardian role carries authority - both authority towards the client and in making claims on services.

The idea of the guardian as a committee, i.e. someone to whom a mentally ill person is 'committed', has provided another historical route towards understanding the guardianship idea in practice. Although the idea of commitment in the literal sense appears anachronistic, there are also grounds for arguing for the reactivation of committee in modern form.

The **Concept Analysis Definition** relates to models of guardianship discussed in Chapter IV. This provides perhaps the most distinctive identification of guardianship characteristics by linking the exercise of surrogacy in practice to advocacy,

casework and case management roles and tasks of social workers, as a differential response to particular needs of people with mental illness.

Consideration of guardianship models goes wider than a basis for definition under 'concept analysis'. Not only are the models used to make comparisons with the social work functions of advocacy, casework and case management, but the models are also used to provide a framework for interpreting results of the survey related to social workers' attitudes.

The models are also the most influential concept in shaping the researcher's working definition (see below).

WORKING DEFINITION

The researcher's working definition provided below draws eclectically on the above definitions as well as expressing its own perspective. It commences with a particular view of mental illness influencing views on use of guardianship to meet the needs of mentally ill people.

The researcher's assumption is that mental illness is often associated with:

- (1) Difficulties with decision-making and choice, i.e. in being able to decide, and in making choices in the client's own best interests. This is seen to be the basis for the substituted judgment model of guardianship, expressed as surrogate advocacy.
- (2) Disturbed relationships, affecting availability of support and understanding from relatives, friends etc.* In the face of this guardianship reveals a 'parent/child' model comparable to casework.

* These problems are not peculiar to people with mental illness but tend to be more obvious, longstanding and socially destructive, e.g. with problems in connecting with services, neglect of self or in causing harm to others.

- (3) Specific care and treatment needs, particularly those requiring consistency and persistence by service providers to compensate for limited volition. This requires case managers to adopt the surrogate role in imposing services when necessary.

Guardianship offers a means of recognising these difficulties in their specific individual contexts, bridging the tasks of assessing, purchasing, commissioning and providing - related to client need rather than service availability.

The guardian is one who uses authority beneficially through advocacy to compensate for lack of capacity in the individual mentally ill person to deal with these problems without taking over the individual's affairs any more than is absolutely essential. Conversely, the guardian is also aiming to restore the ward to his original (pre-illness) position, with full civil rights and the ability to make appropriate decisions or to work towards achieving this situation for the first time, where this applies.

While guardianship is in force the legal system supports the guardian's surrogate decision-making and expects guardians to act in the client's best interests. The guardian is therefore given the responsibility of influencing the client's life style either in a general (total) sense or in a specific (limited) sense. The researcher's assumption is that guardians should ideally be able to require and to obtain a range of powers between total and limited powers in order to deal with the particular situation of the client, as has recently been shown to be the way forward in the Scottish case of **Morris**.^{*} This would seem to be the most rational, ethical and parsimonious basis for surrogacy.

The authority of the guardian to act as surrogate includes his/her standing and credibility; this in turn includes the capacity to gain access to services and resources which will meet the needs of the ward. This will sometimes entail prioritising the ward's needs against those of other service recipients with apparently similar needs. The justification for this is twofold:-

* See page 147

1. The client may already have undergone a total or partial suspension of civil rights. To this extent he/she requires compensation in the form of ease of access to required services, usually referred to as the quid pro quo principle.
2. The authority and standing of the guardian is important to the credibility of the institution itself. If the guardian cannot command access to appropriate services to meet the needs of the client, his/her position will be untenable.

In brief, therefore, guardianship should be viewed as a social institution, rather than a statutory arrangement, through which the special care and protection needs of mentally ill people are met by the exercise of authority of the guardian. The ethical basis for this use of authority is that of trust - both in the moral sense and in its historical connection with trusteeship. Arguably, the legal basis of guardianship for mentally ill people is more closely related to trusteeship, wardship (or even custodianship) than with statutory provisions such as the Mental Health Act. As will be discussed at a number of points during this paper, it is misleading and possibly incorrect to equate the nature of guardianship with powers provided for under the legislation.

Defining the nature of the guardian-client relationship is difficult since one may assume that it has evolved pragmatically without a theoretical base. This writer considers that the nearest prescription of the guardianship relationship can be derived from an analysis of research by Stein and Test⁽⁴⁵⁾ on what constitutes the most effective form of care for people with mental illness - i.e. effective in the sense of preventing the need for unnecessary admission or re-admission to hospital and providing the best possible chance of a person living a normal life outside an institution. These attributes, discussed in more detail later, consist of:

- * A reliable person, able (through experience and training) to provide or organise good quality care.
- * Skilled interventions which are as persistent and assertive as need be given the situation of the individual. This could include the use of compulsion in the imposition of care or treatment.

- * Services made available continuously or as often as is necessary to optimise their effectiveness; and not left to chance or the vagaries associated with variable motivation of client or providers.

Though referring mainly to making effective services available, the research clearly indicates that access is not simply or mainly an administrative matter; rather it is a function of a personalised form of care which will continue to respond to the needs and difficulties of the person over as long a period as is necessary to stabilise them into as normal a form of living as can be achieved for that person in terms of daily activity, friendships and relationships, contacts with family etc., all of which would take place under the least restrictive conditions practicable.

'Restrictiveness' as a key variable within guardianship relates to different needs of individuals, and guardians are advantageously placed to ensure that this is not applied unnecessarily or punitively. In other respects guardianship is not inherently more or less restrictive than other care frameworks - especially since guardianship patients may need to spend periods of time in the restrictive care of hospital.

In summary, guardianship for mentally ill people implies a special form of accountability to answer for, and meet the needs of, individual mentally ill people. It is clearly distinguishable from collective solutions to meeting care needs of which hospitals are the most obvious examples. No collective care arrangements can adequately meet individual needs for consistent, persistent and assertive care with the firm assurance that only an advocate acting in the capacity of surrogate can provide. The surrogate element stems from the presumption that people with mental illness look to others to speak, act and decide for them while ill, as under condition of illness their own ability to articulate their needs cannot be presumed.

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CHAPTER III

GUARDIANSHIP HISTORY AND RECENT DEVELOPMENTS

This chapter covers the following areas:-

- ISSUES OF HISTORICAL DEFINITION AND CONTEXT
- SUMMARY OF HISTORICAL DEVELOPMENTS NOT GIVEN FURTHER ATTENTION
- OUTLINE NARRATIVE TO 1983
- GUARDIANSHIP UNDER THE MENTAL HEALTH ACT, 1983
- THE CODES OF PRACTICE, 1985-1993
- THE MENTAL HEALTH ACT COMMISSION, THE BIENNIAL REPORTS, (1983-1991) AND SPECIAL GUARDIANSHIP
- SUMMARY OF RECENT DEVELOPMENTS
- MAIN GUIDING PRINCIPLES

RESTATEMENT OF HISTORICAL DEFINITION ISSUES AND THE QUESTION OF CONTEXT

The idea of a historical definition, referred to on page 16, emphasised the importance of considering whether the subject being defined has changed in important ways over a given period; so that not only does one look to history for a narrative of events with their causes and effects but to be able to identify how the series of changes have cumulatively determined the present form of the subject.

The first question to arise from this formulation is the period of time over which development is traced. In the case of guardianship, most authorities suggest that Roman law and culture is the most important starting point for understanding how guardianship came about and how it has evolved. This is not to say that earlier cultures did not show

clear signs of recognising the guardianship concept (see page 81 - footnote). However, the importance of starting guardianship history from Roman times rests on the need to understand Roman guardianship and its immediate as well as indirect impact on contemporary guardianship considerations. The indirect nature of this connection is explained at the commencement of the narrative, page 80.

Although, in theory, one could jump straight from a discussion of Roman law through to tracing its influence on the contemporary situation, a narrative of developments in between is necessary in the absence of a standard reference work in order to understand how thinking about the relevance of Roman guardianship concepts to England has changed at various stages.

This researcher's working definition places the guardianship concept within a framework wider than the law towards a social institution for the care, control and welfare of people with mental illness. It is therefore necessary to understand how the reality of providing such a care framework varied from time to time. The idea of maintaining such a framework in contemporary circumstances is seen largely as dependent on the availability of services to which the guardian has access and which effectively provide a support system both to the client and to the guardian. Many of the ideas about guardianship in earlier times did not carry such assumptions in terms of tangible service provision but did carry other supportive assumptions about the nature and behaviour of other people, especially in terms of the client's family and their responsibility for care of the person.

The following account traces guardianship as **an evolvement of individual care responsibilities for people with mental illness by guardians, the legal authority required and the practical means available to support these arrangements.** The latter part of the history identifies these means more specifically as social services and for some purposes includes hospital care as a social service in this context. As has been carefully shown in the section comparing guardianship with hospital (pages 48 to 54) it is inappropriate to see guardianship as an alternative to hospital. It is therefore equally inappropriate to see the history of guardianship as the history of 'non-institutional' (or simply 'non-hospital') care of mentally ill people other than in particularly defined circumstances, which are discussed below. It is interesting to note, however, that the

origins of guardianship go much further back than the origins of hospitals and that the present run-down of hospital care suggests that their demise may be fairly close. Consequently, the rise and fall of hospital care could be said to have taken place in parallel with the much less spectacular but more long lasting developmental path for the guardianship concept.

This researcher adopts Kittrie's broader historical perspective, in distinguishing guardianship both (a) from commitment arrangements for those mentally ill people who offend or whose behaviour is dangerous; and, (b) from the Poor Law which provided so-called 'guardianship' for impoverished mentally ill people, usually by means of the Workhouse.* Both these latter involve institutional, segregated, collective and impersonal solutions to the problems of mental illness which, though arguably necessary in a given context, actually run counter to the guardianship concept identified by the researcher.

For the sake of clarity, listed below are historical contexts and developments which are not expressly addressed in the historical narrative offered below. They are not included because they do not constitute the historical definition of guardianship *per se* but are referred to in passing as more or less relevant at various times. For the most part, also, they are already well documented and referenced, whereas the history of guardianship as a social institution for mentally ill people in England has not been adequately covered anywhere in the literature.

* "The authority for the State's exercise of great power over the person of the insane may be traced to three distinct conceptual sources fundamental to the Anglo-American political system:-

1. The State as protector of the peace may exercise its general policing powers in all cases where public order is disturbed or threatened...[including] the right to restrain the violent...[and] confining of 'furiously mad' individuals in order to stop or prevent acts of violence. [These powers have been] subsequently amplified by specific commitment laws.....

2. A second source for the State's authority was contained in the recognition of the Sovereign's position as *parens patriae*, [i.e.] guardianship of the person and control of the property of the legally disabled....

3. The power asserted by the Crown over the indigent insane as members of the pauper community is the third source of State authority [imposed] by the famous Poor Law of Queen Elizabeth [under which] the destitute insane were generally accorded the same treatment as paupers and both were exposed to the same experiments in public welfare, [such as 'out-relief', the failure of which meant that] well-regulated workhouses were finally recognised as the only proper form of care for the poor [and eventually as inappropriate places for the care of mentally ill people]." (1)

HISTORICAL DEVELOPMENTS NOT GIVEN FURTHER DETAILED ATTENTION IN THIS DISSERTATION

1. **History of Asylums**, i.e. the development of hospitals for the care of mentally ill people from the previous leproscias, and the consolidation of remotely located large institutions to confine mentally ill people away from centres of population, and to provide such security as was necessary for the level of disturbance or violence among such people. A particular characteristic of this movement has been a parallel move towards developing a range of medical specialists to staff such institutions (see below). Likewise, the social policy considerations of the roles of such institutions and movements towards relocating groups of patients in the community receives relatively little attention in the following material other than as a possible reason for the growth in the use of guardianship of recent origins.

2. **Legalism.** Victorian England was notable for a wealth of statutory provision aimed, with varying degrees of effectiveness, at eradicating some of the social ills thrown up by the Industrial Revolution. In the mental health sphere, much legislation was of a highly legalistic kind, providing for every conceivable contingency in the containment, care and provision (i.e. hospital provision) for people with mental illness.

3. **Changes in attitude towards mental illness.** From a relatively enlightened position in Roman times, most authorities suggest much more primitive attitudes towards mentally ill people prevailed in early and medieval England with only a slowly emerging more compassionate attitude towards the end of the Victorian era. As against this, guardianship history suggests that the special needs of people with mental illness may have been better recognised than conventional history suggests. This is discussed on pages 87 to 89. Of more recent origin, more liberal attitudes towards accepting mentally ill people into the community, and avoiding wherever possible inappropriate institutional care, has gained increasing weight. In fact the demise of psychiatric hospitals would seem to be closely bound up with a reluctance to see mentally ill people placed in isolated restricted environments unless absolutely essential.

4. **Changes in Treatments.** Historical narratives are rich in descriptions of barbaric and usually totally ineffective physical treatments for people with mental illness, many of which could only have been carried out in hospital settings. More recently, the development of more sophisticated physical treatments, from ECT to chemotherapy, has raised questions about the use of treatment as primarily a controlling device rather than in a therapeutic, i.e. curative, sense. The relationship between imposition of physical treatments in the hospital environment and the maintenance of people in the community on a minimum level of medication is also of very considerable importance. The net effect of these changes is that more people can be medically treated outside institutions than was the case 50 years ago and that greater expertise in administering minimum dosages of medication has reduced some of the worst side effects of the major tranquillisers and anti-psychotic drugs.

5. **The Rise of the Medical Profession.** Although the development of psychiatry has been characterised by a 'poor relation' position *vis-à-vis* general medicine, psychiatrists have gradually asserted a full range of control over treatment regimes whether administered in hospitals or in community settings. Their influence and control in psychiatric hospitals has been particularly notable and it is arguable that separate legal commitment arrangements related to compulsory admission, detention and treatment within hospitals has turned on the assertion of medical autonomy.

For these reasons, the question of authority over clients/patients as to their welfare and care needs has largely been assumed by the medical profession, including medical auxiliaries, at the expense of people acting in the role of guardian. Whether this is viewed as a natural division of labour or as a fundamental challenge to the authority and influence of guardians is open to question. Obviously this issue is touched on at various stages during the dissertation (particularly pages 52 and 53), but the broader question of medical authority and their control of hospitals and related institutions is not discussed further.

One exception to the above rule relates to the imposition of compulsory treatment in the community. As the history of guardianship will show, it was not seen as appropriate to distinguish between the powers and authority of guardians apropos medical treatment, in or outside institutions, until the mid-1970s so it would seem that on a purely practical level the involvement of hospitals to fulfil such functions effectively took control away from guardians. The recent suggestion that treatment in the community should, in certain circumstances, be compulsorily administered clearly raises the question of whether medical authority outside the institution is being asserted in this particular context. Again, this factor is referred to in the discussion, although without further elaboration.

6. The Growth of Social Services. Donnison identifies five factors influencing the development of social services in Britain during the 19th and 20th centuries:-

- i. "The continuing endeavour to provide the environment required for industrial progress.
- ii. The defence of the nation against economic and military rivals.
- iii. The continually rising aspirations of ordinary people.
- iv. The recruitment and training of a growing number and variety of workers, who in turn play a major part in extending and shaping the services themselves.
- v. Continuous endeavour to prevent or contain disruption of the social order."⁽²⁾

Clearly it would be naive to identify the growth of social services with better meeting the individual care needs of mentally ill people. However, Donnison begins his discussion with a definition of social services which puts the individual first, e.g. in citing Penelope Hall: "The generally accepted hallmark of social services is that of direct concern with the personal well-being of the individual [and its] basis...is...to be found in the obligation that a person feels to help another in distress." Donnison moves from this position only after examining the history, to identify the concern as "a development of collective action for the advancement of social welfare". In other words, because of the nature of social services, their organisation and motivation, they could well have moved from the basis

of meeting individual need to meeting collective/social control needs in a much more explicit fashion.⁽³⁾ Current moves to return to a needs-based impetus for social services arrangements could be seen as a long-term counter trend.

In this context guardianship is seen as a relative constant, in the sense that individual care needs are the starting, continuing and final criteria upon which successful guardianship is based, whilst collective solutions only assist in particular circumstances. Furthermore, for the purposes of this dissertation, hospitals could be included within social services provision, only distinguished by the dominant role of the medical professions. However, the conventional distinction as between the health service and social services is adhered to being seen as statutory services operating under different statutory bases, as well as within distinctive managerial and organisational constraints.

The growth of social services has also to be seen against the broader backcloth of the increasing range of responsibilities assigned to local government. However, it is interesting to note one move in the opposite direction arising from the loss of local authority responsibility for hospitals in 1946 (National Health Service Act).

OUTLINE HISTORY OF GUARDIANSHIP FOR MENTALLY ILL PEOPLE IN ENGLAND AND WALES TO 1983

Introduction

Arguably, the history of guardianship can only be told through the history of legal arrangements, i.e. the various statutes which provide for and modify guardianship arrangements over the centuries. This researcher does not equate the background information thus provided as being the history of guardianship in the fullest sense since this would exclude the social institutional dimension. No doubt many of the causes and effects of changes are more closely bound up with economic and social causes which do not impinge directly on the legal framework.

The commencement of the historical narrative from a discussion of Roman law could be criticised on the grounds that there are few obvious connections between the Roman

society and a Great Britain approaching the 21st Century. The broad contention, however, is that Roman concepts of guardianship, particularly tutor and curator, have had a key influence in shaping of modern guardianship for mentally ill people and that this could only be understood historically. This is particularly so since the pattern of development is not straightforward and because the influences are indirect: the direct impact of tutor and curator are to be found in Scottish law, and it is only by application that we see committee as their English equivalent and as the only element of guardianship remaining in England and Wales with full developmental potential.

Note on the Identification and Perception of Mental Illness in History

It is not considered appropriate for the purposes of this dissertation to present a discussion of the recognition, identification, social significance, or treatment of mental illness in history. Much of the literature referred to discusses whether certain archaic terminology describes what we now call mental illness, or is referring to other related conditions - especially mental handicap - or even to alcoholism and its social manifestation. The material presented by the researcher is selected because the authorities quoted present some evidence that they refer specifically to mental illness. It is, however, necessary to bear in mind that at various times and periods in history mental illness and mental handicap were similarly described, and it is not always clear whether similarities between terms used in description reflect or mask an appreciation of well understood major differences. There were also circumstances for example in medieval England in which it was sound economic sense for parents bringing their offsprings to court to present them as being mentally ill rather than mentally handicapped.

Real or apparent confusion between the two is not confined to early history, and key legislation in England which appears to differentiate between the two groups - e.g the mental deficiency legislation and the Lunacy Act, 1890 - is in fact deceptive in that the language used does not refer to mentally handicapped people and mentally ill people as discrete groups. Many people could be classed as either or both, not only through ignorance but because of similarities in behaviour and social consequences.

Roman* Guardianship

Maine, in his **Study of Law in Primitive Society**, states that:

"The child before years of discretion, the orphan under guardianship, the adjudged lunatic, have all their capacities and incapacities regulated by the Law of Persons. But why?...The great majority of Jurists are constant to the principle that the classes of persons just mentioned are subject to extrinsic control on a single ground in that they do not possess the faculty of forming a judgement on their own interests...."⁽⁶⁾

The position of mentally ill people is clearly recognised here with the need to protect their interests cast within the context both of law and of codes of ethics governing personal relationships generally and family relationships in particular.

Guardianship in early Roman culture appears to have emerged from the need to specify the subordinate position of wives to husbands and children to parents, particularly sons to fathers, as a reinforcement or recognition of the paternal authority referred to by the Romans as *Patria Potestas*.

Maine, here discussing a later period, says that:

"All the Germanic immigrants seem to have recognised a corporate union of the family and the **mund**, [i.e. Guardianship] or authority of a patriarchal chief; but his powers are obviously only the relics of a decayed *patria potestas*, and fell far short of those enjoyed by the Roman father."

* Roman influence on the development of the law of guardianship in England (and even more so in Scotland) is well accepted and documented. However other cultures and traditions evidence a law or code of Guardianship applicable to mentally ill people:-

- For example, Harrison refers to a lawsuit which came before the Archon (Athenian Head of State, circa 8th Century bc) as including an "action for...insanity [and] for the establishment of a Guardianship".
- A further example can be found in Islamic law which, according to Nasir, has always shown clear recognition of the impact of mental illness on a person's capacity to decide and act in his/her own best interests. Its history demonstrates a well established and clear-cut role for Guardians in acting as legal surrogates for such people for as long as their disability persists.⁽⁵⁾

Included among such powers were:

"...a peculiar contrivance of archaic jurisprudence for retaining a woman in the bondage of the family for life. This is the institution known to the oldest Roman law as the Perpetual Tutelage of Woman under which a Female though relieved from her Parents' authority by her husband's decease, continues subject through her life to her nearest male relations as Guardians. Perpetual Guardianship is obviously neither more nor less than the artificial prolongation of the Patria Potestas...." (7).

According to Maine, writing in 1861, this excessive subservience demanded of women in the guise of guardianship gradually died in the West, but survived "in absolute completeness" in India where a "Hindoo (sic) Mother frequently becomes the ward of her own sons."⁽⁸⁾ A background of complex functions derived from the imposition of authority and subservience can be said to characterise early guardianship history.

In contrast to the "various forms of archaic Guardianship" referred to above can be contrasted the emergence of curatio, here explained by Maine:

"one of the very oldest monuments of Roman legislation...the Lex Laetora or Plaetoria which placed all females who were of full years and rights under the temporary control of a new class of guardian, called Curators, whose sanction was required to validate their acts or contracts. [Thus]...for protection against physical weakness and for protection against intellectual incapacity, the Romans looked to two different institutions [tutores and curators] distinct both in theory and designs. The ideas attendant on both are combined in the modern idea of guardianship."⁽⁹⁾

One may perhaps criticise this 19th century suggestion that modern guardianship is a combination of tutela and curatio since the distinctions have been meaningfully preserved in Scottish law, discussed on page 58.

Tutelage applied to children and orphans while guardianship for mentally ill people was provided by curators.* By the main Roman legal code, the XII Tables, Buckland tells us that lunatics conceived of as capable of lucid intervals were placed in the cura of their families or family substitutes (agnates or gentiles).**

"The praetors extended similar protection to all cases of mental incapacitation and even permanently incapacitating disease. In cases clearly not within the XII Tables, the magistrate appointed the curator, [though usually only where] there were not agnates...or [for the] exclusion of unworthy relatives....The curator had the care of the person of the furiosus: apart from this, his functions were similar to those of tutor infantis [the other form of guardianship as applied to care of children]. The XII Tables gave him the power of alienation for administrative purposes of the lunatics' property...The furiosus regained capacity in lucid intervals and the curator ceased to act, but, though there have been doubts in later law, he needed no reappointment on relapse. The law as to removal [etc] was similar to that in tutela [as were remedies for maladministration]....A furiosus minor*** had a curator, qua minor." (12)

As Neaman explains:-

"When the child reached majority, guardianship remained in force in those cases where it was needed...[such as for] the legally insane.....The title of the guardianship was then changed from 'guardian' or 'tutor' to 'curator'. [When the need for guardianship] was apparent in cases of insanity which began in adulthood [a curator furiosa was appointed - being either one of the person's family,] a curator legitimus, [or] a curator dativas [appointed by a magistrate]." (13)

* In Epistles, Horace observes:-

"If, when some uneven barber has cropped my hair, I come your way, you laugh; if haply I have a tattered shirt beneath a new tunic, or if my gown sits badly and askew, you laugh. What, when my judgement is at strife with itself, scorns what it craved, asks again for what it lately cast aside; when it shifts like a tide, and in the whole system of life is out of joint, pulling down, building up, and changing square to round? *You think my madness is the usual thing, and neither laugh at me nor deem that I need a physician or a guardian (curator) assigned by the court, though you are keeper of my fortunes, and flare up at an ill-pared nail of the friend who hangs upon you and looks to you in all.*" (10)

** Horace observes in Satires:-

"He who conceives ideas that are other than true, and confused by the turmoil due to sin, will be held distraught and, whether he go astray from folly or from rage, it will not matter. Ajax, when he slays harmless lambs, is insane. When you purposely commit a crime for empty glory, are you sound of mind, and is your heart, when swollen with pride, free from fault? Suppose one chose to carry about in a litter a pretty lamb, and, treating it as a daughter, provided it with clothes, maids, gold, called it 'Goldie' or 'Teenie', and planned to have it wed a gallant husband: *the praetor by injunction would take from him all control, and the care of him would pass to his sane relations.*" (11)

*** Under later Roman law puberty was fixed at 14 for males and 12 for females.

Some further reflections by Buckland on the Law of Persons clarify the position, viz.:

"Persons are considered *sui iuris* only so far as they were under disabilities. Owing to defects of various kinds they might be under guardianship, either tutela or cura (curatio). Tutela of children ended at puberty, was retained but supplemented by such devices as...curatio, which gave similar but less effective protection."⁽¹⁴⁾

Buckland describes both tutela and curatio in general terms as 'care and control', conveying the idea that the tutor/curator took responsibility for decision-making from the ward. However, he acknowledges that at various times during the development of Roman law, wards were allowed and expected to exert greater autonomy and arrive at some consensus with their tutores.⁽¹⁵⁾ The motivation for the appointment of tutors/curators seemed often to be to do with preventing loss of property from the family. How much of the actions of tutors/curators was protective in a more general 'best interests' sense is difficult to say. Tutor and curator were sometimes used together. Thus, if a person under tutela was mentally ill at the time when the tutela was due to terminate, an appointment of a curator could be considered - i.e. to run in parallel for the time being with that of the tutor. They could be the same person or another person, and a tutor could enlist the help of a curator to undertake functions which he was unable to accomplish.*

Early English Law

The limited amount of available information about guardianship in England prior to 1324 is summarised by McLaughlin thus:

"In very early English law, guardianship of the mentally disabled was called tutorship [rather than the logically and semantically more consistent 'curatorship'] and was the responsibility of the Lord of the Manor. It was a protective responsibility that related to both property and the person, but the chief reason for its existence was proprietary."⁽¹⁹⁾

* Little is known of how curators were chosen, but Buckland notes that mental illness was not a bar to being a tutor: "lunacy (furor) seems to have been always regarded as curable, and thus was not a disqualification but a ground of temporary excuse. In classical law it was no bar at all in legitima tutela".⁽¹⁶⁾ However Pope notes that by 1791 an English court found that "A lunatic cannot be govern himself will be unable to manage another or his concerns."⁽¹⁷⁾

De Prerogativa Regis, 1324

The passing of the Act may have been aimed at reducing abuses or failures to carry through guardianship duties by Lords of the Manor or was possibly due to attempts on the part of the Crown to extend and consolidate the King's powers.* However it is from this point that commentators see more clearly the King as "father of all his subjects" and in particular as "guardian over those people that a jury of 12 found to be idiots or lunatics."⁽²¹⁾

The Act clearly acknowledged the distinction between mentally handicapped people and mentally ill people and provided for forms of guardianship under different terms for these groups. A common objective remained in identifying Royal powers for protecting the interests of people unable to fend for themselves. Section 10 of the Statute reads as follows:-

"Lunatics:- Also the King shall provide when any, that before time hath had his wit and memory happen to fail of his wit as there are many (with lucid intervals) that their lands and tenements shall be safely kept without waste and destruction, and that they and their household shall live and be maintained competently with the property of the same, and the residue besides their sustentation shall be kept for their use to be delivered unto him when they come to right mind, so that such lands and hereditaments shall in no wise be alienated; and the king shall take nothing to his own use. And if the party die in such estate, then the residue shall be distributed for his soul by the advice of the ordinary."

Maitland considers the Prerogative Regis to be the oldest English document to provide us with:

"...any clear information about a wardship of lunatics [through which] we see prerogative rights growing, while feudal claims fall into the background; and in the case of lunacy we see a guardianship, a *mund*, which is not profitable to the guardian, and this at present is a novel and a noteworthy thing."⁽²²⁾

* Maitland suggests another possibility: "Robert Walerand, a minister of justice and favourite of the King, procured this ordinance foreseeing that he must leave an idiot as his heir and desirous that his land should fall rather into the King's hand than into the hand of his lords."⁽²⁰⁾

The effect of this (contrasting with the situation of people with mental handicap, whose lands were seized and rights in the land denied, with no duty on the King to maintain them) is explained by McLaughlin as follows:-

"The King was not allowed to profit from the lands and was under a duty to maintain mentally disordered persons and their households out of the profits of the lands, had to make full account of profits, and had to return the property upon return to lucidity. However, when mentally disordered persons died while still mentally disordered, their property did not pass to their heirs but is distributed by the King...."⁽²³⁾

Neugebauer confirms that mentally ill people were dealt with by the Crown more generously than mentally handicapped people and also that the latter gained the Crown greater revenues. The King could not profit from his own custody of lunatics, so could not require fines or rents from guardians, as was the practice with mentally handicapped people. As a consequence many cases brought before the Court of Wards were referred to as 'idiots' when in fact they were probably more accurately referred to as mentally disturbed. Tests were administered to find any lack of intellectual capacity on the part of the plaintiff. Mentally ill people were subjected to a different set of tests aimed at establishing that the person's disordered behaviour was precipitated by physical illness, injury or shock, which were considered the most frequent 'causes' of mental disorder according to contemporary views.

Neugebauer goes on to confirm from his researches that:-

"...guardians of lunatics were accountable for more extensive stewardship [than was the case with mentally handicapped people]. A lunatic's guardian was obligated to maintain the lunatic and his family at a level commensurate with his social rank, not simply the necessities, and to preserve and protect the estate."⁽²⁴⁾

Although Royal protection was now statutorily assured, "actual care of the individual and his estate devolved to friends or relatives".⁽²⁵⁾ Lindman, here discussing American interpretation of the law of this period, maintains that it follows closely the approach observed by Blackstone, namely that commitment to the care of relatives was a common measure "on the first attack of lunacy" and that only violent people will necessarily need to leave the care of their family. On the other hand, the court was more likely to commit

a person to the care of a friend, leaving family members, other than his heir, responsible for managing his property. Giving custody of a person to the heir was discouraged, Blackstone tells us, "to prevent sinister practices".⁽²⁶⁾

The Court of Wards and Liveries

The King's powers, exercised by the King's Governors, were vested in the Court of Wards and Liveries in 1540. The Court recognised that the position of the Crown *vis à vis* mentally ill people was similar to that of a trustee. Much discussion in the literature concerns the similarity and differences between guardianship and trusteeship, on one hand, and guardianship and wardship on the other.*

Although the Court of Wards had proprietary interests in the outcome of cases concerning mentally ill people, including transactions under feudal laws for the sale of guardianship, Custer considers that it was "largely motivated by humanitarian rather than financial concerns". He cites the continuing practice of committing mentally ill to the individual's closest friend for care as illustrative of this and adds:

"...The Court itself serves in this instance principally as a protective institution, one that exemplified the spirit of the later articulated *Parens Patria* doctrine."⁽³⁰⁾

Bell maintained throughout his study of the role of the Court that it was generally more concerned with the humanitarian needs of mentally ill people than to exploit them for financial gain⁽³¹⁾ and this view is supported by MacDonald and Neugebauer.

* McLaughlin observes: "The position of mentally disordered persons was more akin to that of beneficiaries of a trust".⁽²⁷⁾

Pope says: "...[In 1324]..., by the terms of the Act of [17 Edw. 2, cc 9, 10,] the King became the owner of an idiot's lands...while of the lunatics estate he was merely a trustee....Gradually [however, the position of the former was assimilated into that of the latter] and the relation of the Crown to both classes approached more nearly the relation of trustee to beneficiary....The Lord Chancellor, chief judge in matters of trust,...acquired immediate jurisdiction in respect of these classes, and administered the trust on behalf of the Crown [after the abolition of the Court of Wards]".⁽²⁸⁾

According to Bell: "In the person of a lunatic...the King had no certain interest, but only the duty of exercising a sort of trusteeship over his lands."⁽²⁹⁾

MacDonald says that:

"...towards lunatics the court behaved with uncharacteristic delicacy...[seeking principally]...to help families bear the burden of harbouring a mad man."

and goes on to explain, citing a Royal Commission Report of 1617/18, that:-

"King James instructed the court to ensure that lunatics be freely committed to their best and nearest friends that can receive no benefit by their death, and the committees, bound to answer for...the very value of their estates upon account, for the benefit of the lunatic....*The order was obeyed.*" (This writer's emphasis)⁽³²⁾

In addition to its jurisdiction over mentally handicapped and mentally ill people, the Court of Wards had a wider concern to administer revenues accruing to the Crown through the operation of feudal land law, so that although:

"a guardian was expected to look after the lunatic's entire family and was held responsible for his expenditures and income, [and the grants of lunatics, including covenants obliging committees to account annually for their receipts and disbursements] the analogy between the legal status of wards and of the mentally ill...should not obscure very real and important differences. Wardship was a direct product of feudal land law and the King's rights in this area were circumscribed by the nature of feudal tenure. In contrast, the Crown's authority over idiots and lunatics was in no way linked to land law. It derived from the Crown's general right and duty, as *pater patrae*, to protect the persons and, where necessary, the properties of individuals unable to care for themselves."⁽³³⁾

Neugebauer maintains that:

"...disturbed persons with real estate...could be brought to official notice...through the Court of Wards and Liveries...and offered protection and, to some degree, a monitored Guardianship system [which becomes available to] persons across the English social spectrum [indicating] a small but nonetheless real, social welfare dimension of this royal jurisdiction."⁽³⁴⁾

Guardianship/wardship for wards who were neither mentally ill nor mentally handicapped did not, according to Neugebauer, evidence the same tendency towards humane and caring handling as did the jurisdiction towards people with mental disorder and there was growing exploitation of wards' estates by guardians and the Crown:

"In the sixteenth and seventeenth centuries the fiscal dimension [in respect of mentally disordered people] gradually disappeared while the welfare aspects were significantly expanded. In this respect, the Crown's attitude was far more humane and benevolent toward the mentally ill than it was towards wards."⁽³⁵⁾

The *Parens Patriae* doctrine has been highly influential in maintaining the notion of Royal responsibility for the care of mentally ill people and as a basis for the later development of 'welfare' legislation. In the USA, accordingly to Curtis, the doctrine has been adapted further for this purpose, whereby the state "as Quasi-Sovereign" acts "as a guardian of the well-being of its general populus and economy."⁽³⁶⁾

Fitzherbert is also referred to by Staunford as authority for the broad assertion that:

"[t]he king is the protectour of all hys subiectes and of all their goods, landes and tenements, and therefore of suche as cannot gouerne them selues nor order their lands and tenements his grace (as a father) must take vpon him to prouyde for them, that they them selues and their things may bee preserued."⁽³⁷⁾

Custer suggests that this 1567 reference is the first time that the Crown is described as a parent and says that this may well have been the origin of the doctrine of *Parens Patriae*.⁽³⁸⁾

Lindman discusses the *Beverley* case (1603), which apparently provided Lord Coke with the opportunity to expound the "law of insanity as it had developed in England", focusing in particular on those who were included within the umbrella term "noncompos mentis". Including 'lunatics' within this category, he observed that such people were responsible for acts done by them during lucid moments, but that acts performed during non-lucid moments were of the same effect as those performed by an 'idiot' (a mentally handicapped person) who could not be found guilty of serious offences. Continuing his discussion of this case, Lindman goes on:

"Lord Coke then gives an interesting comparison of the civil [i.e Roman] and common [i.e. Anglo-Saxon] law....He notes that all acts performed by one non compos mentis without the accord of his tutor are void in the civil law. The lack of a similar requirement in common law is cited as a defect in the common law system. [However] Lord Coke points out that the Law of England could in fact provide a tutor in the form of the King...the King is accountable to the Lunatic

when the latter again becomes normal. [Whilst] the English law of 17th century established many methods to protect the property of the insane...Lord Coke also relates that the King was given custody of the person of the afflicted individual as well as his lands."⁽³⁹⁾

By the seventeenth century, Neugebauer maintains, the Court was providing:

"an informal system of monitored Guardianship [by which] protection was made accessible to nearly property-less persons. Thus a small social welfare dimension emerged [and] a more consistently benevolent jurisdiction was developed that sheltered a wider social class range of English subjects."

Under these arrangements, he continues, "private subjects, usually the petitioner, received custody of the incompetent individual. These guardians supervised the mentally ill...[and] defended them and their property against exploitation."⁽⁴⁰⁾

Although the Court was "unable to mandate goodwill" it:

"selected guardians bound to the insane by affection or identity of economic interests...the nearest of kin...sound in religion, of good governance in their own families, without disillusion, without distemper, no greedy persons, no stepmothers; wherever possible avoiding giving the disabled person over to the mercy and power of a stranger."⁽⁴¹⁾

Land Tenures Act, 1660

This statute, 12 CAR.2.c.24, at 176, abolished the Court of Wards, formalised guardianship arrangements for children and defined a particular aspect of guardianship for adults.

For mentally ill people, guardianship in the form of committee of the person could follow a Chancery Court finding of lunacy by inquisition, preceded by a writ *de lunatico inquirendo*.

Custer, reviewing developments in the doctrine of the Crown as guardian of mentally ill people, refers to the 1669 case of *Falkland v Bertie* in which the Lord Chancellor Somers pronounced:

"In this Court there were several things that belonged to the King as a pater patria, and fell under the care and direction of this Court as lunatics etc, afterwards such of them as were of profit and advantage to the King, were removed to the Court of Wards [in 1540]; but upon the dissolution of that court, came back again to the Chancery."⁽⁴²⁾

The relationship between Chancery and guardianship functions following the demise of the Court of Wards is summarised by Lindman, thus:

"The King's guardianship was exercised through the Lord Chancellor. This was accomplished by virtue of a special commission issued to him by the Crown rather than by the general authority of the Chancery Court. In exercising the power, the Chancellor held an inquisition to enquire into the condition of the mentally disabled person and to appoint a committee for her person and property if he was adjudged an 'idiot' or a 'lunatic'. It was the further duty of the Chancery Court to supervise and control the conduct of such a committee."⁽⁴³⁾

One way of stating the implications of the 1660 measure for guardianship of mentally ill people is to say that whilst the Crown remained the ultimate guardian, i.e the 'guardian of guardians', responsibility now delegated to the Chancellor, served by the Chancery Court, rather than the previous arrangement whereby the Court of Wards were involved in sales and transfers of feudal guardianship rights. The Chancery Court, in turn, chose a person whom they would supervise and to whom the mentally ill person could be committed (i.e. as a 'committee') to exercise *de facto* guardian's protective and controlling responsibilities following a finding of incompetence to manage person or affairs by the Chancellor's Inquisition. Further detail on the role of committee is provided in Appendix D.

A committee, according to Theobald, "has complete control over the person of the lunatic and it is his duty to make all necessary arrangements for his care and treatment".⁽⁴⁴⁾ Probably, this followed previous practice of including all forms of care and treatment wheresoever provided. Neugebauer, for example, mentions that:

"On July 19th 1631 the Court ordered that the guardian of Robert Banckworth 'shall take care...and cause the said [lunatic] with...convenient speed and privacie...to bee removed...to the howse of Dr Bartlett to bee with him placed for the recoverye of his health'."⁽⁴⁵⁾

In being responsible for a whole range of what would now be referred to as domiciliary, day care and residential (including hospital) services, the committee required the assistance of others, which led to a further delegation of responsibility. For example, Neugebauer mentions that:-

"Physical supervision and care of the disabled party were commonly handled by retaining a live-in servant, the so called 'lunatic's keeper'. For example: Jane 'was sometimes...very unruly whereby the [Guardian] was enforced to have sometimes two sometimes more [servants] a whole week together to be with [Jane] and attend her day and night'."⁽⁴⁶⁾

Though a limited care responsibility and function judged by modern terms, this does bear relationship to guardianship in showing a sensitivity* to need and in specifying a continuing responsibility of one individual over another.

A major implication of the 1660 Act was that these 'total' powers of guardians were exclusively vested in practice in committees (acting on guardians' behalf) and could only

* Historical instances showing such sensitivity to the position of the mentally ill person in being subject to guardianship or committee are difficult to reference but the following give an inkling of how some people in the 18th century apparently reacted when considering that they had been inappropriately placed on guardianship.

Describing guardianship arrangements in colonial Massachusetts during this period, Jimenez illustrates from case examples how guardianships for mentally ill people were contested, especially by wards themselves. Quoting the case of Henry Dove as 'probably typical' she refers to a court finding of the client: "At times he has lucid intervals, yet at other times he is so wild and ungovernable that we are of the opinion that he is in no way capable of managing his affairs". A guardian was appointed but the guardian and ward disputed the amount which the guardian was to be paid for his services:

"Dove [the ward] won his case for a lower payment...and was eventually released from Guardianship. Like others under Guardianship, Dove was rational at times. It is clear that persons assigned Guardianship were not presumed to be permanently incapable of handling their own affairs."

Jimenez quotes also the example of Benjamin Hall who appealed against his guardianship status in 1770 "on the grounds that he was now 'compos mentis'." The court asked 'selectmen' (specially appointed town councillors) whether the client had been seen in taverns, spending unwisely or unnecessarily and after receiving an assurance that this did not apply they responded that "Mr Hall was a gentleman [they] imagined he was capable of conducting his own affairs [based on the view that he was able to run his business]." The guardianship was revoked, and Jimenez observes that:

- Court records indicate that the guardianship status was always revoked when the person in question managed to argue his case as far as the appeal court."
- In a further example quoted, a ward gained revocation of guardianship by virtue of his argument that he was "worse for being under Guardianship".⁽⁴⁷⁾

operate following a finding from an inquisition. The question remaining, therefore, was whether guardians retained any independent capacity to operate, i.e. to exercise care and protection powers, independently of a finding of inquisition and without delegation to committees.

Much of the literature covering this period seems to have assumed that the only form of guardianship for mentally ill people operating was in the form of committee. However, Collinson, writing in 1812, provides a section in his treatise on lunacy law headed 'Guardian' which states that:

"If a person in the condition of a lunatic, though not found so by inquisition, be made a defendant, the Court, upon proper information of his incapacity, will direct a guardian to be appointed. In this case a special application should be made by motion or petition on a Affidavit, stating the particular circumstances of the party, and praying a commission to appoint a guardian....The order for the commission...in no case differs from the form of a commission to appoint a guardian to an infant except in stating that the party is incapable by age or infirmity; and a proceeding under commission of this kind is Mutatis Mutandis, the same as in executing a commission to appoint the guardian to an infant." [This writer's emphasis]⁽⁴⁸⁾

The statutory basis for this assertion is not referred to, but it may be conjectured that guardians' direct powers had never been entirely lost.

The Lunacy Act, 1845

Section 95 of this Act confirms Collinson's understanding of the situation as follows:

"...it shall be lawful for the Lord Chancellor from time to time to make orders for the appointment of a guardian, or otherwise for the protection, care, and management of any person who shall by any such report [from the Masters in Lunacy] be found to be a lunatic, and such guardianship has the same powers and authorities as a Committee of the Person of a lunatic found such by Inquisition now has, and also to make orders for the appointment of a Receiver, or otherwise for the protection, care, and management of the estates of such a lunatic, and such Receiver shall have the same powers and authorities as a Receiver of the Estate the lunatic found such by an Inquisition now has...."⁽⁴⁹⁾

Furthermore, there were some interesting observations forthcoming from the 1891 **Report of the Lord Lieutenant of Ireland on Lunacy Administration**, Section 34 of which referred to Chancery lunatics and observed:

"The statutory Prerogative of the Crown, delegated by Special Warrant is the foundation of the authority which is exercised in regard to lunatics by the Lord Chancellor, who stands in this matter as Pater Patriae."

For Chancery lunatics, the appointment of committee of the person and committee of the estate upon a commission of inquisition could take place but, the Irish report said,

"it may be correctly said that it is with reference to the care of property rather than care of persons of lunatics, that the powers of the Lord Chancellor, acting for the Crown, are called into operation".

This offered little or nothing for lunatics with small properties who also needed to be provided for and whose possessions were "just as important to the possessor". The Committee's Report argued furthermore that the person of the lunatic with small properties should also be protected and suggested:

"If the Lord Chancellor's care of the person is needed and is good...this also should be taken on [by the country for these less well off people]."

In this respect the Report considered that practice in Ireland was ahead of England in that it allowed the Lord Chancellor:-

"When satisfied that any person has a weak mind and is temporarily incapable of managing his affairs...in a summary way and **without directing any inquiry under a commission of lunacy, [to] appoint a guardian of the person and property...specifying the nature and extent of the powers to be exercised by such guardian.**" (This writer's emphasis)

The Committee's Report observed that this provision, which was for 6 months only and could not be renewed more than once, "in our opinion is of practical value" (Section 34 (c)).⁽⁵⁰⁾

Finally, according to Pope, (1890) "the Chancery Division of the High Court of Justice has jurisdiction to give directions for the maintenance of a person of unsound mind not so found [by inquisition] as part of its general jurisdiction over the administration of trusts". However, he could find only one case* as precedent for the Chancery Court to "appoint a person to act in the nature of a guardian" and regarded this ruling as without authority.⁽⁵¹⁾

Hoggett has detailed the reluctance of Courts to follow this precedent and concludes that Chancery guardianship was confined in effect to committees of the person appointed following inquisition.⁽⁵²⁾

Although the 1845 Act was repealed by the Lunacy Act, 1890, no explicit reference was made forbidding or avoiding this form of guardianship by the 1890 measure, and it might therefore be assumed that it was little used or had fallen into disuse, possibly through disinterest of Chancery in assisting mentally ill people with limited wealth and few possessions.

The Lunacy Act, 1890

Repealing earlier legislation, this Act made detailed provision for the care and control of people with mental illness inside and outside hospitals (but particularly the former) defining the role of committee as key to facilitating provision of all care and treatment. McLaughlin seems to assume that any distinguishable guardianship function was subsumed under these provisions, and he applauds the measure as the first consolidation of guardianship law since De Prerogativa Regis to contend with "the hodge-podge nature of the development of guardianship law over the centuries".⁽⁵³⁾

Against this view it could be maintained that by apparently excluding a role for guardians independent of inquisition arrangements, the Act further reinforced the place of inquisition proceedings in determining the care and treatment needs of people with

* Vane v Vane, L.R. 2Ch.D.124 (1876)

mental illness. In practice, as the Irish Committee had noted, this meant that the needs of people with limited means would not have access to this assessment or the care and treatment that would arise from it.

It is also important to note that inquisition procedures were already showing signs of being regarded as anachronisms judged by the amount of use. The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency noted that by 1957 the procedures were only occasionally used, involving in the region of 30 people in the whole of England and Wales.

The Royal Commission on the Care of the Feeble Minded, 1904-1908 ⁽⁵⁴⁾

The findings and deliberations of this Commission were significant for guardianship in two ways. Firstly, the recommendations to the Commission relate to the first revision of statutory guardianship under English law and, although this was intended primarily for people with a mental handicap, the distinction between mental handicap and mental illness was sufficiently blurred by the official language of the time to insure that at least some mentally ill people were included within its provision. These may have resembled the so-called "highgrade defectives" who were "neglected, abandoned, cruelly treated, or without visible means of support", or who were to be found in a "lunatic asylum" but who could live outside provided they were enabled to live a protected life in the community (p.342).

The second major significance of the Royal Commission was the fact that it presented a wide-ranging discussion of use of guardianship in order to examine whether this form of care could be further advanced, thereby reducing the need for institutional care. In discussing guardianship arrangements in other countries, and for other care groups, the Commission also reflected on the different types of guardianship as they perceived them as being largely determined by the different legal systems within which they operated. A summary of the Commission's important review of various types of guardianship was offered in Chapter II, pages 59 and 60, and further detailed in Appendix D.

From the discussion offered by the Commission, it was clear, once again, that although the focus was on people with mental handicap the alternative forms of guardianship presented were equally applicable to people with mental illness, with perhaps a bias towards those people whose mental health problems made them a social problem and/or who were likely to come within provision of the Poor Law unless some alternative was offered - i.e. a clear indication of guardianship being seen within a preventative role, i.e preventing people with mental illness being made subject to the Poor Law, and therefore illustrating the clear distinction between guardianship for mentally ill people and Poor Law guardianship.

The Mental Deficiency Act, 1913

By Section 10(2) of this Act:

"an order that a defective be placed under Guardianship shall, subject to regulations made by the Secretary of State, confer a person named in the order as guardian such powers as would have been exercisable if he had been the father of the defective and the defective had been under the age of 14...."

This legislation resulted in part from the recommendations of the Royal Commission on the Care of the Feeble Minded, 1904-1908, (see above) but departed in a number of ways from those of the Commission's recommendations, which were against the consolidation of statutory guardianship.

Royal Commission On The Law Relating To Mental Illness And Mental Deficiency - 1954/1957 ⁽⁵⁵⁾

The report of the Royal Commission is discussed below under five headings: *The Commission's Historical Perspective; Main Statements on Changes in Guardianship; Recommendations Not Pursued; Philosophy: Implications for Guardianship and Social Work; Passage of the Bill in Parliament.*

The Commission's Historical Perspective

Perhaps the most notable aspect of the Commission's view of guardianship was their apparent assumption that no appropriate statutory provision for people with mental illness outside hospital was in force at the time of their review, with the implication that other arrangements were insufficiently formulated or too outdated to be effective. Their commitment to bring legislation for mentally handicapped people and mentally ill people together may also have influenced their decision to model future statutory guardianship for mentally ill people on existing mental deficiency laws, though the Commission would no doubt have appreciated that a number of people with mental illness were in fact regulated under mental deficiency legislation.

The picture conveyed in the Commission's discussion of existing guardianship arrangements for mentally ill people as at 1954 can best be described as a review of 'quasi-guardianship'. This term is used as a convenient shorthand to describe a variety of arrangements for care and control of mentally ill people in the community arising from provision under previous legislation. The Commission summarised (Sections 796-798) the situation as follows:

"The Lunacy and Mental Treatment Acts allow 'persons of unsound mind' to be taken into the care of, or reside with, private individuals as certified, temporary or voluntary patients in certain specific circumstances. These include certifiable temporary patients who have been in a hospital or licensed house and who have left it either to be 'boarded out' in the care of relatives or friends or 'on leave' or 'on trial'; these patients remain under the general supervision of the hospital and may be recalled to the hospital if necessary. 'Persons of unsound mind' may also live as certified, temporary or voluntary patients as 'single patients' in the care of private individuals."

The Report indicated an estimated 100 people in England and Wales who were boarded out or in single care (undifferentiated) but adds: "On December 31 1956, there were 44 certified patients and 4 voluntary patients in single care. The majority of these were patients who had been previously in a hospital; only a few had gone direct into single care." The Commission summarised the position as follows:

"Patients may be admitted to [hospitals etc] or received into the care of private individuals as 'single patients or as voluntary, temporary or certified patients only'."

A notable omission from the Commission's discussion was any indication of the effectiveness of quasi-guardianship, since the Commission apparently did not investigate existing arrangements or known problem areas. A possible presumption therefore is that the Commission sought only to tidy up and formalise these arrangements. It would seem unlikely that they were concerned by the small numbers involved since (as later discussion will show) they apparently only envisaged guardianship for mentally ill people being required in the future for a small minority of people.

There was certainly some imprecision in the use of the term 'single care', as is confirmed by Jones.

"This term is used, as it was used in the 19th century, to indicate all who were confined alone. The state of single lunatic varied enormously, since it depended entirely on the arrangements made by relatives and friends for their confinement."⁽⁵⁶⁾

It does seem fairly certain, however, that single care was not guardianship as such but a care arrangement arising from guardianship which had the effect of linking the actual arrangements - what would now be generally referred to as foster family care - with guardianship law, as applied in other countries and particularly in Scotland.

Aside from quasi-guardianship, the Commission gave attention to the role and function of a **committee**, indicating that:-

"...the procedure of legal inquisition for determining the control of the property or of the person of the patient, or both, remains in existence and is still occasionally used...."

and emphasising the point that:-

"The person appointed as 'Committee of the Person' following an inquisition can determine the patient's place of residence and can order his admission to

and detention in hospital without using the certification or other admission procedures which are now used for other patients...."

Resort to use of committee of the person and committee of the estate seems to have become infrequent* to the extent to which inquisition proceedings became obsolete. Alternative arrangements for committee of the estate, which became the responsibility of the Court of Protection, were clearly required and enacted (Mental Health Act, 1959). However, no reference can be found to the winding up or translation of committee of the person - an issue which strangely appeared not to have concerned the Commission. Possibly the fact that committee of the person involved so few people in England and Wales at the time of the Commission may have led them to conclude that this was a purely residual or token form of guardianship.

The Commission appears not to have taken into account the other existing statutory guardianship arrangements for mentally ill people contained in the Lunacy Act, 1845. Neither do they comment on borough guardianship or canon law guardianship for this care group** from which it might be assumed that these arrangements had fallen into disuse. If the Commission thought that there was an alternative model of guardianship operating under the Lunacy and Mental Treatment Acts, this was not made explicit and the overall impression gained from the Commission's report and from evidence supplied to the Commission is that they did not recognise a form of guardianship *per se* as applicable to mentally ill people at that time. Instead they could be said to have recognised and reviewed the forms of quasi-guardianship for mentally ill people discussed above.

* The Commission report noted:-

"On 1st January, 1957, there were 37 patients...found...of unsound mind by inquisition...[20 of which were resident in England and Wales. There] were 17 in which the Committee of the Estate was also Committee of the Person [and] 2 persons in which the Committee of the Person and Committee of the Estate were different individuals".

Hoggett estimates that at this time there "were 16 people who were under the jurisdiction of a committee of the person".⁽⁵⁷⁾

** Discussed under Historical Typologies, Appendix D.

The Commission may be criticised for not having looked more fully at guardianship historically or at arrangements in other countries, which latter had been undertaken by the Royal Commission on the Care of the Feeble Minded, 1904-1908. Whilst it may have seemed inappropriate to have retraced the steps taken by the earlier Commission, especially since this had produced very little by way of useful development, there was certainly a case for looking at guardianship arrangements in countries whose legal systems have a close correspondence to those of England and Wales. For example, Scottish guardianship arrangements, which would in any case need to be recognised under English law for practical purposes, were not discussed, even though there were well known connections with the idea of guardianship and 'curatorship and tutorship' (i.e. curators bonis and tutors dative) which applied under the Scottish legal system.

Main Statement on Changes in Guardianship Law Sought

The Royal Commission had been given the following terms of reference:-

"to enquire...into the existing law and administrative machinery governing the certification, detention, care...absence on trial or licence, discharge and supervision, of persons [who are mentally ill or mentally defective and] to consider...the extent to which it is now, or should be made, statutorily possible for such persons to be treated, as voluntary patients, without certification; and to make recommendations".

It was therefore to be expected that the main task facing the Commission was to examine the possibility of providing mentally handicapped and mentally ill people with the same access to care and treatment, particularly in hospital but also in the community, with minimum resort to compulsion. Previous arrangements under the Lunacy and Mental Treatment Acts and under mental deficiency legislation generally required that those needing care and treatment in hospital could only receive this on a compulsory basis. The position about care and treatment outside hospital was much more complicated and is discussed further below.

Apart from minimalising the use of compulsion, the Commission also wished to:

- i. reduce the legalistic requirements for compulsory orders to be agreed by magistrates. Instead doctors should be empowered to determine not only a person's 'state of mind' but also their 'care needs'. (Sections 42(iv) and 40)
- ii. reinforce earlier official pronouncements (e.g. 1926 Report of the Royal Commission on Lunacy and Mental Disorder) that mental illness should be treated and viewed in the same way as other illnesses. (Section 5)
- iii. endorse the increasingly accepted view that community care services should be developed and used wherever possible in place of institutional care. (Sections 294 and 601, in particular)

The attitude of the Commission to guardianship was complicated by their adherence to the resolutions referred to above. In particular their determination to unify mental deficiency and lunacy legislation meant that they had to decide the future of 'mental deficiency guardianship', while at the same time weighing up the needs of mentally ill people for guardianship under the same terms and conditions for its successor. Their view of guardianship was basically paternalistic and the implications of this are further discussed below, see pages 109 and 110.

The Commission's main statements on guardianship are contained in Sections 399/400 and 832 of their Report. The following key sentences apply to guardianship for mentally ill people:

"399. Community care can be given only if the patient can be persuaded to co-operate with the officers of the local authority and to accept the help and advice which they have to offer and the arrangements which are made for employment, occupation or training. It should therefore usually be given without using compulsory powers. Sometimes, however, the possession of legal authority may make it possible to obtain a patient's co-operation which would not be given otherwise; in such cases compulsory powers may justifiably be used to place the patient under the legal control of guardianship...."

"...Powers of guardianship may also sometimes be needed to ensure proper care for people with mild or chronic forms of mental illness or infirmity who do not need to be in hospital; in the great majority of such cases, care could be provided without compulsion; but there may be occasions on which community care under guardianship would be more appropriate than compulsory admission to or continued detention in hospital, especially when facilities for community care are expanded as recommended in Part V of our report. In such cases guardianship would replace the present powers of control over certified patients 'in single care' or 'boarded out'; it could be used as a method of arranging suitable residential care, in local authority homes or elsewhere, for some elderly people in circumstances not covered by the powers of removal contained in Section 47, National Assistance Act, 1948."

Section 832 indicates that 'private guardianship' (guardianship provided by an individual not employed by a local authority) would be equally applicable to the prescriptions referred to above and to "exercise control over the patient equivalent to that of a parent over a child...." In the above (Section 399) reference to the possibility of guardianship being used "as a method of arranging suitable residential care...for some elderly people...", it has to be a matter of conjecture whether these elderly people would be classed as mentally ill. In one sense, strict diagnosis is perhaps unimportant; on the other hand, the Mental Health Act insists that a mental disorder is present before people are subject to compulsory powers, so presumably this overarching criterion was in the minds of the Commission when this section was drafted. Similarly, the Commission report dwells at some length (Sections 654 onwards) on the situation of school leavers and the services available for young people who may be 'maladjusted or mentally backward', but by inference were also considering young people showing signs of behaviour disturbances and psychological problems at home which called for additional help on leaving school, such as specialist residential care. The Commission explain their perspective thus:

"When the need for residential accommodation of this sort arises from unsatisfactory home conditions, it may be necessary for young persons to be placed under the guardianship of the local health authority or of a suitable individual. Guardianship in the community should be more widely used so that the young person is not removed from the general community and the chances of normal employment and sent into hospital....[After-care for these young people is very important and should be initiated by a Mental Welfare Officer of the local authority while they are on licence] before the approved school order expires, thus providing the maximum continuity of individual care. If a longer period of compulsory control is needed for the patient's own welfare or for the protection of others, admission to guardianship would be possible using the procedures recommended...."

It is plain from the above extracts that the Commission were only considering one form of guardianship - the compulsory statutory guardianship applicable to people with mental handicap, psychopathy and mental illness - and felt that these groups should be similarly provided for legally and administratively. This seems to have influenced their decision to follow mental deficiency legislation in making the criteria for the use of compulsory powers (hospital or guardianship) the same, viz.:

"We recommend, that subject to the use of the new procedures [referred to elsewhere in this report] the law should in future allow mentally ill patients to be admitted compulsorily to hospital or to be placed under guardianship in the community 'when the use of compulsion is necessary for the patient's own welfare or for the protection of others'." (Section 325) (This writer's emphasis)

These were substantially similar criteria to those applicable under previous legislation, though using different terminology. The somewhat elliptical phraseology of the 'welfare criterion' is expanded upon in Section 317 of the report where the grounds for the use of compulsory powers for people with mental disorder (i.e. with mental handicap, psychopathy or mental illness) are indicated thus:

- "a. there is a reasonable certainty that the patient is suffering from a pathological mental disorder and requires hospital or community care; and
- b. suitable care cannot be provided without using compulsory powers; and
- c. if the patient himself is unwilling to receive the form of care which is considered necessary, there is at least a strong likelihood that his unwillingness is due to lack of appreciation of his own condition deriving from the mental disorder itself; and there is also either
 - i. good prospect of benefit to the patient from the treatment proposed - an expectation that it will either cure or alleviate his mental disorder or strengthen his ability to regulate his social behaviour in spite of the underlying disorder, or bring him substantial benefit in the form of protection from neglect or exploitation by others; or
 - ii. a strong need to protect others from antisocial behaviour by the patient."

From the above, one may 'profile' the groups of mentally ill people envisaged by the Commission as suitable for guardianship as "people with mild or chronic forms of mental illness and [mental] infirmity" who are prone to "neglect or exploitation by others" and who may display "anti-social behaviour". The criterion for the need for compulsory control in the community therefore is that the person is unwilling to receive community care on a voluntary basis "due to a lack of appreciation of his own condition deriving from the mental disorder itself". The person does not need to be in hospital and consequently guardianship is more appropriate than compulsory admission to or continued detention in a hospital.

Royal Commission's Recommendations not accepted or pursued

1. The 28 Day Guardianship Order.

The Commission recommended an 'emergency' guardianship order, based on the view that:-

"...if powers of control are necessary [to arrange community care] it should be possible for the local health authority to assume powers of guardianship in an emergency by the use of a simpler procedure than normal, [ie. a mental welfare officer's initiative accompanied by one medical recommendation...By these means] the powers of guardianship should be exercisable for a period of up to 28 days [extendable if required]."

No explanation can be found as to why this proposal was not pursued and it is interesting to speculate as to whether the Commission's view expressed in Section 411 of the Report, that guardianship arrangements could become effective in providing an alternative to hospital care within such a short period of time, had been greeted with some degree of scepticism.

2. Guardianship for Young Mentally Disturbed People Upon Leaving Approved Schools.

This view of guardianship use was not pursued and would therefore only be applicable on an individual basis, i.e. where the person was found to be mentally ill, and 'sectionable' within formal procedures.

3. Local Authority Duty to Accept Guardianship.

Section 387 of the Report refers to the duty of local authorities "to arrange for the provision of community care to include a duty to accept the responsibility of guardianship whenever guardianship is appropriate and cannot otherwise be arranged". On the other hand, in Section 381 of the report, the Commission argued that compulsory powers over a patient "should be regarded as authorising the hospital authorities to admit and detain him, not as ordering them to do so" and in a footnote added that "similar principles should apply when the patient is placed under guardianship in the community". In other words, the Commission argued, local authorities should not be legally obliged to accept all *bona fide* guardianship proposals but should maintain a general 'fall-back' responsibility to assume guardianship responsibilities where no other satisfactory arrangement could be made.

4. Development of Community Care.

The Commission recommended an expansion of community care services, by which they mainly meant local authority residential, day care and social work services. Indeed, they saw as appropriate an increasing use of guardianship taking place "when facilities for community care are expanded". (Section 399). It is generally accepted that this growth is not occurring within the time scale envisaged by the Commission and is still only slowly taking place. Barbara Castle writing in her Foreword to **Better Services for the Mentally Ill** in 1975 gave an unambiguous acknowledgement of the problem:-

"...it is 16 years since the Mental Health Act of 1959 gave legislative recognition to the importance of community care, but supported facilities in a non-medical, non-hospital setting are still a comparative rarity." (Para.3)

The main body of the report (para 2.8) reiterates this admission, saying that:-

"...by and large the non-hospital community resources are still minimal, though where facilities have been developed they have in general proved successful. The failure, for which central government as much as local government is responsible, to develop anything approaching adequate social services is perhaps the greatest disappointment of the last 15 years."

However **Better Services** makes no reference to guardianship or to the assumption of developing services upon which the future of guardianship was seen to depend. References to the working of the Mental Health Act, 1959, expressed general satisfaction, indicating only that there was a "need to look critically at the detailed working of the Act", and referred to a consultative document shortly due to be published (Section 2.16).⁽⁵⁸⁾

The Commission's Philosophy and Implications for Guardianship and Social Work

1. **Aversion to use of Compulsion.** This view is expressed at every conceivable opportunity in the report, reinforced by way of a normative use of the words 'could' and 'should'. For instance, Section 399, (quoted above), provides two typical comments by the Commission:-

- (a) "It [community care] *should* therefore usually be given without using compulsory powers";
- (b) "...in the great majority of [cases of mild or chronic forms of mental illness or infirmity that do not need to be in hospital] care *could* be provided without compulsion.

Thus, despite other comments indicating an anticipated increase in use of guardianship, the sentiments more often point to an appeal for people to consider guardianship as a last resort, and certainly not as an option of choice.

2. **Guardianship must inevitably entail Compulsion.** Following closely on point (1), but apparently contradictorily, is the reinforcement given to this idea and no reference is made in the Report to a voluntary basis for guardianship, despite the Commission's expressed intentions to limit use of compulsion as much as possible.

3. **Service Provision without Compulsion.** The Commission refer at a number of points to their concern to reverse the previous pattern by which services, i.e. care and treatment inside or outside hospital, were normally only available to people who are subject to certification, i.e. compulsion. In particular in Section 603 there is reference to the fact that: "after-care should be provided by the local authorities as long as is

needed, and should not be dependent on the continuation of compulsory powers such as licence or guardianship". Section 306 contains a similar sentiment, that: "there should be no question in future of compulsory powers being prolonged simply to give authority for the provision of after-care or in case the patient may need re-admission to hospital later in life...."Thus, the Commission may have inadvertently laid the basis for later official interpretations of the principles here enunciated to ensure that the idea of guardianship was not connected with particular entitlements to services.

4. **Rejection of 'Supervision'**. Having apparently detached the idea of guardianship (intended to form the basis for new legislation) from service provision, the Commission also (possibly unwittingly) shut the door on another relatively clear function of guardianship, i.e. to provide an effective monitoring system to ensure the person was not neglected or exploited, by its rejection of the term 'supervision'. The expressions 'voluntary supervision' and 'statutory supervision' had been used within the mental deficiency legislation and the Commission wished again to break from some of the language and terminology of that approach.

While it is true that the Commission mainly had in mind the disassociation of formal supervision with the care of mentally handicapped people in the community, it is also true that the term 'supervision' does not appear in any of the Commission's functional descriptions of guardianship. In other words, the Commission could see that control in the community could be one means of ensuring a person received community care but were reluctant to specify what control should be exercised as a means of achieving this end. Although the issue has remained a concern ever since, the term 'supervision' was soon rehabilitated - see discussion on the following page, and the 1978 White Paper interpretation of the Commission's view referred to on page 124.)

The Commission's main dislike of the term (supervision) seems to have stemmed from their belief that it "suggests enforcement of control, so that *it is preferable to use the term 'community care'.*" (sic) (*Section 606*) [This writer's emphasis]. The reference here to community care is ambiguous but Bean considers that the Commission were hoping guardianship would "...be used as a form of compulsion to guarantee community care for those who would choose otherwise", so as to become the "fulcrum of the community care

system".⁽⁵⁹⁾ Such a proposition is difficult to reconcile with the discussion offered in (3) above on entitlement to services. Arguably, guardianship could become essential in implementing community care policies only if it were also to be recognised as the means (i.e. as a vehicle in the widest sense or more narrowly as a 'trigger') for providing services to those who would otherwise refuse them.

5. The Quid Pro Quo Principle. In their general consideration of the future basis for compulsory powers (Section 312) the Commission state that:

"restriction of liberty is usually accompanied by the provision of special forms of care, treatment, training or occupation for the person who is placed under detention or control. Sometimes need for special forms of treatment or training is itself an essential element in the grounds on which compulsory restriction of liberty is accepted as justified."

The Commission then go on to examine the wider basis for the use of compulsion in society drawing a parallel with compulsion applied to children of school age as a means of ensuring that they receive necessary education. Thus the Commission appear to occupy an ambiguous position. On one hand they state the quid pro quo principle but at the same time do not wish the use of compulsion to be linked with entitlements *per se*. Possibly a fair statement of their view would be that whereas compulsion is justified in facilitating care and treatment for mentally ill people when it cannot otherwise be provided, the converse should not apply, i.e. compulsion should not be used, and certainly not justified, as a means of obtaining these ends.

6. A Paternalistic Basis for Guardianship. In general, the Commission avoided conceptualising guardianship and it is difficult at some points in the report to identify how the term is being used. In the absence of conceptualisation, the report nevertheless clearly conveys that the guardian's role is to exercise parental functions in the way described under previous mental deficiency legislation. Thus, within Section 400 of the report, the Commission say:

"When the procedures are used to place a person under guardianship, *the local health authority would exercise control equivalent to that of a parent over a child.* The patient would usually continue to live in the general community but the local

authority acting through its medical officers and social workers would be able to control his place of residence or employment and his use of his earnings and to ensure that he is provided with training or occupation or other forms of care."

The Commission's approach even extended to their view of how a local health authority should respond towards a person previously on guardianship who is admitted to hospital in circumstances where the local health authority would have "relinquished formal control over the patient ... [but who should continue to] have a duty to keep in touch with the patient *and act towards him as a good parent*". (This writer's emphasis).

At no point in the report is there an examination of whether a paternalistic basis for guardianship would be appropriate for people with mental illness, and the only likely explanation for this is that the mentally ill people envisaged by the Commission as included within the extended guardianship framework would be likely to have similar personalities and social situations as people previously subject to guardianship under mental deficiency legislation.*

7. The Social Work Connection The Royal Commission Report provides no discussion of the effectiveness of the key parties in the operation of Guardianship and therefore an opportunity to understand the extent to which social workers were involved in making guardianship applications or in becoming guardians was lost. No other literature can be found to shed light on this area.

An important strand in the development of statutory social work can be traced through developments of functions from those of relieving officers, duly authorised officers, to the title preferred by the Commission, namely mental welfare officers. However, in contrast to their successors (ASWs under the 1983 Act) no prescription was laid down as to whether these officers of local authorities would be social workers, either by background or by professional training. Nevertheless, the expectation that mental welfare officers would be drawn from the social workers employed by local authorities has been generally regarded as a recognition of a formal link forged between guardianship and social work, in that social workers (as mental welfare officers) were given responsibilities

* Kathleen Jones in a personal communication confirmed that this was the Commission's basic assumption.

to make applications for guardianship and would be expected to act as *de facto* guardians by delegated responsibility from medical officers of health.

Only one contemporary journal article concerned itself with the social work aspect of the change in legislation, considering increased local authority responsibilities through the extended guardianship approach, but even here the role of social workers as *de facto* guardians is not explicitly alluded to. This single reference to guardianship by Heap said that:

"The general duties of preventive social work [including] the supervision (sic) of patients under guardianship are not new...but this type of work may be very greatly increased under the new proposals whereby guardianship is to be extended to all classes of patients as may seem appropriate."

The article added:

"It is important to distinguish between compulsory detention in hospital and compulsory guardianship. The latter provision, which can be applied to any of the three categories of patients (mentally handicapped, psychopaths and mentally ill) raises the question of *the introduction of compulsion into social work*. One might question whether or not compulsion can in fact be applied in this way without some sort of sanction. The probation officer has the sanction of the court and of the prison behind him. Is the mental hospital to be the sanction behind the mental welfare officer or the psychiatric social worker? One would think the Royal Commission does not intend this, yet otherwise what meaning can the measure have? Again, how would such arrangements affect the casework relationship with casework techniques. This might be usefully considered with reference to the experience of the workers already in the field (sic)..." (This writer's emphasis).⁽⁶⁰⁾

Passage of the Bill in Parliament

Guardianship was not debated during the passage of the Bill through either House of Parliament but received some attention in the Standing Committee where Dr Donald Johnson (Member for Carlisle) argued that the inclusion of mental illness as a category within guardianship was open to abuse. He thought that the definition of mental illness was too wide and that people who were eccentric rather than mentally ill would be liable to be drawn into this provision by people who wanted to obtain their property and sought to control them. He said that there was:

"An incentive to unscrupulous people to take action in which...they may gain power over relatives of inconvenient people".

In response, the then Minister of Health, Derek Walker-Smith, claimed that there were adequate safeguards to prevent such abuse, namely the same stringent definition and criteria arrived at for hospital admissions and the scope for appeal to the Mental Health Review Tribunal. He went on to say that there was already:

"Some provision for the equivalent of Guardianship under the present law: and it is capable, I think, of useful expansion in the future, in particular in these two ways:

1. To prevent people needing to become inpatients who could be outpatients or day patients instead, or because they would be living with somebody who would be able to exercise a general control over their living conditions and so on;
2. (a) After care for patients who have not yet been fully rehabilitated; and for
(b) Chronic patients [unable to be further helped by hospital treatment who] could live in the community if, but only if, he (sic) is under some appropriate degree of control over his general living conditions".

For these groups, the Minister thought, Guardianship was "tailor made".⁽⁶¹⁾

The Mental Health Act, 1959

This section of the Review deals with the Act itself, the Memorandum of Guidance which accompanied the Act, and to the regulations governing guardianship issued by Statutory Instrument No 1241 in 1960.

The main section of the Act relating to Guardianship of the Person are Section 33 and 34 which laid down procedures and grounds for reception into guardianship.

Section 33(2) says that:

"A guardianship application may be made in respect of a patient on the grounds:

- (a) that he is suffering from mental disorder...[specifically mental illness or severe subnormality]...and that his disorder is of a nature or degree which warrants the reception of the patient into guardianship under this section; and
- (b) that it is necessary in the interests of the patient or for the protection of other persons that the patient should be so received."

Section 34 (1):

"conferred on the authority or person therein named as guardian, to the exclusion of any other person, all such powers as would be exercisable by them or him in relation to the patient if they or he were the father of the patient and the patient were under the age of fourteen years."

The 1960 Memorandum of Guidance gives clear and articulate expression to the scope and intention behind the new guardianship framework specified under Section 33 of the Act, and the following brief notes indicate the areas covered. Section numbers of the Memorandum are referred to in the left hand margin:

- (74) The new guardianship replaces guardianship under the Mental Deficiency Act and:-

"may also be used as a form of control over mentally ill patients who do not need to be in hospital" (replacing single patient and boarding out arrangements).

- (75) Guardianship should be unnecessary "in almost all cases" as services and help from family and the local authority should be sufficient. Furthermore,

"placing a patient under guardianship does not confer extra powers to provide services...it merely (sic) provides powers of control...necessary in a small minority of cases for the sake of their own welfare or for protection of others."

- (76) "The powers of guardians are....equivalent to the powers of a father over a child under the age of 14."

- (81) The local authority will have "duties of visitation and supervision" and remains responsible for this wherever the patient resides while under the guardianship.

"When the guardian is a private individual it will no doubt be usual for the patient to live with or near him, but if the patient resides temporarily or permanently in another area, eg. in residential employment, the responsible local health authority is the authority in whose area the guardian resides."

- (83) "The Minister does not think it necessary or appropriate, in present conditions, to specify such prohibitions as mechanical restraint or corporal punishment [prescribed under mental deficiency laws]. He expects local authorities to satisfy themselves that for [private] guardians - no less than the person put in charge of patients - who are directly under the authority's own care, whether under guardianship or not - are persons who understand the need always to bear in mind the special disabilities and special needs of...a mental patient placed in their care and who will look after the patient with proper knowledge and sympathy".

Also guardians had a "positive duty to act as a good parent would do" and particularly:

"To promote the patient's physical or mental health and to provide for his occupation, training or employment and general welfare and recreation, in a manner suitable to the individual patient".

The Mental Health (Hospital and Guardianship) Regulations, 1960, refer among other things to "General powers and duties of guardians" at Section 6 in the following terms:-

- "(1) The guardian shall, so far as is practicable, make arrangements for the occupation, training or employment of the patient and for his recreation and general welfare and shall ensure that everything practicable is done for the promotion of his physical and mental health.
- (2) ...the guardian may restrict to such extent as he thinks necessary the making of visits to the patient and may prohibit visits by any person who the guardian has reason to believe may have an adverse effect on the patient.

- (3) Nothing in this regulation shall operate to restrict the visits of any person authorised on their behalf by the responsible local health authority or the Minister."

THE GOVERNMENT'S REVIEW OF THE MENTAL HEALTH ACT, 1959

This part of the literative review considers the 1976 Green Paper, the responses by BASW, MIND, the Butler Committee and the Royal College of Psychiatrists; the 1978 White Paper 'Review of the Mental Health Act 1959' and the 1981 White Paper.

Apart from some discussion of the inappropriateness of statutory guardianship for some groups of people with mental handicap, the literature is silent between 1959 and 1976 on the subject of possible changes in law or practice in guardianship which would affect the situation of mentally ill people. With numbers around 20 mentally ill people per annum, it is surprising not to find comment indicating a 'failure' of the measure for this care group or the need for constructive practice guidance on its use. No Code of Practice followed the 1959 Act and the professional literature seemed not to see a need to make up for its absence.

The overwhelming consideration in the Government's decision to review the legislation was concern over civil liberties and possibilities of abuse under existing powers. However, none of the recorded concerns related specifically to guardianship.

The 1976 Green Paper makes no specific comment on guardianship for mentally ill people and only discusses guardianship in general terms in a brief six paragraph chapter (No. 5). The Review, after pointing out that the number of guardianship cases has decreased considerably and steadily since 1959, points out that:

"Guardianship provides the only effective form of control for those mentally disordered adults in the community for whom some form of compulsory powers are required...[and offers] a useful half-way measure between detention in hospital and complete freedom in the community."⁽⁶²⁾

The Review felt it was important to ascertain the reasons for limited use of guardianship before following the Royal College of Psychiatrists, MIND and the Butler Committee in recommending greater usage for the future.

In many ways the response of BASW to the White Paper, **Mental Health Crisis Services - A New Philosophy** ⁽⁶³⁾, obscured its thinking on guardianship by its arguments for the introduction of 'community care orders' (CCOs), intended "to provide care within the community for use when the individual person refuses or is unable to agree with the recommendation that he is in need of such care", without at the same time being clear as to the need for guardianship to continue to parallel with the CCO. At one point (Section 4.2) the CCO is claimed "to a large extent supersede the existing powers under Guardianship" whilst elsewhere (Section 19.3) it is said that "even if CCOs were introduced we think it would be necessary to retain Guardianship".

BASW made recommendations for modifications of guardianship (which might be presumed to mean that they saw a continuing role for it in addition to CCOs), but their recommendations that guardianship needed "simplifying in terms of streamlining its administration so that it is locally based and easily accessible and accountable to the patient and interested parties" is unspecific and imprecise.

The main differences between the proposed CCO and guardianship would seem to have been as follows:-

1. The CCO is seen strictly speaking as an alternative form of care to hospital care, whereas guardianship can continue whilst a person is in hospital and, indeed, a guardian could be instrumental in facilitating hospital care as part of his or her role.
2. The compulsory element and the responsibility for exercising it would reside with the local authority in a much more explicit way than with guardianship, in that a social worker would have responsibility for deciding whether a CCO was appropriate or not, exercising the necessary compulsion; and, in carrying through the order. The social worker would "have power to commit his authority to act as care agent..." and the local authority's responsibility would be "to provide treatment, care and control for a person subject to a CCO".

3. The compulsory powers are exercised by social workers who would be "approved", i.e. not only authorised as qualified to exercise their powers (as was basically to be the rationale for the introduction of ASWs under the 1983 Act), but carrying a level of responsibility on behalf of the local authority, comparable to that of a medical practitioner in relation to health service facilities for hospital admissions, which would give them access as of right to social services facilities.

In other respects there were obvious similarities between CCOs and guardianship and BASW refer to the powers under CCOs as including:

"To determine the place of residence, require attendance at specified places for specified purposes, and require that persons receive visits at this residence or elsewhere."

CCOs were described by BASW in a way as to suggest that they were mainly considering the needs of mentally ill people, having said (Section 7) that people with mental handicap should be excluded from the operation of the Mental Health Act. They argued (curiously) that since "the present powers of guardianship are rarely used, we can see little purpose in retaining them for the mentally handicapped" (ignoring the fact that most usage of guardianship at that time related to people with mental handicap). BASW argued that preferable arrangements for people with mental handicap would be "some form of non-statutory guardianship provision with the accent on advice and guidance rather than compulsion". The guardian "should be independent of any person or agency which is professionally involved with the mentally handicapped person" along the lines advocated by the (then) National Association for Mentally Handicapped Children,⁽⁶³⁾ and more specifically by Mason.⁽⁶⁴⁾ The BASW paper did not explain whether this non-statutory guardianship could also serve the needs of people with mental illness or whether it was assumed that the latter already received voluntary and informal kinds of guardianship.

If statutory guardianship for people with mental handicap had been removed from the Mental Health Act, this would have left both a (revised) guardianship and CCOs to run

in parallel to meet the needs of people with mental illness with an indistinct difference between the way these two forms of statutory provision would meet clients' needs. However, whilst it can be said that these proposals did not assist in clarifying the guardianship concept or in furthering its use, BASW's views seems to have stimulated thought around the need for guardianship measures. Possibly, this is because their approach emphasised the following important arguments which advocated:-

- "Concentrating resources upon the individual and his living group rather than upon hospital based-services."
- "Developing a legislation which aims at relieving the stress within the living situation rather than concentrating upon removing the individual to hospital."
- "Recognising that alternatives to compulsory hospital admission are to a certain extent dependent upon the provision of appropriate facilities and services."
- "The importance of searching for alternatives to compulsory admission, and of making an assessment of the ability of the family or the community to cope with the patient at home."
- "Care for a patient [should be provided] in the least restrictive conditions possible and within their own living environment."

BASW considered that developments of mental health services and changes in the legislative framework should be looked at together and their comments on the White Paper therefore also included a critique of **Better Services** concluding that "the overall aims should be to promote a system which stresses 'growth and development' rather than 'illness and treatment'."⁽⁶⁶⁾

The Report of the Butler Committee on Mentally Abnormal Offenders, 1975⁽⁶⁷⁾ was mainly considering Guardianship from the point of view of use by the courts for offender patients. They compared guardianship with probation orders in terms of their effectiveness and concluded:

"Guardianship orders impose certain obligations which are not involved in psychiatric probation orders, and they are imposed compulsorily whereas probation orders are accepted by the offender on a voluntary basis. Guardianship

is a valuable form of disposal which is at present very little used...explained in part by general lack of understanding of what is involved...[and also by] reluctance of the social services departments to accept the addition to their already substantial burden of the heavy demands that the law makes in these cases...[However] as regards the comparison with the probation order there is an important difference between the effect of the two orders. The probation officer can bring back to court an offender under his supervision who does not cooperate, but with the adult under guardianship there is no sanction for breach of the order."

Representation from MIND, associated with a campaign for the enhancement of civil rights within revised mental health legislation, expressed criticism of the position taken by BASW in advocating a wider range of powers to provide care in the community.

However, Gostin, at that time legal adviser to MIND, has offered two important but rather different views of guardianship. In 1977, he was writing that:-

"Guardianship is a powerful tool, which can be a viable and effective alternative to hospital admissions. It would obviate some of the need for expanding tribunal powers...a use of guardianship orders which is in practice quite rare. They could in many more instances be a viable and beneficial alternative to admission for treatment, and should be used more frequently by the medical profession (sic) as a means of assuring community-based treatment."⁽⁶⁸⁾

On the other hand, by 1983, Gostin had decided that guardianship of the person (as distinct from guardianship of the estate) needed to contain two distinct elements:-

1. "[recognition of the fact of] incompetency of an individual to make certain decisions"; and
2. "the authority delegated to another person to make decisions on behalf of the Ward."

Notably, however, Gostin goes on from this latter analysis to argue for the introduction of limited forms of guardianship in which the extent of the client's capacities are valued and weighed against the need to act on his/her behalf. He also argues strongly for the introduction of *facilitative guardianship* which would place on the guardian:-

"positive duties to support, assist and encourage the patient towards greater independence".⁽⁶⁹⁾

The wider significance of Gostin's analysis is in support of a proposal for combining guardianship of the person with guardianship of the estate.

Representation from the Royal College of Psychiatrists as part of their formal response to the Review of the Mental Health Act, 1959, looked at the Act section-by-section and observed of guardianship that it has:

"rarely been used in relation to mental disorder by the Local Authorities...[and we note that] there is uncertainty at the moment as to who will be responsible for making the recommendation for Guardianship [- health or social services... Nevertheless...] the need for Guardianship will increase and [we] therefore recommend retention of these Sections [of the Act]"⁽⁷⁰⁾.

The College did not support the setting up of a parallel scheme of advocacy or 'patients' advisers'.

THE 1978 WHITE PAPER⁽⁷¹⁾

This White Paper contained a 'green' element at Chapter 4 where some far-reaching considerations regarding guardianship and compulsory powers in the community were discussed. The Government looked at the views of MIND, the Royal College of Psychiatrists, the Butler Committee and in particular at the above mentioned views of BASW in favour of introducing CCOs. The Government was impressed by BASW's argument that it is "undesirable to admit people to hospital simply because of a lack of services in the community" and that in the absence of appropriate compulsory powers in the community "persons needing care and control may be faced with perhaps unnecessary detention in a hospital". On the other hand they raised the familiar question about the sufficiency of "sanctions in the event of the patient's failure to comply with the requirements laid on him" and questioned whether "social services staff might be unwilling to take on the responsibilities involved in new compulsory powers, or might be unable to take on the burden of extra commitments".

The White Paper also expressed concern about 'net widening', i.e. the possibility of more people being subject to compulsory powers through the introduction of CCOs, and doubted whether doctors would be happy with social workers exercising such powers in respect of people who, the doctors might argue, would probably be more appropriately admitted to hospital in any case. Partly countering their own arguments, they thought that social services' reluctance to take up the use of guardianship would effectively prevent any significant increase in use of compulsory powers generally and also acknowledged that "the lack of an effective sanction can be said to apply to most forms of compulsory detention in hospital at present, particularly where open door policies are fully operative". The White Paper's proposals were the now famous "three main options", which were really five options of which only three were seriously considered. The five options were as follows:

1. *Guardianship in a Revised Form* (Sections 4.14 and 4.15)

The White Paper considered that one of the reasons for comparative lack of use of guardianship was a view that the powers of the guardian were too wide, to the extent possibly of including a ban on marriage and of being unable to make a valid legal contract. Most of all, however, the White Paper felt that the 'parental' powers were out of place and inappropriate other than for severely mentally handicapped people who need total protection ("where there is a need to protect the individual from neglect and exploitation and to make more, if not all, of his decisions"). In short, guardianship had failed to be used for the mentally disordered in general (but particularly the mentally ill) as "a real alternative to detention in hospital" for these reasons - see option (4) below.

As far as the White Paper was concerned, the excessive breadth of the powers were encapsulated in the phrase "necessary *in the interests of the patient* or for the protection of other persons" and the formula "*patient's welfare*" was put forward as an alternative. Other changes proposed were to reduce the periods of guardianship in line with those of admission to hospital for treatment under Section 26 of the 1959 Act - i.e. to six months.

The White Paper said that: "the Guardian would continue to have power to consent to treatment on the patient's behalf", a surprising statement considering the disputed nature of this power - but see the White Paper proposal and the essential powers' approach outlined below.

2. *Community Care Orders.*

This proposal, as outlined in the BASW document, was for "a range of community care orders paralleling compulsory hospital powers" in which the Government were interested particularly as means of avoiding unnecessary hospital admissions. However, the 1978 White Paper's response was that:-

"...the extent of control which community care orders will entail is so wide that this option might well suffer from the same disadvantages as Guardianship has in the past". (Section 4.16)

3. *The 'Essential Powers' Approach: Introduction of 'New Specific Powers'*

This option would limit "restricting the liberty of the individual only to the extent necessary to ensure that various forms of medical treatment, social support, training or occupation are undertaken", i.e. powers:-

- i. To require residence in a specified place;
- ii. To require attendance at specified places for treatment, occupation or training;
- iii. To require access to be given to a particular person (for instance a doctor or a social worker) in the patient's home or elsewhere. (Section 4.17).

The White Paper left it as an open question (Section 4.18) as to whether it was "desirable to have a power to impose treatment on people subject to such an order

under the same arrangements as those for people detained compulsorily in hospital".

4. *The co-existence of the Essential Powers and Traditional Guardianship arrangements,*

This would involve the availability of "two different powers for two different groups of people", namely: guardianship for those with "little or no understanding, empowering guardians to consent to or refuse treatment, arrange admission to hospital etc. where necessary on his behalf"; while the 'Essential Powers' would, by implication, deal with mentally ill people and those with some understanding who yet needed a framework of control which would minimally consist of the three powers referred to above. (Section 4.20)

The significance of this suggestion in the White Paper was that it was in practice suggesting a two-tier approach to guardianship: plenary or total guardianship for those whose overall life style required supervision and control, and a form of limited guardianship for those who did not require complete control. By implication, the latter would be people suffering from mental illness.

5. *CCOs and Guardianship coexisting*

It is not clear whether it would have been practicable or desirable for these two forms of order to coexist since the scope of the powers was broadly similar and the CCO was not the equivalent to limited guardianship in the same way as the essential powers would have been. The advantage of the two coexisting was said to be to provide "flexibility". (Section 4.20)

The White Paper also raised again the issue discussed by the Royal Commission of the need for a short term emergency guardianship order and suggested that it could still be introduced. However it rejected again the Royal Commission's proposal that local authorities should have a duty to assume the responsibility of guardianship "whenever there are no other suitable guardians", considering that local authorities "must be free to

assess the desirability of their assuming compulsory powers in the light of their knowledge of each individual case" and proposed no change (see comments on this Royal Commission recommendation in the BASW document).

Contrary to the Royal Commission's actual choice of words about the relationship between guardianship and supervision, the 1978 White Paper says (Section 4.11) "The Royal Commission saw [compulsory supervision in the community] as one of the appropriate uses of guardianship" and announced the Government's view at that stage as seeking "a single power for compulsory supervision intended to prevent unnecessary admission to hospital and for compulsory after care following discharge from hospital".

Elsewhere (Section 4.9), the 1978 White Paper asserts that the Commission had hoped that guardianship would be considered "as a way of reducing unwillingness to accept help and as a way of providing supervision, guidance and control which would be a real alternative to detention in hospital".

Under the heading 'Practice since 1959', at Section 4.7, the 1978 White Paper says that:-

"The use of guardianship powers has declined steadily since their introduction and practice varies considerably between local authorities. The Royal Commission expected that as community psychiatric services developed, guardianship would become more frequent but this hope has not been borne out. Nor has their hope that guardianship would be used for the mentally ill and psychopaths. In practice, guardianship has been used predominantly for the mentally handicapped and the severely mentally handicapped and only rarely for the mentally ill."

This statement is problematic in a number of ways. The first sentence implies that guardianship powers were introduced in the Mental Health Act, 1959, whereas modern statutory guardianship dates from 1913 (for mentally handicapped people); and the predominant use for this group, though diminishing, dates from the 1920s and 1930s. By comparison, use for mentally ill people is small, but has been (and is) increasing as a percentage of use as between mental illness and mental handicap since 1959. (See Appendix B).

1981 WHITE PAPER⁽⁷²⁾

The 1981 White Paper said that guardianship was intended for:-

"A very small number of mentally disordered people who do not require treatment in hospital, either informally or formally, [but] nevertheless need close supervision and some control in the community as a consequence of their mental disorder. These include people who are able to cope provided that they take their medication regularly, but fail to do so, and those who neglect themselves to the point of seriously endangering their health."

The White Paper does not make plain whether the mentally disordered people referred to are mainly those with mental illness but this seems to be confirmed by their further assertion that existing powers:

"[i.e. those of] a father over a child under 14...are very wide as well as somewhat ill defined, and out of keeping, in their paternalistic approach, with modern attitudes to the care of the mentally disordered".

Also suggestive of a focus on mental illness is reference to people who "fail to take their medication regularly", and the 1981 White Paper identifies the essential powers approach (the third option identified by the 1976 White Paper) as including the power to ensure that the person on guardianship "receives medical treatment...." However, without further reference to the 'open question' left in the 1976 White Paper as to the desirability of imposing treatment on those under guardianship, the 1981 White Paper announces in Section 45 that:-

"One of the effects of the proposed change in guardianship powers [towards option 3, the essential powers approach] is that the guardian will clearly not (sic) have implicit power to consent to treatment on behalf of the patient."

The 1981 White Paper acknowledged the wide range of responses to the 1978 White Paper proposals but stated that the view most widely supported was that "guardianship powers should be retained, but...the guardian should have only the 'essential powers' rather than all the powers of a father over a child under 14 has at present." The essential powers were identified as the:

- (a) power to require the patient to live at a place specified by the guardian;
- (b) power to require the patient to attend places specified by the guardian for medical treatment, occupational training;
- (c) power to ensure the doctor, social work or other person specified by the guardian can see the patient at his home.

The 1981 White Paper also adopted the change of wording in the criteria suggested by the 1978 White Paper, substituting "in the interests of the welfare of the patient" in place of "in the interests of the patient" as "this will clarify (sic) the purpose of guardianship and ensure that the power is not so wide".

Finally, the 1981 White Paper, in summarising the main improvements which would be achieved by the impending Bill, refers to guardianship thus:

"Guardianship powers are made to fit current good practice" (page 2)

Notably, however, there is no indication of: (a) what constitutes good practice; (b) the connection between the statutory procedures and the facilitation (or otherwise) of good practice; or (c) the identification of the practitioners referred to, as between social services managers, social workers, general practitioners, consultant psychiatrists or others.

The Passage of the Bill in Parliament

As with the 1959 Act, it was only at the Committee stage that issues related to guardianship received attention. In their discussion of Clause 7, the Special Standing Committee⁽⁷³⁾ were addressed by Mr Terry Davies who proposed that the guardianship arrangements provided for under Clause 7 should be supplemented by a 28-day guardianship order. He maintained:

"The suggestion was put forward by the British Association of Social Workers. It would make possible short-term Guardianship where the facilities are available and, in a sense, it is a paving power".

In response, the Minister, Mr Kenneth Clarke, voiced his interpretation of BASW's proposals as follows:

"During the relatively restricted period [of 28 days] the guardian - either the local authority or someone nominated - will be able to direct a person to various places of residence...particularly...to go to a crisis intervention centre rather than to a hospital. That would be a startling change in the nature of Guardianship compared with that contemplated before and would perhaps not be an altogether welcome improvement.

Guardianship has always been regarded as a long-term arrangement to enable a patient suffering from mental impairment or mental illness to cope in the community".

The Minister added that he saw the traditional role for guardianship as providing protection against exploitation, and considered the new proposal as a restriction on peoples' civil liberties. In any case, the notion that crisis intervention centres could provide alternative care on a compulsory basis seemed to him unrealistic, as there was no evidence of them being able or willing to function in this way. The move was "going in the opposite direction to the Bill" and would add to the amount of compulsion being used rather than to limit it. Even though the Royal Commission, the 1978 White Paper and BASW had supported such a proposal, in fact their intentions varied; there were inconsistencies between them, and the BASW current proposals were unrealistic and unsupported by others, including MIND.

Terry Davies counter-argued that the measure should be viewed as an experiment in providing a flexible alternative to hospital care, one of the original objectives of guardianship as defined by the 1959 Act. The Minister retorted that the short-term power was open to abuse by relatives, doctors and social workers. He was opposed to the idea of a 'cooling off' period in which the patient was placed in a hostel or in some other setting as an alternative to hospital admission and the notion of flexibility did not appeal to him. Even if the measure was renamed a 'community care order' (with or without some of the definitions offered by BASW of CCOs), the Minister saw no greater virtue.

In short the Minister articulated the prevailing ethos, namely that changes in the mental health legislation should be seen to identify clearly with enhancement of civil liberties and firm intentions to reduce aspects of compulsory care and treatment which unduly restricted civil liberties. He therefore chose to view the 28-day proposal as a form of 'net-widening', i.e. additional compulsion being invoked rather than a different or alternative form of intervention.

The Mental Health (Amendment) Act, 1982

The review of the 1959 Act culminated in amending legislation. This provided for Guardianship in terms explicitly linked back to those of the 1959 Act (the principal Act), but redefined guardianship grounds and powers as the revised 'essential' minimum necessary. The wording is otherwise identical to the 1983 Act (see Statutory Definition, pages 27/28).

GUARDIANSHIP UNDER THE MENTAL HEALTH ACT, 1983

Introduction

The remaining material in this chapter refers to contemporary guardianship law under Sections 7 and 8 of the Act and the Memorandum of Guidance and is complementary to the statutory definition offered from page 27 onwards as applicable to people with mental illness. After discussing the Act and the Memorandum of Guidance, main attention is given to the various Codes of Practice and to the Biennial Reports from the Mental Health Act Commission. The most recent of these latter (1989/91) is judged to provide authoritative contemporary comment.

Mental Health Act, 1983 Sections 7/8

Sections 7/8 of the Mental Health Act 1983 followed the terms of the previous interim legislation, the Mental Health (Amendment) Act, 1982 and are regarded as essential reference points for social workers making decisions about the use of guardianship. For instance, the latest Code of Practice specifically enjoins practitioners to eliminate the use of guardianship from their thinking if one or more of the three powers referred to in

Section 8(1) are not required. The following concentrates on key aspects of the Act, i.e. criteria for use of guardianship powers, such as they are.

Section 7 says that guardianship is applicable to people with mental illness over the age of 16 provided the "mental disorder is of a nature or degree which warrants his (sic) reception into Guardianship..."; and that "it is necessary in the interests of the welfare of the patient or for the protection of other persons...." Two medical recommendations are required and the guardian may either be social services or a private guardian, provided social services accept the guardianship on behalf of that person. Section 8 contains the three 'essential powers': the residential requirement; the attendance requirement; and the access requirement. Section 8(4) effectively provides the nearest relative with a veto on a guardianship application and requires social services to consult him or her unless this is impracticable.

Making a comparison between guardianship arrangements for mentally ill people under the 1959 Act and the 1983 Act, enables us to say that the 1983 Act:

- Reduced the periods over which the order is in force from 12 months to 6 months with pro rata changes in the renewal provisions.
- Done away with the age limits apropos persons suffering from "psychopathic disorder or subnormality".
- Changed the criteria from "necessary in the interests of the patient" to "necessary in the interests of the welfare of the patient".
- Narrowed the scope of the guardians' powers, though without indicating how a guardian would go about enforcing these powers.
- Increased the lower age limit of applicability from 14 to 16 so that there is no longer any overlap between child care legislation and mental health legislation.

The 1983 Memorandum of Guidance, an official pronouncement on guardianship and a key reference point for social workers in making decisions, is quoted extensively on pages 28/29. The Memorandum reverts to earlier normative language in saying that guardianship is suitable only for "a small minority of...mentally disordered persons...to enable relatives or social workers...to manage [to provide care] in his (sic) own home or in a hostel, where the alternative would be admission to hospital". Apparently anticipating discussion about the connection between guardianship and consent to treatment, the Memorandum goes on to say that:

"the purpose of Guardianship is therefore primarily to ensure that the patient receives care and protection rather than medical treatment, although the Guardian does have powers to require the patient to attend for medical treatment (but not to make him accept treatment)". (Section 45)

Of the essential powers, the Memorandum comments that the residential requirement could "be used to discourage the patient from sleeping rough or living with people who may exploit or mistreat him, or to ensure that he resides in a particular hostel or other facility". Of the access requirement, the Memorandum explains that this is available "to any doctor, approved social worker, or other person specified by the Guardian ...[in order] for example, to ensure that the patient did not neglect himself". Although the client cannot be prevented from leaving his place of residence within the terms of a guardianship order, "he may be taken into custody and returned within 28 days of leaving" these premises (Section 138 of the Act).

Of the credentials of a guardian (i.e. of a private guardian explicitly, but by inference anyone acting as *de facto* guardian) the Memorandum says that this should be:

"a person who can appreciate the special disabilities and needs of a mentally disordered person and who will look after the patient in an appropriate and sympathetic way. A Guardian should display an interest in promoting the patient's physical and mental health and in providing for his occupation, training, employment, recreation and general welfare in a suitable way." (Section 48)

There are two surprising and interesting elements in these notes, namely the comments in Sections 43 and 48.

In Section 43 there is a reversal of approach to a reiteration of the position that the "control of guardianship" should generally not be necessary, as if to imply again that guardianship is a last resort or an admission of failure. Also in the last line of this section is the reference to guardianship as an alternative to hospital, a highly questionable assumption, given the definition discussion, on pages 48 to 54. This is confirmed elsewhere in the regulations, in the same way as was the case for the 1959 Act, where it is said (Section 91) that patients under guardianship may be admitted to hospital. Guardianship can remain in force whilst a patient is admitted under Sections 2 or 4 but does not remain in force when the patient is admitted under Section 3 for treatment (Section 6(4)).

Section 48 of the Memorandum gives some insight into how the guardian as a person with specific attributes is regarded, although it is notable that despite the apparent change in style brought about by the move to limited guardianship and away from total guardianship, the kind of response expected from the guardian himself or herself retains a good deal of the paternalistic values/attitudes that one might have expected from guardians operating under the old model.

THE CODES OF PRACTICE, 1985-1993*

Four attempts have been made to provide a Code of Practice regarding the implementation of the Mental Health Act, 1983: the 1985 draft prepared by the Mental Health Act Commission; the 1987 draft prepared by the Department of Health; the 1989 revised draft provided by the Department of Health together with a steering group drawn from representatives of the professions and other interested parties; and the finalised version of this document published as the 1990 Code of Practice. In view of the long time lag between the first draft and the final publication, it is assumed (with some verification from scrutiny of committee papers of individual social services departments)

* A revision of the 1990 code has recently (June 1993) been produced by the Department of Health, but is unchanged in respect of guidance on Guardianship.

that each draft was studied and used as a *de facto* code on an interim basis to varying degrees by social services in general and ASWs in particular.* For this reason, each draft is referred to below for its particular features with regard to guardianship.

The 1985 Code

By far the most expansive and descriptive of the four versions, the Mental Health Act Commission's draft sought to create an imaginative profile of guardianship, its uses and ways of developing the concept professionally and organisationally.

In terms of concept, the Code offers no less than six definitions of guardianship, as follows:

1. Section 3.3 Synopsis: "Guardianship is the least restrictive [and most humane] mode of compulsion with the minimum imposition on patients."
2. Section 3.2 (ii): "A degree of real authority to supervise and control but at a level less restrictive than that available in hospital."
3. Section 3.5 (i): "Either the immediate alternative to admission or the mode of transfer to the patient detained in hospital who shows stable improvement but still needs some degree of control; or to provide some degree of supervised care and protection of patients."
4. Section 3.6 (ii): "A means to promote the welfare of the patient by providing such physical, social, emotional recreational and spiritual conditions as are conducive to his well being."
5. Section 3.8 (ii): "[An arrangement conferring on] the Guardian a particular responsibility to motivate, persuade and encourage the patient to participate in the plan of treatment and to accept the treatment prescribed by the doctor."
6. Section 3.10 (v): "A subtle mixture of compulsion, persuasion and freely agreed co-operation [between Guardian and Client]", the nature of which the Code of Practice does not explain.

* It has to be borne in mind that the codes are intended to guide all professional groups involved in implementing the Act - not just social workers.

The Code provides criteria for the 'success' of guardianship but does not define the end product or ultimate objective in a way which would clarify whether success has been realised or not. The Code says that "the success of Guardianship depends on at least seven factors":

1. "The competent and willing guardian".
2. "Professional support and advice for the guardian as necessary"
3. "An acceptable place of residence for the patient which facilitates care and treatment, and ensures the protection of others".
4. "The services for day care, for education, training and occupation accessible to the patient".
5. "A mutually-co-operative relationship between the patient, the approved social worker, the nominated medical attendant or responsible medical officer, the nurses in the community, and the guardian and the persons responsible for the day to day needs and care of the patient".
6. "An endorsement of the arrangement by all concerned for the welfare of the patient, and, where appropriate, the support of the patient's family and relatives.
7. "The patient's condition being such that care in the community is the most appropriate arrangement".

The Code does not refer directly to the amount/quantity of guardianship usage, nor to the idea that the present amount of usage is insufficient. Instead the Code refers to positive benefits which would be gained by "an increase in the use of guardianship" as follows:-

- "A committed interest by professionals to provide good care in the community".
- "An effective relationship between the National Health Service and the local authority Social Services departments at both the clinical and planning level..."
- "...a willingness to take practicable steps to maintain and protect civil rights when considering the needs of patients".

These comments are significant in their three respective references, viz.:

1. This is the first time that the use of guardianship has been equated with quality of care to clients *per se*.
2. The Code at this point demonstrates a willingness to bridge the gap between individual decision-making about guardianship and the stances and intentions of the respective statutory authorities, thereby implying the need for agency commitments or policies in the area of guardianship which are generally seen to be conspicuous by their absence.
3. The linking of the use of guardianship with the promotion of civil rights in this way contrasts with commentary in the UK and the USA suggesting that guardianship should be viewed as a threat to civil liberties - (see, for example, Mitchell⁽⁷⁴⁾).

The idea of a promotional document on proper use of guardianship is advanced (Sections 3.6.5) and its contents indicated as follows:

"The arrangements for considering applications; the criteria for acceptance by the local Social Services authority; the powers and duties of a guardian; the arrangements for maintaining contact during the department and the guardian and other persons responsible for the day-to-day care of the patients;

"The procedures for discharge, transfer and appeals; the arrangements for regular professional review of the circumstances of each particular person under guardianship including the plans for his care and control of medical treatment; the practices involved in the instruction and supervision of those who have day-to-day responsibility for caring for the person under guardianship; the criteria for places specified which a patient under guardianship can reside".

The Code also says that local authority social services departments should devise "a plan of care and treatment for clients for whom guardianship is intended" (Section 3.10.1) which would include:-

- suitable arrangements for day attendance for occupation or treatment;
- clear arrangements for providing the guardian with access to the client;
- provide a clear indication of specific medical treatments required;
- clear understanding that medical treatment can only be provided by voluntary agreement in the absence of "legal authority to compel the patient to accept it". (Section 3.10 2/4)

By inference, discharge arrangements from guardianship should also be part of the plan, i.e. as "a positive act taken with regard to the patient's condition and needs, [as distinct from] the consequence of merely allowing a guardianship order to run out".

The Code also offers a wider range of comment on the groups of clients for whom guardianship is "particularly appropriate", viz.:

- for "old people with mental disorder [who] may be unable to live outside hospital ...guardianship should be considered more frequently as treatment of choice...as a real option";
- for young people over 16 leaving care of local authorities and (previously under child care legislation) " to provide a better means of meeting needs, particularly where [they] are liable to become homeless, exploited or a danger to others";
- "...young offenders, when resident in hospital and treatment is not essential";
- "brain damaged people presenting serious problems in care, thus providing for their care and for protection of others from their behavioural difficulties".

Finally, the Code offers a view on the service-providing assumptions upon which guardianship might be expected to be based, to a pre-condition of "appropriate and adequate facilities and resources [being] available" (Section 3.1); while duties of local authorities are listed as including those of endeavouring to secure sufficient facilities and co-operation to enable those patients who would benefit from being received into guardianship to be thus received. Furthermore, in a section headed "rights conferred on a patient", the Code says that "guardianship confers on the patient the right to have his or her welfare maintained and promoted [by the local authority social services department]".

In other respects, the Code is largely a re-statement, somewhat expanded, of the Act itself and of the Memorandum of Guidance, in some instances changing the wording but without explaining the significance of these differences. This is particularly important in Section 3.8.1, which refers to the duties of a guardian (as 'duties' rather than 'powers') listed as three ways of "ensuring that..." rather than as the three powers defined in the Act.

Seemingly the Code was at some stage intending to discuss more fully the role of social worker *vis-a-vis* guardianship but became involved in some internal dissension on the subject. This was concluded without further explanation by brief reference to the matter in a 'side letter' to the Draft Code:-

"Is an individual social worker a desirable (sic) person to be appointed as guardian? The inference from the specific tasks of the guardian is that a social worker should act *in support rather than at first hand.*" (this writer's emphasis)

It can only be deduced from this comment that some members of the MHAC identified with arguments discussed in Chapter IV (pages 201/202) supporting the idea of the guardian as someone acting independently of the agencies concerned with service provision.

The 1987 Draft Code of Practice

This draft concentrated on making its observations as brief as possible and therefore followed the legislation more closely than the 1985 Code and without expansion.

The main distinctive points made in the Code refer to powers of confining the person under guardianship within a place of residence, namely that:

"Guardianship does not allow detention of a patient in hospital or other accommodation. It may only be used for securing the admission of an unwilling person into Part III accommodation if this is part of an overall care and treatment plan for his mental disorder."

In relation to general guidance for the appropriate use of guardianship and possibilities for greater use, the Code reverts to the sentiments of the earlier draft by arguing that:

"...an approved social worker or any social worker...[should] be able to help a patient in the community without needing any particular powers under the Mental Health Act. Only if this is not possible over an extended period is it likely that guardianship may be necessary."

Guidance as to the significance or anticipated length of an 'extended period' was not offered.

Finally, this Draft Code attempted to expand somewhat on the welfare criteria for the use of guardianship under the Act, viz.:

"In considering the patient's welfare all factors which might affect the patient's future well-being have to be taken into account to ensure the patient receives care and protection."

The 1987 Draft Code has a substantial section on 'Monitoring' but the content is largely related to a re-statement of the duties of local authorities to keep themselves informed about guardianship arrangements, particularly when these are being undertaken by a private guardian. No notion of a role for central Government, or any other over-arching body is seen for monitoring guardianship practice developments or to comment on changes in the pattern of guardianship usage.

The 1989 Draft Code of Practice and the 1990 Code of Practice

The 1990 Code is substantially the same as the 1989 Draft Code and the two are discussed together below. It is the most up-to-date statement of recommended practice in operating statutory guardianship, and the most salient points in the 1990 Code are indicated below.

In the first place (Section 13.1), guardianship is here arguably viewed in two contrasting ways: both as "an authoritative framework"; and essentially as "part of the patient's overall care and treatment plan". In the latter light, practitioners should view guardianship "as a positive alternative...to admission to hospital and continuing hospital care". Discussion about the appropriateness of guardianship should take place within a multi-disciplinary framework, making use of the case conference format unless time constraints preclude this.

Most important of all, the Code spells out the need for, and the nature of, "a comprehensive care plan...which identifies the services needed by the patient, including as necessary his care arrangements, appropriate accommodation, his treatment and personal support". The component parts of the plan are identified thus:

- a. an acceptance of the authority of the guardian by the client;
- b. the guardian's advocacy role with regard to services required by the client;
- c. local authority support to the guardian;
- d. an appropriate place of residence;
- e. access to appropriate day care facilities;
- f. co-operation and communication between all those involved;

- g. commitment from those involved that care should take place in the community.

The Code goes on to state the duties of social services departments, largely reiterating the legislative requirements, but also stressing the following:-

- * arrangements to process applications should be undertaken speedily;
- * progress of guardianship should be monitored (including maintaining detailed records and ensuring that a review takes place towards the end of the guardianship period);
- * ensuring that guardianship clients receive information on their rights, especially entitlement to apply to an MHRT;
- * ensuring that guardianship orders are discharged rather than being allowed to lapse.

The Code emphasises that guardianship does not provide powers to forcibly detain or remove a person, so that if a client consistently declines to accept the guardian's directions, this (in the view of the Code's authors) indicates that guardianship is inappropriate.

Finally, the Code stresses that, whilst guardianship can operate legally whilst a person is in hospital (e.g. to receive treatment as an informal patient or to be detained under Sections 2 or 4), guardianship clients should not remain in hospital longer than is absolutely necessary in order to arrange another place of residence. While guardianship may have a part to play in providing the authority base for moving a person from hospital care into an alternative place of residence, such as a residential care home, it should not be used exclusively to facilitate transfer of unwilling persons. The question of whether a hospital patient under guardianship who was without a home address effectively resided in hospital as his or her 'place of residence' is not tackled.

THE MENTAL HEALTH ACT COMMISSION, THE BIENNIAL REPORTS (1983-1991) AND SPECIAL GUARDIANSHIP

The MHAC have a monitoring role related to persons subject to compulsory measures under the Mental Health Act. Their formal remit is confined to people placed in hospital care and does not extend to compulsory powers under guardianship for people cared for by local authority social services departments. On the other hand the MHAC were charged with providing the Secretary of State with the first draft Code of Practice on the 1983 Act, and this included guidance in the use of guardianship.

Their position would therefore appear to be that they take an interest in use of guardianship in relationship to other compulsory powers under the Act, and indeed visit social services departments to discuss guardianship alongside other actions and practices involved in the running of an ASW service.

The MHAC are clear in their pronouncements about their lack of remit for existing guardianship arrangements but suggest that their responsibility towards guardianship would change with the introduction of 'special' guardianship as this would, in their view, involve the admission and detention in hospital of persons under guardianship in order for treatment to be administered. The MHAC do not indicate whether they see themselves having a particular responsibility for guardianship clients who, for whatever reason, are presently in hospital - whether this involves compulsory treatment or not.

The MHAC do not maintain data on guardianship clients and therefore do not boast a comprehensive picture of numbers or types of guardianship clients.* More surprisingly, the MHAC do not appear to be well briefed on the statistics on guardianship use, publicly available from the Department of Health, since at various points in their reports they refer to a small amount of guardianship use unsupported by the actual figures.

* Confirmed in personal correspondence, Professor E. Murphy, Vice-Chairperson, MHAC: "... We carry no data on individuals [or] figures.... The Commission has no data whatever on the use of Guardianship or the profile of Guardianship clients' backgrounds." (Quoted with permission from letter dated 23 March, 1992.)

MHAC have produced four **Biennial Reports**. Emphases have varied but consistent themes in respect of guardianship have been as follows:

1. Guardianship is being insufficiently used because of fears of social services managers about the demand on resources.
2. Guardianship is seen as ineffective particularly in the area of treatment but also in the absence of the power to convey patients to a required place of residence.
3. There are few resources in the community that could adequately be regarded as an alternative to hospital with or without use of guardianship.
4. Social services departments tend to create "internal procedural difficulties" which make guardianship procedures "unduly lengthy". (Second Biennial Report)

The Third Biennial Report (1987/1989) additionally discusses the relationship between guardianship and compulsory treatment in the community and the possible introduction of special guardianship or community treatment orders (CTOs). The whole issue of guardianship and consent to treatment is a difficult one which was obscured by the 1983 changes. (These effectively outlawed compulsory treatment; arrangements under the 1959 Act, though never tested in the courts, appeared to provide powers for compulsory treatment.) Potentially the most far reaching set of changes to affect community care of people with mental illness, the MHAC's original (1986) draft paper **Compulsory Treatment In The Community** is contained in Appendix C in summary form.

Basically, the argument offered by the MHAC favoured the introduction of compulsory treatment in the community within the framework of guardianship to effectively create a fourth 'essential' power for certain clients. This view distinguished the MHAC's position from that taken by the Royal College of Psychiatrists in their 1987 discussion paper on '**Community Treatment Orders**', which made comparable proposals which would operate independently of any relationship with guardianship.

The MHAC were particularly concerned about people whose mental health deteriorates outside hospital through failure to take medication. However, this proposed additional power would not provide an authority base for compulsory treatment outside hospital but merely a rationale for removing a person on guardianship from the community into hospital for the specific purpose of commencing or recommencing treatment. In other words, the Commission proposed different (less stringent) conditions for imposing compulsory treatment on a person entering hospital in these circumstances than the ones applied to people admitted on other compulsory orders. A clear parallel exists here between concern as to the likelihood of circumventing due processes which has been experienced in the USA, discussed in Chapter IV, page 195.

However, the Commission do not tackle the most important argument raised by Section III of their analysis, namely the rationale for the distinction between how treatment would be enforced in the community compared with how it is in practice enforced in hospitals. Possibly over-familiar with the legal distinctions formalised in the 1959 and 1983 Acts, where compulsory powers are, on the whole, bound up with the role of the hospital, their paper seems to assume that totally different standards of patient freedom and self-determination must inevitably apply to anyone detained in hospital.

It would arguably therefore be essential before launching special guardianship to clarify for whom the three existing guardianship powers are in fact 'essential', in order first to answer the question: do the powers arrived at in the 1983 Act actually coincide with requirements of people for structured support in the community? It would otherwise be difficult to predict whether, and for whom, compulsory treatment in the community would become another 'essential' ingredient within a guardianship package.

Major hurdles on the way to launching special guardianship could include lack of available data on the pattern of use of 'ordinary' guardianship. Official recognition of a need for such an investigation dates back to the 1976 Green Paper (Section 5) but has so far not been acted upon. There is also a marked lack of monitoring of developments in Guardianship practice which could place the need for CTOs in context.

Ordinary guardianship itself could be said to raise unresolved questions about the willingness and ability of social services to provide effective community care for those mentally ill people who do not need to be in hospital. Special guardianship, on the other hand, would introduce a new authority base for the viability of the order. Not only would medical recommendations have to be made to initiate the order, but medical authority would need to be invoked in order that the treatment programme could be maintained. Thus, the net effect of special guardianship would be to combine responsibilities of SSDs and DHAs. This could be viewed as a major break-through were it soundly based, but it is questionable whether the medical lobby would allow themselves to be placed in a subordinate position to the main authorising agency, i.e. social services. As Rhode has said:

"Guardianship puts the responsibility and power in the hands of local authority social workers, while the power and responsibility to prescribe medicines is in the hands of an NHS doctor."⁽⁷⁵⁾

The Third Biennial Report goes on to discuss the reception given to the MHAC discussion paper on compulsory treatment in the community and explains that a revised paper to be submitted to the Secretary of State would include reassurance that:

"non-compliance with medical treatment would not result in its forceful administration in the patient's home. The patient would be re-admitted to hospital".

The Commission's main recommendation to the Secretary of State was for the:

"creation of an enhanced form of Mental Health Act Guardianship, where the guardian in particular circumstances would have the power to require the patient to receive medication...accompanied by specific safeguards".

The Fourth Biennial Report (1989-91) continued to press for a power to convey patients under guardianship to hospital but adopted a more pessimistic stance as to the prospects of stimulating more active consideration of guardianship use:

"...the statistics for Guardianship give the impression that it is little used [sic]. Few Departments have a written policy, and where they do, express continuing reservations about the usefulness and effectiveness of this provision in the Act. Many social workers feel that the three specific powers given by the Act to Guardians are unenforceable without the co-operation of the client, and there are no sanctions for non-compliance. They argue that if clients are willing to co-operate, Guardianship is not necessary, or may indeed be an unethical restraint on individual freedom."

The Fourth Biennial Report does not comment further on the development of special guardianship but instead discusses compulsory treatment in the context of proposed developments of CTOs. Their views on CTOs are discussed below.

SUMMARY OF RECENT DEVELOPMENTS AND DEBATES

Compulsory Treatment in the Community

As above noted, the MHAC would appear to have moved away from a position which advocated a form of special guardianship as a means of providing compulsory treatment for certain guardian clients and have instead concentrated recently on the feasibility of the compulsory treatment order.* Discussion in their most recent (fourth) Biennial Report does not indicate whether their vision of CTOs includes application to clients on guardianship, and therefore leaves it as an open question as to whether the two means of providing compulsory treatment in the community are now seen as similar or as in fact merged proposals.

There is also a detectable move to a critical review of CTO feasibility and the MHAC report indicates this as follows:-

"Concern has continued to centre on...whether a CTO would promote the welfare of patients. The increasing changes in the development of the pattern of care from large institutions to small community settings has prompted the Commission to review the issues in the period under review.

* Current proposals from the Royal College of Psychiatrists to introduce Community Supervision Orders (CSOs) are not discussed in detail here. They are clearly exclusive of (i.e separate from) Guardianship and seem to involve legal powers which would be exercised by medical authority rather than social services. The definitions of 'Supervision' is limited, contingent and does not contain the main guardianship concepts or safe-guards discussed in this dissertation. (Community Supervision Orders, Royal College of Psychiatrists Report, January 1993).

The Commission decided...[at its Conference in York in April 1991] that there is not enough evidence to indicate that CTO is needed, but it will monitor future developments and encourage research."

Other commentators on CTOs, in particular Cavadino (1989),⁽⁷⁶⁾ and Bean and Mounser (1993),⁽⁷⁷⁾ have criticised the CTO in concept and application and in so doing have seen ideas of special, enhanced or 'beefed up' guardianship as included within these criticisms. The basic arguments advanced by these commentators are extensions of those indicated in Appendix E, where the MHAC outlined their arguments for and against this development, but they offer much greater detail on the moral and practical problems involved in introducing CTOs. The Law Commission Review has also discussed the issues and suggests that compulsory treatment should be confined to hospital, ⁽⁷⁸⁾ although they make no comment on the fact that all proposals for compulsory treatment in the community actually involve the removal of the person from the community before compulsory treatment is administered. It is an open question as to whether this element of the proposals actually contradicts the idea behind them of compulsory treatment actually taking place in the community.

There would seem to be five linked arguments advanced against CTOs, and by implication compulsory treatment within guardianship:-

1. *Unwarranted change of 'Ground Rules'*: a development from the argument of Fisher whose basic assumption was that different ground rules apply (and should continue to apply) in hospital than to the community regarding any form of compulsion or coercion, as it was neither practically or morally justified to attempt to impose care or treatment outside hospitals. Cavadino and Bean and Mounser strengthen this argument specifically referring to compulsory treatment by elaborating on the inappropriateness of extending this form of coercion and control into the community ostensibly as a support to the Government's policy on expanding community care. Coercive psychiatry, i.e. enforced treatment, should be reduced or phased out altogether rather than extended.

2. *Net-widening*: the effect of introducing CTOs is seen as actually or potentially extending the amount of coercion and compulsion used to administer treatment, and as bringing more people within the ambit of social control. There was also concern that this would occur on a less regulated basis than in hospital with the possibility of indeterminate lengths of time over which compulsory treatment would be administered.

3. *Poor targeting*: i.e. imprecise information on who would benefit from CTOs in terms of specific treatment needs. Without disputing the fact that some people with long term psychiatric disabilities, particularly schizophrenia, do poorly in the community as their resolve to take medication weakens, thereby creating a pattern of recurrent admissions without corresponding benefits or improvements in their general lifestyle, for only a comparatively small number of patients could enforced treatment be expected to reverse the pattern. Indeed the very nature of these groups, in terms of personality and disposition towards psychiatry, probably makes them less likely to respond positively to the treatment once administered.

4. *The inefficacy of drug treatment*: the uncertainty and concern as to the benefits to be gained from drug administration specially on a long term basis and of actual risks to health through continuous administration of certain drugs. There is specific reference to the risks of tardive dyskinesia as an outcome from continuous inappropriate administration of phenothiazines.

5. *Encroachment on civil liberties*: by which CTOs are seen as a further invasion of civil liberties and as an unjustified assumption of the need for paternalistic interventions in people's lives. The broad argument is that the need for such interventions should be confined to where evidence is undeniable, which broadly coincides with the criteria applied to the need for compulsory hospital admission.

The Morris Case

A recent case from Scotland has involved parents asking the Court for tutor's powers of guardianship over their learning disabled son rather than the guardianship available under the Mental Health Act, 1960 (as applies to Scotland).*

* The Morris Case (1986) is cited by Ward⁽⁷⁹⁾ as important for demonstrating the following:-

1. Tutors dative can operate alongside the curator bonis (guardian of the estate in Scotland) or can assume powers of guardian of the estate. They can also operate alongside Statutory Guardianship.
2. Tutors dative are assumed to acquire total powers (as a parent over a child) but in this instance the Court limited these to the particular needs of the client.
3. Duration of powers was also limited by the Court (subject to review) whereas unlimited duration was the old assumption.
4. The selection of appropriate powers was undertaken by reference to the list of powers provided for guardian under Alberta's Dependent Adults Act, 1978, below. Of these following powers a., d., e., f., and h. were granted.
 - a. The right to decide where the dependent adult is to live, whether permanently or temporarily;
 - b. the right to decide with whom the dependent adult is to live and with whom the dependent adult is to consort;
 - c. the right to decide whether the dependent adult should (or should be permitted to) engage in social activities and, if so, the nature and extent thereof and matters related thereto;
 - d. the right to decide whether the dependent adult should (or should be permitted to) work and, if so, the nature or type of work, for whom he is to work and matters related thereto;
 - e. the right to decide whether the dependent adult should (or should be permitted to) take or participate in any educational, vocational or other training and if so, the nature and extent thereof and matters related thereto;
 - f. the power and authority to decide whether the dependent adult should apply or should be permitted to apply for any licence, permit, approval or other consent or authorization required by law;
 - g. the right of commence, compromise or settle any legal proceeding that does not relate to the estate of the dependent adult and to compromise or settle any proceeding taken against the dependent adult that does not relate to his estate;
 - h. the right to consent to any health care that is in the best interests of the dependent adult;
 - i. the right to make normal day to day decisions on behalf of the dependent adult including the diet and dress of the dependent adult.

The Alberta Statute is referred to again on page 198 in the context of attempts to reconcile guardianship measures with principles of normalisation.

Their request was granted and the effect of this was to bring back into operation what Ward refers to as personal guardianship as distinct from the statutory version. The personal guardian has in theory a total range of powers available to him or her in respect of both the property and the person of a client. However the particular significance of the Morris case was that the court chose to follow the pattern of guardianship development in Canada where guardians are given specific and limited powers by the Court in relation to the particular needs of a client. Notably, among these powers given to the tutor by the court in Scotland was the power to ensure that the person receives treatment.

Committee

As was maintained by Pope,⁽⁸⁰⁾ committee is the English equivalent of Scottish tutors and it is interesting therefore to note that both powers of tutors and those of a committee have recently shown signs of revival. The Morris Case referred to above discusses recent use of tutor.

Revival of committee depends on the reassertion of Royal Prerogative powers, a subject reviewed by the recent Law Commission Report. Arguably inquisition powers disappeared with the 1959 Act, in which case there remain no Royal Prerogative powers. It is contended however by Hoggett,⁽⁸¹⁾ following Gunn,⁽⁸²⁾ that although current mental health legislation provides an apparently complete code of powers and responsibilities toward incapacitated persons who are mentally disordered, covering the territory previously governed by Royal Prerogative powers, the Royal Prerogative could be 'resuscitated or restituted' to deal with issues not explicitly covered in the legislation.

If this argument were accepted, it would require the Queen to reissue a Royal Warrant under a Sign Manual to enable a judge to appoint a committee of the person following a form of Inquisition, presumably modernised (eg. by multi-disciplinary assessment), to determine incapacity. Given the preceding notion that committee of the person was a form of 'total' guardianship, this would thereby provide the committee with authority to consent on the clients' behalf - for example to necessary treatment.⁽⁸³⁾

Although these suggestions might seem unlikely to be realised, current interest in them may indicate the depth of concern felt about the need to provide a means of substitute decision-making, i.e. surrogacy, on matters concerned with consent to particular actions, such as abortion for pregnant women with severe learning difficulties who are adjudged unable ever to be able to consent on their own behalf. Although these issues are less acute for people with mental illness, some of the same principles apply and a revival of Royal Prerogative powers to deal with gaps in the 1983 Act as regards guardianship responsibilities for people with mental illness cannot be ruled out.

Introduction of 'Private' Law Guardianship

As referred to in the outline of Guardianship typologies, page 59, the Law Commission are suggesting introducing forms of 'private' guardianship which would operate alongside the 'public' form, namely the Mental Health Act, 1983. ^(84/85/86)

These new forms of guardianship would include formalising powers of family and carers, the recognition of personal managers and introduction of some specific powers over, for example, where a mentally ill person lives, along the lines of the Children Act, 1989, Section 5(1).

All these proposals are at the consultation stage (June 1993).

Case Management

As is discussed elsewhere (pages 168/9) proposals for introducing case management and/or care management are part of the expectations on local authority social services following the enactment of the Health Service and Social Services Act, 1990.

Discussion continues on the models (implicit or explicit) involved in care management implementation. Here, it is noted that one facet of case management proposals include that of providing **assertive outreach**, possibly one of the most easily identified connections with guardianship methods or practice. It is also of interest to note that only one model of care management appears to correspond with the case management

requirements of mentally ill people noted by **Research and Development for Psychiatry**,⁽⁸⁷⁾ though their appeal for the inclusion of assertive outreach within care management is not now as clear as it was in their original pronouncements.

Review of the 1983 Act

Reference has been made (page 131) to the fact that the Department of Health is currently engaged in updating the Code of Practice, but that the 1993 revision does not change the guidance on guardianship.

The Department of Health is also considering proposals for the introduction of Community Supervision Orders and these discussions could lead to some wider revision of the legislation.

Innovative and Controversial Uses of Guardianship

Some journal articles have identified special, and in some cases, contentious uses of guardianship, particularly for elderly people, either on discharge from hospital or to maintain them at home. These are discussed elsewhere (page 204 onwards)

The special needs of elderly people under Mental Health Act guardianship is a contentious area in itself, but this researcher's assumption (on page 36) is that the differentiation on an age-related basis is not helpful for consideration of the main issues of guardianship for people with mental illness.

MAIN GUIDING PRINCIPLES

Origins of Guardianship for Mentally Ill People

A recognisable form of guardianship, i.e. complying broadly speaking with the working definition to be found on pages 64 to 67, can clearly be identified with the approach to the care and control of mentally ill people evolved in Roman culture, with some elements of this also applying to Greek, Islamic and other cultural traditions. The idea that

guardianship for mentally ill people was 'born'⁽⁸⁸⁾ with the Mental Health Act, 1959, is incorrect. There is no recognised reference work detailing guardianship history for this care group, hence this writer's detailed exposition.

The Significance of the Mental Health Act, 1959.

The Mental Health Act, 1959, was significant in two key respects apropos guardianship for mentally ill people. This was the first piece of legislation which provided specifically for a combined form of guardianship for people with mental illness and people with learning disabilities. Prior to this, the guardianship arrangements for these two care groups had followed very different courses, with guardianship for people with learning disabilities being provided for under mental deficiency legislation and guardianship for mentally ill people being provided for under lunacy legislation. However, specific guardianship arrangements for mentally ill people, originally legislated for under the 1845 Lunacy Act, appear to have fallen into disuse.

The second significance of the 1959 Act was to link statutory guardianship with social work functions - i.e. because social workers were defined as those who initiate guardianship proceedings and as appropriate persons to become *de facto* guardians of mentally ill people, as a delegated function from medical officers of health (arrangements subsequently modified by the 1983 Act to refer to ASWs acting under delegated responsibilities from directors of social services).

Guardianship for Mentally Ill People Compared with Guardianship for Other Care Groups.

The history described above clearly distinguishes guardianship for mentally ill people from guardianship for other care groups, though the close relationship between guardianship for people with learning disabilities and guardianship for people with mental illness is problematic, and a factor which has confused development in guardianship for mentally ill people since 1959. The link with guardianship for children has been indicated, as has the connection between guardianship and wardship - normally considered more applicable to children than to adults. The idea of generic guardianship

(guardianship on the same basis for all care groups) is not discussed in this history but is referred to with a brief comparison with guardianship experience in other countries (see pages 54/55).

Guardianship of the Person and Guardianship of the Estate.

This distinction, which is discussed in further detail on page 54, received considerable attention historically and the indications are that guardianship of the person received as much attention as guardianship of the estate. A popular view that guardianship concerns were mainly about property and funds and that the person of mentally ill received relatively little attention has been shown to be false.

Specific Functions of Guardianship of the Person.

It has been shown that the needs of mentally ill people for care and protection is historically rooted in the trust relationship. The Crown as trustee has been shown to be the ultimate guardian and expression of the welfare function of guardianship.

Lunacy Law and Poor Law.

The aspect of lunacy legislation concerned with guardianship predates the Poor Law, and has been shown not to be related to that form of state intervention. The overlap in terminology is an unfortunately confusing factor but Poor Law guardianship was essentially a collective and impersonal solution to the social problem of poverty.

Role of Committee.

In order to understand the role of committee, it is essential to appreciate: (1) how Scottish tutors and curators developed from their Roman equivalents; and (2) the relationship of the latter to committees of the person and estate respectively.

The history shows that committee, generally assumed to have ceased to exist through the terms of the 1959 Act, is capable of being reformulated as a way of providing guardianship for mentally ill people on a wider basis than that provided for under the 1983 Act. Apart from effectively widening the range of guardianship powers, it could provide a form of personal guardianship legally recognised as operating in parallel with the statutory version.

Statutory Guardianship.

Although no trace exists of the provision of statutory guardianship for mentally ill people under the 1845 Act, as distinct from guardianships (committees) arising from inquisition, it is conceivable that this could also be reactivated and possibly subsumed within the modern version of committee, effectively re-enforcing the case for the reinstatement of alternative forms of legal guardianship.

Guardianship and Hospital.

These have never formally been alternatives and it is inappropriate to consider them in this way. They have different roles and functions with very different assumptions about the basis of care and protection, yet can in fact overlap when individual clients under guardianship require hospital care unless arranged under Section 3 of the Mental Health Act, 1983.

Compulsory Treatment in the Community: Roles of Guardians and Committee.

Guardians and committees have historically been able to arrange for treatment to be imposed on clients either at home or in hospital and this is still the position broadly speaking in countries other than Britain.

The effect of the 1983 Act was to limit guardians' powers and to exclude powers related to enforcing treatment which are, in practice and in law, delegated to health authorities and the medical profession.

Committees would be under no such legal limits and could conceivably impose a 'higher' level of authority and accountability, i.e that of the Crown, to meet particular needs of mentally ill people, by ensuring that treatment was imposed on clients in their best interests when necessary.

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CHAPTER IV

SOCIAL WORK AND GUARDIANSHIP

This chapter contains the following sections:-

- DEFINITION OF SOCIAL WORK AND COMPARISON WITH GUARDIANSHIP DEFINITIONS
- GUARDIANSHIP MODELS: RELATIONSHIP TO SOCIAL WORK AND ISSUES ARISING
- THE 'SOCIAL WORK-ISTIC' MODEL OF GUARDIANSHIP
- GUARDIANSHIP, SOCIAL WORK AND THE POSITION OF SOCIAL SERVICES DEPARTMENTS
- SUMMARY AND DISCUSSION

DEFINITION OF SOCIAL WORK AND COMPARISON WITH GUARDIANSHIP DEFINITIONS

Introduction

The approach to defining social work in these notes follows broadly the same framework and sequence as those adopted in defining guardianship. However, comparative/context definitions are discussed together with the operational definition.

I FORMAL DEFINITIONS

The **dictionary definition** of social work is:

"work of benefit to those in need of help, especially professional or voluntary service of a specialised nature, concerned with community welfare and individual or social problems arising mainly from poverty, mental or physical handicap, maladjustment, delinquency etc."

A social worker is defined as:-

"one who undertakes social work, especially someone professionally trained".

The latter definition is oblique in its treatment of the social worker/client relationship, i.e. referring in a general sense to the recipients as "those in need of help", and these recipients are not identified explicitly as the clients of social workers. However, the dictionary definition of 'client' includes a specialist use of the term to mean "a person helped by a social worker; a case". The difference between recipients of social work as 'clients' rather than as 'cases' is acknowledged as significant by the dictionary in citing C. Morris, **Social Casework** (1950), viz.:

"the 'case' has a derogatory sense when used of a person. Reluctantly, therefore for want of a better word, we refer to 'the client'."

**Definition Adopted by the Relevant Professional Organisation
(British Association of Social Workers)**

From among a number of attempts by professional social workers to define their roles, the following extract from **The Social Work Task** (1977) is chosen as representative and authoritative, viz.:

"social work is the purposeful and ethical application of personal skills in professional relationships directed towards enhancing the personal and social functioning of an individual, family, group or neighbourhood...."⁽¹⁾

This dissertation only concerns social work with individuals and their families. The above definition is 'generic', i.e. it applies to all client groups. Here, however, the individual clients are those suffering from mental illness, some of whom may of course have a range of other problems or labels - including learning disability, for certain 'borderline' clients.

Comparison with Guardianship Definitions

The respective dictionary definitions see the guardian defined in terms of having custody over a person albeit in a protective sense, whereas the social worker is essentially seen as a helper. In both there is limited reference to the recipient of guardianship and social work *vis-à-vis* the 'correlative' position of the ward or client respectively.

Guardianship in dictionary terminology has both a 'legal' and a 'general' meaning, without the general meaning being elaborated. On the other hand, social work is not defined in legal terms and the authority of the social worker would seem to stem from professional training alone.

The statutory definition of guardianship does not have its counterpart in relation to social work. The terms of the Mental Health Act, 1983, refer to powers conferred on a guardian in complying with laid down procedures, whereas the BASW definition of social work is considering particular skills and the 'professional relationship' as the hallmark of the activity. The interconnection rests on the fact that those who follow and comply with the statutory guardianship procedures may also be pursuing good social work practice.

The 1983 Memorandum gives some attention to the personal characteristics of guardians in relationship to their wards. Conceivably, this could have been dealt with more simply by referring to the desirability of the person being a social worker; instead the Memorandum discusses suitability in terms of sympathetic interest and ability to promote the ward's health and welfare (Memorandum of Guidance, Section 48, outlined on pages 28/29).

II OPERATIONAL, COMPARATIVE AND CONTEXT DEFINITIONS

For the purposes of this paper, the BASW **Social Work Task** analysis is adopted. This was based on consideration of twenty distinguishable social work roles, derived from research into job descriptions of generic social workers which BASW had earlier undertaken.

There is acknowledgement from BASW that these roles overlap to a large degree and that they are not exclusive to social work. The distinguishing element which make these into social work roles and tasks is the context in which they are practised, and the professional value and skill base with which they are approached. The need for professional social work training is assumed in roles numbered 1, 2, 6, 8, 9 and 19.

BASW's definition of social work as a categorisation of **social work roles**⁽²⁾ provides the following (paraphrased) descriptions:

1. **Diagnostician** - Conceptualising and classifying the problems, needs and behaviour of a client.
2. **Planner** - Setting objectives and devising a programme with a client.
3. **Adviser** - Giving of factual information.
4. **Clarifier** - Providing the client with the necessary clarifications in order that he himself can decide and initiate courses of action.
5. **Enabler** - Help and encourage the client to devise and follow solutions to his own problems.
6. **Counsellor** - Assisting client in resolving problems of an emotional nature, often in connection with his personal relationships.
7. **Social Educator** - Teaching socially acceptable behaviour.
8. **Attitude/Behaviour Changer** - Modification of behaviour, values and attitudes which are deemed socially inappropriate or incapacitating to the client.
9. **Consultant** - Acting as an advisor to other social workers.
10. **Mobiliser of Resources** - Utilisation of any available resources in order to help the client.
11. **Agent of Social Change** - Using knowledge obtained from practice to attempt to modify the social environment to make it more conducive to social well-being.
12. **Public Educator** - Seeking to increase general understanding of social attitudes and problems.
13. **Researcher** - Data collection, study and dissemination of information so that other social workers, other professionals, social service agencies, the public and social policy makers can be better informed.

14. **Advocate** - Acting on behalf of a client, to represent the client, with a view to achieving the objectives laid down by the client usually in connection with an organisation or agency which is withholding services or pursuing activities which are harmful to the client's perceived interests.
15. **Mediator** - Attempting to resolve a dispute in the most constructive way possible.
16. **Care Giver** - Expression of concern when the worker is unable to provide other immediate help.
17. **Protector** - Providing protection either for his client or from his client. Exceptionally it may involve protecting the client from himself. It is most often performed in relation to children, the mentally ill or in working with offenders. The role is implicit in social work values and has not just evolved from statutory responsibilities. As with care giving, 'protection' underpins most social work activity.
18. **Agent of Social Regulation:** "Exercising social control...discouraging undesirable behaviour in the interests of the client as well as of others...a logical extension of the 'protector' role."
19. **Director** - Implementing a plan of action, or co-ordinating its various facets.
20. **Manager** - Management of the resources which are available to a social worker personally.

The Context Of Mental Health Social Work and Approved Social Work

The list of social work roles considers social work in a general (as well as generic) sense and pays little regard to context.

Identification of the context within which social work is practised both limits the number of roles applicable at any one time, and also provides a more realistic backdrop against which to consider the operational role.

The social work setting referred to throughout this dissertation is local authority social services, mental health social work in general and particularly arrangements by which ASWs operate, providing assessments of clients and making decisions as to admission to hospital or into guardianship.

None of the roles explicitly refers to the executive area of decision-making which is the prerogative of ASWs undertaking Mental Health Act assessments as to appropriateness of use of guardianship or of compulsory hospital admission. However the National Institute for Social Work survey of roles and tasks of mental health social workers/mental welfare officers operating under the Mental Health Act, 1959, ⁽³⁾ indicated that these social workers saw their particular tasks as: counsellor, advocate, diagnostician (providing 'a broad eclectic and holistic approach to assessment'), protector (particularly by safeguarding civil liberties and in seeking out alternatives to hospital admission), agent of social regulation and social educator. Other roles, such as adviser, clarifier, enabler, mobiliser of resources and care giver are possibly implicit.

Advocacy, Casework and Case Management

As these are the three main reference points for the comparison of guardianship and social work within the concept analysis undertaken from page 173 each requires some comment, viz.:

Advocacy is referred to at item (14) but does not discuss the possible conflict of interest which may arise when a social worker needs to be advocate for a client towards his/her own agency. Some surrogate function is acknowledged.

Casework had become an 'unfashionable' term by the time this list was produced but the elements which go to make up casework are easily identified, namely a combination of items numbered, 1-12 and 16-18. However, the theoretical and methodological elements are missing, particularly relevant in psychotherapeutic work with mentally ill people.

Neither **Case** nor **Care Management** are to be found in the above list because these were not generally seen as social work roles in 1977. It might be assumed that a combination of roles numbered 1, 2, 10, 14, 19 and 20 cover case/care management tasks - other than in relation to budget-holding.

For the purpose the following analysis of the therapeutic model of guardianship, a firm distinction is drawn between 'case management' and 'care management' (page 191).

In many other contexts the terms are used interchangeably. Arguably, the terms should have retained distinct differential usage during the post-Griffiths community care debate but responses to the Department of Health consultation clearly indicated dislike of 'case management' and preferences for 'care management', so this was subsequently adopted as the alternative in the official literature.

Care management has been promoted by the Government as a key shift in the operational approach to assessing, purchasing and providing services for adult care groups, originally spelt out in the Griffiths Report and enacted in the Community Care and Health Service Act, 1990. The practical application of these ideas was at an early stage when the fieldwork part of this research was carried out and the meaning of the terms when used was often imprecise. No questions directly on care management found their way into the questionnaire for social workers other than in regard to budget-holding.

It is important to note that neither case nor care management are seen as the exclusive prerogative of social workers, and experience elsewhere (particularly in the USA) has confirmed that the role has been taken up by a number of professions.

Paragraph 3.3.3 of **Caring for People** says that:

"case management provides an effective method of targetting resources and planning services to meet specific needs of individual clients [if it includes]:

- * identification of people in need, including the systems for referral;
- * assessment of care needs;
- * planning and securing the delivery of care;
- * monitoring the quality of care provided;
- * review of client needs."

With regard to the role of case managers as budget-holders, Section 3.3.5 discusses perceived advantages and adds:

"this need not be pursued down to the level of each individual client in all cases, but - used flexibly - is an important way of enabling those close to the identification of client needs to make the best possible use of the resources available".⁽⁴⁾

Comparison with Guardianship

Discussion under the respective operational definitions of guardianship and of social work show clear differences with the former seeking to indicate how guardianship works in an overall sense while social work is described in terms of roles. The two interconnect in that a number of social work roles occupied by guardians can be indicated alongside some apparently guardian-like roles within social work.

Only the specific social work roles of advocate, caseworker and case manager are discussed in detail below.

III DEFINITION BY PERSPECTIVE

The perspective of social work considered in detail in this study is to do with how social workers perceive their own roles and tasks in relationship to guardianship as a basis for making key decisions. This is the main subject of this research.

A full discussion of a 'perspective' definition of social work would include consideration of how social work is seen by social workers and by a range of other professionals as well as various lay views, including those of clients, families and carers. It is not intended to offer such definitions in this paper and suffice it to say that the profession is viewed in a wide variety of ways by professionals and by the lay public. The discussion would, of course, need to distinguish between criticisms which are levelled at all professionals, especially perhaps those which are particular to the caring professions, as, for example Illich against the medical profession⁽⁵⁾ as distinct from criticisms of social work *per se*, for example by Brewer and Lait.⁽⁶⁾

IV DEFINITION BY TYPOLOGY

Only social work with mentally ill people is considered in this paper and social work with other care groups is not discussed. Distinctions between casework, group work and community work are not referred to further in this discussion as it is the casework approach that will connect social work most clearly with use of guardianship.

Guardianship as a type of Social Work

Guardianship, both informal and formal, could be described as a type or category of social work with mentally ill people. Interestingly, the social work role as guardian *per se* is not included in the list offered by BASW, and the surrogate role is only weakly represented, eg in the role of Advocate. If the surrogate element is assumed to apply in varying degrees throughout it might be assumed that the role of guardian in practice covers the following from the roles listed:

Adviser	Mediator
Enabler	Care Giver
Counsellor	Protector
Resource Mobiliser	Agent of Social Regulation
Social Change Agent	Director/Manager,
Advocate	(i.e. Care Management)

This is a much wider range of roles than is commonly attributed to guardianship, but the test of the actual perception of roles is reserved for the empirical research.

V HISTORICAL DEFINITION

Historical definitions of social work in general, or specifically of social work with mentally ill people, are not attempted in this dissertation.

Instead, the historical chapter has located the connection between the roles of social workers and guardians for this care group in the context of evolving statutory responsibility.

It may however be broadly asserted that the histories of guardianship and social work for mentally ill people proceed on very different lines. Guardianship is a much older form of care, predating the Poor Law before becoming effectively part of lunacy legislation. Social work on the other hand is derived from the Poor Law with only a fairly late expression of specialist interest in work with mentally ill people.

VI CONCEPT ANALYSIS

A concept analysis approach to social work definitions follows this section in the form of an examination of guardianship models and their relationship or applicability to social work.

RELATIONSHIP OF GUARDIANSHIP 'MODELS' TO ADVOCACY, CASEWORK, CASE MANAGEMENT AND DISCUSSION OF RELATED ISSUES

The following schema indicates the subject matter of the following discussion and the relationship between the themes pursued.

Model Name:	Substituted Judgement	Parent-Child	Therapeutic
Alternative name or description:	Legal, or Legalistic, Surrogacy	Parental, or Developmental, Authority	Welfare Services, Imposition of
Criteria/ Justification:	Substituted Judgement	Individual Best Interests	Generalised Best Interests
Specific Functions shared with social work:	ADVOCACY	CASEWORK	CASE MANAGEMENT
'Mental Illness' perceived as:	Incapacity (inability to decide or evidence of seriously impaired judgement)	Vulnerability (harm to self or to others) 'Underfunctioning' or 'Immaturity'	Medical view of Deviance (clinically diagnosed Disease/Pathology)
Issues raised:	<ul style="list-style-type: none"> * Independence of Advocates * Private Guardians * Guardians' Credentials * Role of Court of Protection (in passing) 	<ul style="list-style-type: none"> * 'Natural' guardianship * Parental analogy * Parental substitution * Authority * Normalisation * 'Institutional' care 	<ul style="list-style-type: none"> * Social control and Compulsion * Least Restrictive Alternative/ Most Beneficial Alternative * Net Widening/ More coercive alternative * Therapeutic Capacity in Social Services * Care Management

The models of guardianship discussed are derived from those identified by Frolick who uses the three model names: 'substituted judgment', 'parent/child' and 'therapeutic' respectively.⁽⁷⁾ An alternative formulation by McLaughlin uses a two-model analysis as

between the 'legalistic' and the 'social work-istic'⁽⁸⁾. The legalistic model is broadly equivalent to Frolick's substituted judgement while the social work-istic model could reasonably be seen as a combination of Frolick's parent/child and therapeutic models.

Important issues raised by McLaughlin's analysis of the social work-istic model of guardianship are discussed from page 199, serving as a bridge between social work practice issues and concerns related to the organisational base of social work and guardianship.

THE SUBSTITUTED JUDGEMENT MODEL AND ADVOCACY

According to Gostin's (1983) view, mainly influenced by experience in the USA, guardianship consists of two key components: formal recognition of the fact of a client's incompetency to make important personal decisions, determined by formal assessment; and delegated authority to another person to make decisions on that person's behalf.⁽⁹⁾ The delegated authority of the guardian is the legal basis for the assumption of two roles: surrogate and advocate.

These three elements - incapacity, surrogacy and advocacy - are considered in turn below.

Incapacity

The term 'incapacity' has different meanings under English law according to context, but has a clear descriptive implication, namely that the person is unable to act or decide for him/herself.

English law is not clear on the question of whether the powers available to the guardian under Section 7 of the Mental Health Act, 1983, are, actually or notionally, related to the incapacity *per se* of the patient. Certainly, the medical recommendations and the application made by the ASW do not contain statements to that effect, and therefore the presumption would seem to be that the person suffering from mental illness and needful of interventions within the terms of the Mental Health Act are not thereby deemed

incapable. A question then arises, however, as to why the powers of guardians are invoked if the client is not demonstrably incapable in one or more of the key areas referred to in Section 8 of the Act, namely in the need to determine (or maintain) place of residence, to ensure attendance or to gain access to a person's home.

Arguably, the nearest to explicit findings of incapacity under English mental health law are actions under Section 94(2) of the 1983 Act related to the role of the Court of Protection which, in effect, becomes guardian of the estate on receipt of two medical opinions confirming that a person is suffering from mental disorder. Substituted judgement could be a reasonable description of the criteria applied by the court in managing the patient's affairs or, more immediately, by the person appointed as receiver by the court to deal directly with patient's monies etc.

In other legal systems, particularly in the USA, courts are asked to receive petitions asserting that a person with mental illness is incapable of managing his or her person, affairs or property, and the outcome of this petition is a decision by the court for or against the appointment of a guardian. The appointment of guardians by petition in these circumstances follows the pattern noted in the historical chapter as applying in England and Wales at least up to the 1890 Lunacy Act. The old terminology is indicative of the thinking about the nature of mental illness as, for instance, in the use of a phrase such as 'lucid intervals' to refer to those periods where mentally ill people cease to be (to use another antiquated term) 'non compos mentis'.

Surrogacy

In contrast to the position of people with learning difficulties, the historical assumption in the application of the principle of surrogacy to people with mental illness has concerned the variability of the disability and the notion that recovery is achievable, i.e. that mental illness is a phase (however long) in a person's life, not a permanent state of affairs. (See Chapter III, Footnote page 84.) Consequently, the issue at stake in determining how best to represent the needs and wishes of that person while ill is the extent of knowledge of his or her disposition prior to the mental illness or, if applicable, subsequent to a previous mental illness.

Thus the concept of surrogacy rests firmly on the notion that the guardian substitutes his/her judgement for that of the person during the time the illness affects the person's capacity to decide. Therefore, the justification for the surrogate role of guardian is that the guardian acts as advocate for the person with mental illness on a temporary basis during the period of incapacity.

Conceivably, guardianship understood in these terms would be seen by social workers as a denial of client self-determination, while the assumption of a formalised surrogate role by a social worker could be viewed as perpetuating the problem. It is also to be expected that social workers would wish to move away rapidly from an assessment which concentrated on a client's incapacity on to one which stressed strengths and remaining abilities.

Some of these assumptions and doubts are explored in the empirical research. Meanwhile, anecdotal evidence suggests that social workers working with mentally ill clients often recognise lack of self-determination as realistically part (or the whole) of their client's problem, and one which puts pressure on them to assume a surrogate role (without legal formality or safeguards) whether they want to or not.

Advocacy

Advocacy is well-accepted as a beneficial way of assisting those unable to speak or act for themselves and this is arguably one of the most important of the social work roles listed in the BASW definition. Wolfenberger* has argued that advocacy is more 'expressive' in the way it conveys others' needs than the more 'instrumental' guardianship.⁽¹⁰⁾ Fisher's interpretation of the 1978 White Paper echoes this distinction, seeing advocacy as more 'relevant' than guardianship.⁽¹¹⁾

* Much has been written on the role of advocate with mentally ill people and there are a number of well-established forms of advocacy for mentally ill people, eg the Dutch scheme based on the idea of the advocate acting as intermediary between the client and officialdom in its various guises. The justification for containing this discussion within the Wolfenberger approach is to highlight the distinction he elucidates between guardianship and advocacy and its implications.

However, Wolfenberger does not rule out the possibility of combining advocacy and guardianship into a tool which is both expressive and instrumental, provided these operate under the right conditions of independence from interference from other parties, among whom he would include managers of protective services.

The researcher's working definition of guardianship (see pages 64/67) referred to the need for an advocacy component. It is argued here that advocacy and substituted judgement are logically linked by the appropriateness of, and need for, one person speaking or acting on behalf of another on the basis of need.

Advocacy within guardianship thus carries many of the same features as ordinary advocacy but is distinctive in that its rationale is wider, viz, to respond to the recognised and assessed incapacity of a person, as well as to exercise substituted judgement on this person's behalf, so that the guardian becomes in effect a **surrogate advocate**.

Social Services/Social Workers as Advocates*

It may be conjectured that social workers see themselves as potentially effective advocates for people with mental illness without needing or wishing to be their clients' guardians. Indeed, some may not associate the guardian's role with advocating on behalf of the client.

Wolfenberger sees advocates as needing to be independent of agencies on which the client is or will be most reliant in gaining necessary help. To him, the idea of a social worker acting as advocate within a social services agency is contradictory, not only in failing to meet the independency criterion but also because a social worker cannot give of his/her time and effort to the client without being constrained by the needs of other clients or of agency management policies. Furthermore, much that passes as advocacy

* It is well to note the possibilities of semantic confusion, in that 'advocate' can mean lawyer under other legal systems (eg USA), in which case there is a merger of role between advocacy and representation in the legal sense. Whereas a private guardian under English mental health law could be a lawyer, the lawyer would not be referred to as an advocate. On the other hand, social services guardians are, technically, directors of social services who invariably delegate the role to social workers.

within the helping agencies is often insufficiently proactive to be counted as such, since, for Wolfenberger, advocacy means a definite speaking-out for the client's situation; consequently: "There is no such thing as 'silent advocacy'".⁽¹²⁾

From this viewpoint, social workers cannot expect to succeed as advocates because of their lack of independence and the insufficiency of accountability to a single client. According to McLaughlin, the same problem affects social workers acting as guardians, and the implications of this are discussed below.⁽¹³⁾

Mental health legislation provides for 'private' guardians invested with the same powers as social work guardians but who may be lay persons (including family members) or persons from another helping profession. Private guardians are a rarity but could be seen as able to achieve a measure of independence from statutory agencies. They have for some time been seen in this light within the Scottish legal system (which makes broadly similar provision in this respect) as being in a potentially better bargaining position for a client than a social work guardian. Their position is often seen to be more beneficial to a client insofar as they are free to exercise pressure on agencies to provide necessary care and services without the constraints of accountability towards the organisation or to their other clients, i.e. they are able to operate in very similar ways to those envisaged by Wolfenberger for the ideal advocate.

Rights and Entitlements

There is an interesting though troublesome debate about the connection between the use of guardianship and the rights of people with mental illness. Some see statutory interventions such as guardianship as inevitably a threat to, if not a literal suspension of, a person's civil rights and therefore by definition a prejudicial deprivation, or negative discrimination. The argument would be that, however benign or well disposed the guardian, nothing compensates for the loss of dignity and integrity involved in a person being constrained from making their own decisions in life. The opposite point of view is that this argument ignores the reality of mental illness itself as disabling people to the point where they are not in a position to protect their interests or speak up for

themselves, and therefore require someone to do this on their behalf. This is an important right which should not be denied people while ostensibly promoting civil rights in the broadest sense.

From the latter point of view the institution of guardianship is a counterbalancing measure which serves to protect rights of mentally ill people by application of the principle of quid pro quo.⁽¹⁴⁾ Through this, the assertion of the guardian's authority over a client's actual, i.e. expressed, wish during a period of mental disturbance, is counterbalanced by the benefits that a guardian may obtain for the client during this period. There is a clear link here with anticipated beneficial or 'therapeutic' impact of care, services or treatment, and this is picked up during the discussion of the therapeutic model of guardianship. Meanwhile, the question of rights and entitlements of people with mental illness to particular help or services can be located within what Gostin refers to as the ideology of entitlement.⁽¹⁵⁾

Considering guardianship to be a service to clients from which they could gain advantage, Bean argues that the failure of local authorities to provide this service in many instances is a denial of rights within the ideology of entitlement. Expressing some sympathy for client access to guardianship on an equal basis across local authorities, Bean nevertheless concludes that resort to Secretary of State's default powers in an endeavour to ensure this would merely raise questions about variations in the quality of service rather than its availability - i.e. reluctant authorities would simply express their disinterest in the way they provided the service. Bean sees the missing connection in this discussion to be the professional judgement of social workers, acting as gatekeepers, while at the same time being able to function efficiently only when service options are available.⁽¹⁶⁾

Fisher maintains that:

"Guardianship can protect the erosion of civil rights by taking formal powers in circumstances where persuasion of dubious authority may otherwise be used...[as for example] an elderly person 'taken' to a Part III home might arguably be better placed under the protective powers of guardianship because of the danger that such actions infringe her or his rights."⁽¹⁷⁾

Finally, on a more general basis, Henkel (1985) has discussed the 1983 Act in terms of positive and negative freedoms, suggesting that:

"The dominant themes [in this legislation] are those of negative freedom, procedural justice, and enhanced rights of citizenship. The values of enhancement of choice and better quality care and treatment are more widely represented but there is an unsatisfactory commitment to entitlement of services. Nonetheless, at least implicit in the Act is an expectation that social workers and social services have a distinctive contribution to make to the enhancement of choice." (18)

Part of the ideology of entitlement asserts the benefits of legal formalism in providing safeguards against the use of substituted judgement by professionals on the grounds of their actual or presumed expertise rather than on the needs and wishes of the client.⁽¹⁹⁾ However, this approach can also be criticised for making insufficient allowance for the impact of mental illness on a person's judgement and decision-making capacity.

Guardians' Credentials

A further point concerns the status and credentials of the guardian and their appropriateness for exercising substituted judgement. In the USA, lawyers and even consultant psychiatrists⁽²⁰⁾ may fulfil this role and exercise substituted judgement over a range of factors, including giving consent on a client's behalf to admission to hospital and to receive psychiatric treatments (though usually with limitations in respect to the more far-reaching or controversial psychiatric treatments). Arguably, the authority position of social workers is uncertain and ambiguous in relation to guardianship as defined in the 1983 Act, while being relatively clear-cut in relation to compulsory admission to hospital.*

The credentials of the guardian, i.e. professional qualification(s) and personal attributes, are clearly of paramount importance within the exercise of substituted judgement. However, the position in England and Wales means in practice that *de facto* guardians

* In some respects, the role of ASWs in arranging compulsory hospital admissions could be viewed as a form of substituted judgement and of a limited guardianship specifically providing sanction for the enforcement of these powers.

are either social workers exercising delegated powers from the director of social services (who may or may not have professional qualifications or any particular personal attributes) or a private guardian with no specifically defined or formal qualifications.

On the face of it, therefore, this lack of clear prescription might indicate that these guardians are viewed as already fulfilling a defined and manageable task within which expectations are substantially less than where a person is expected to decide or act for another over the full range of personal functions. On the other hand, some personal attributes are mentioned in the various Memoranda of Guidance and Codes of Practice (Chapter III) though it is notable that these have not markedly changed between the arrangements under the 1959 Act and the 1983 Act.

Given the striking lack of information about how guardianship actually worked for mentally ill people under the 1959 Act, it may be assumed that the exercise of total control over clients' lives was rarely realised; certainly there is little evidence of guardians consenting to treatment on behalf of clients which was, in theory at least, part of the expectation of the guardian acting as a good parent in respect to a youngster up to the age of 14 years.

THE PARENT/CHILD MODEL OF GUARDIANSHIP AND SOCIAL CASEWORK

This view of guardianship sees the guardian adopting a role analogous to that of a parent, with the ward viewed as vulnerable to life in ways similar to that of children and young people. Indeed, the assumption behind this model is that the role of parents towards children is appropriately described as 'natural guardianship'.

The most common reference to the role of parent in guardianship is to be found in the legislation and supporting official literature which describes guardians as having the same powers over wards as a parent would have over a youngster. This, however, is to stress only one side of the parental role; whilst parents do, of course, have powers over their children, their responsibilities towards them are, if anything, even more important. And the most important responsibility of parents is to enable their offspring to grow and develop to their full potential. The fact that people with learning disability were assumed

in the past to have very limited developmental potential has been influential in shaping criticism of guardianship as being 'too paternalistic'. This was discussed in the historical context of the position of the Royal Commission in apparently not seeing the inappropriateness of grafting a paternalistic view of guardianship applicable (in their view) to people with learning difficulty, on to a form of guardianship also to be used for people with mental illness.

Thus from an anachronistic position, justly criticised for inappropriate paternalism, this model of guardianship can also be seen as applicable to the parent-child relationship. The guardian accepts the relationship as an 'unequal' one and capitalises on this to best effect in assisting the ward to overcome difficulties and to grow towards maturity. In many ways this parallels the use of the social worker-client relationship in the enabling/ counselling/ advising roles which together make up the activity called 'casework'. Whereas at the commencement of casework, the inequality in the relationship may need to be understood, most casework strategies for continuing work will seek to reduce the elements which tend to perpetuate the social worker being seen as a parent figure, so that the clients will need help, for example, to modify overtly regressive behaviour towards a position closer to that of parity between client and worker.

Caseworkers of a psychoanalytic persuasion would no doubt criticise the above view for denying the transference phenomenon through which the very conditions of the relationship will generate and maintain a tendency for the client to project parental views and attitudes onto the social worker. Even here, the idea of growth and change is not denied but is seen basically as a far more complex process than the modelling activity of ordinary parenting.

The essential view incorporated in this model therefore is of guardianship in a functional rather than legal sense, derived from a comparison with parental roles, particularly in roles connected with offering a parental model or substitute parenting.

'Natural' Guardianship

Taking the widest view of guardianship in its social and psychological senses, sets the scene for a consideration of natural guardianship, in which the concept of guardianship commences with parenthood and with parents as the natural guardians of their offspring. The position in child care law as to which takes priority - role of guardian and role of parent - is complex and has recently been reviewed⁽²¹⁾ but there would seem to be a further area requiring clarification, namely when parental or guardian functions cease in relation to young people emerging into adulthood whose psychological or emotional development has been impaired or disrupted. In which sense, do parental responsibilities extend throughout the maturation period, however long that may be, on the basis of 'extended childhood', or are parental responsibilities confined to boundaries of chronological age? Certainly for the family of a young person on the threshold of adulthood showing clear signs of incipient mental illness, a limited range of adult functions and achievements, and/or with overtly disturbed behaviour, this question could be vital.

There is not only the question of how long parental responsibilities would apply in this situation but the capacity and endurance of parents to fulfil the guardian role, which could become more onerous as they themselves age.⁽²²⁾ Their position may be compared with those of foster families, increasingly referred to simply as carers in England, but who themselves are referred to as guardians in other countries, e.g. in Scotland and in the USA.

Parental Analogy

The parent-child model of guardianship could be said to apply the parent-child relationship by analogy to the needs of certain adults with mental illness problems. Alternatively it may be said that this goes beyond application by analogy into an actual expression of parent-type responses. The association of guardianship in England with mental handicap and mental deficiency legislation has created a view of guardianship as being inherently paternalistic⁽²³⁾ which has led to all the following being described as within the control of the guardian:

- to contract on behalf of the ward;
- to give permission to marry or to bar marriage;
- to determine place of residence;
- to determine occupation and activities;
- to determine relationships and the company kept; and
- to decide who shall be permitted to visit the client.⁽²⁴⁾

The inappropriateness of this view of guardianship to meet the needs of people with mental illness might appear self-evident unless one views all mental illness as a manifestation of psychological or emotional immaturity. Even from this point of view it is difficult to justify the blanket term 'immaturity' to explain the need for total surrogacy.

Criteria and Justification of the Parent/Child Model

The parent/child model of guardianship is normally associated with the best interests basis of decision-making, which by implication refers to the best interests of the individual client in-so-far as these are known or ascertainable. With regard to future needs, however, more generalised best interests criteria may apply, coinciding with the two primary functions of parenting, namely protection and promoting development. These may be said to express respectively the conservative/cautious parental attitude and the radical/risk-taking aspect of parenthood, both of which are necessary if youngsters are to be safeguarded from dangers but also enabled to take risks and to learn from these.⁽²⁵⁾ It might be argued that these comparisons raise again the question as to whether the parent-child model of guardianship is for application by analogy or whether actual parental functions are at the heart of the guardianship idea.

Social Casework: Informal Guardianship within Social Work

Given the family context within which the care of mentally ill people is best approached, including the issue of absent, defaulting or rejecting families, there are some important areas of similarity and difference between the role of guardian and social worker, i.e. as

between a guardian social worker and a social worker working with this care group outside the statutory framework.

Authority: Guardianship and Social Work

Social workers qua social workers and guardian social workers share the characteristic of being authority figures, though with some important differences. As both are employed by social services departments, there is a line of accountability and responsibility as between the social worker and a social services committee which invests social workers with delegated authority, though in the case of guardian social workers this is more explicit and prescribed in relation to an individual client. Non-guardian social workers can acquire this prescriptive authority through statutory interventions other than guardianship, as for example when undertaking compulsory hospital admissions. Nevertheless, social workers often resist being cast in the role of an authority figure because they feel that this approach may be damaging to the relationship with the client or the client's family in undermining constructive or enabling work which seems to minimise the status difference between social worker and client. Explicitly there may also be attempts to avoid engendering transference phenomena and to avoid creating or perpetuating dependency between clients and social workers.

By contrast, the guardian is in an authority position which is both unequivocal and continuous, being the essential component within the structure of guardianship. Attempts by guardian social workers to make explicit a more limited basis of authority than the three 'essential' powers enjoined on them by the legislation, may be harder to achieve than for non-guardian social workers. The need for a limited form of guardianship which is facilitative and enabling is often mentioned as a means of reducing both the dependency level and inappropriate paternal attitudes which may otherwise occur.⁽²⁶⁾ There is no explicit recognition of the role of guardianship in a developmental mode, though this function is clearly expected of parents.

Parental Substitute Role: Guardians and Social Workers

Situations arise where both guardians and social workers act as family substitutes or facilitate access to a substitute family for the client. Both have to contend with the fact that clients may be prone to rejection by families because of their behaviour or attitudes and may need help to re-assert their position within the family, while at the other extreme the client's family may be judged to be the pathological factor as whole or part cause of the client's difficulty. In both examples, avoidance of further social rejection could often be a shared aim of guardians and social workers. Both may face the fact that their clients can experience rejection by their families in traumatic circumstances, as for instance when a client's planned discharge from hospital cannot be taken forward because the family are unable or unwilling to cope with the return of the client which will upset a new-found equilibrium. Where family care has failed in this actually or potentially damaging way, guardianship might be seen as a more explicit counter-balance in its emphasis on continuity, structure and in making formal requirements of the client's lifestyle.

Neither guardians nor social workers are likely to wish to act themselves as alternatives to family, other than on a short-term basis, but it may be that private guardians are chosen because they can provide either a substitute family themselves or are seen as a means of maintaining the existing family link, i.e. by strengthening the standing of the family member in question. No empirical data is available to verify this.

On the other hand, the Scottish family fostering arrangements, where carers are also guardians, provides an illustration of guardianship which can be seen both as an expression of good natural parenting as well as the best alternative to good natural parenting. These arrangements are monitored by the Mental Welfare Commission for Scotland ^(27/28/29) and it would seem that the criteria for good guardianship is the degree to which it resembles good family care, i.e. with as few distinctions as are practicable between the position of the client and those of other family members. Implicitly it would seem such assessments employ the concept of 'good enough' parenting as a bench mark for deciding whether or not certain behaviour on the part of a parent substitute/guardian requires attention.

McLaughlin's basic rationale for his 'social work-istic' model of guardianship (see page 199 onwards) is that:-

"Society through professional social workers should take over those functions that the family would perform if it were available and functioning." ⁽³⁰⁾

Normalisation: Guardianship and Social Work Valorization

Wolfenberger, as well as having developed thinking around the relationship between guardians and advocates, is usually credited with being the prime mover in propounding ideas on normalisation.⁽³¹⁾

From these there are important messages for service providers and professionals, namely to ensure that their interventions and help are made available in a manner which draws their clients away from normal living as little as possible, thereby reducing the possibility of institutional dependence and stigmatisation.

Social workers working with mentally ill people may well include within their strategies attempts to convey to the client and key others in his/her environment that he/she can live a normal life with the minimum of changes which set the client apart from friends, neighbours, relatives etc. On the face of it, therefore, the form of intervention known as guardianship may seem to be at the opposite end of this spectrum in being formal, intrusive and explicitly demanding of the client's co-operation, and many social workers would probably view this and all other kinds of statutory intervention in clients' lives in much the same way.

It could nevertheless be argued that any form of intervention, however formalised, which prevents a client having to live in the artificial environment of the institution is a step towards normalisation and this objective could be a shared one between guardianship and ordinary social work strategy. In short, because guardianship can be used as an alternative to an institutional environment for certain clients, this in itself is a step towards normalisation, however many other factors need to be tended to in order to support this arrangement.

The latter views have been taken particularly seriously in Alberta, Canada, where Section II of the Dependent Adults Act, 1978, includes the proviso that:-

"A guardian shall exercise his power and authority...in such a way as to encourage the dependant adult to become capable of caring for himself and of making reasonable judgments in respect of matters relating to the person..."

Thus, according to Christie,⁽³²⁾ "the principles involved in the implementation of the guardianship order therefore parallel those involved in normalisation".

Normalisation and Residential Care

One 'normalisation' assumption behind guardianship could be that any residential requirement on behalf of the client is intended to achieve, maintain or be a step towards normal family life. Looking to the legislation or statutory rules to confirm this is not particularly helpful, as these refer only to the need to exercise "control over patient's place of residence"⁽³³⁾ and good practice assumptions have therefore to be made. The position becomes much more contentious where guardians have definite duties to place clients in residential care (possibly including hospital) as, for example, in America.

This issue comes to the fore for clients under guardianship placed in residential care where the authority of the head of the institution *vis-à-vis* that of the guardian is questioned, as for example in the maintenance of discipline or in the avoidance of absconding. Some heads of residential establishments see themselves as being *de facto* guardians of residents, and in the USA and elsewhere this responsibility may be statutorily recognised. The form of collective guardianship operating in Gheel, Belgium (see page 374) provides an example where the head of the community is defined as guardian of every member.

A related issue concerns clients placed in social services residential units who then become the responsibility of residential social workers (possibly with the implication of the case actually being closed by the original social worker) but in other respects the work of guardians and the work of social workers may proceed in parallel with the

institutional phase. From the point of view of these arguments, it is misleading to see social workers and guardians as providing a service which is an alternative to institutional care though this may clearly be an objective in certain circumstances, e.g. where the client can be sustained in the community given other key supports and where the social worker or guardian can access those supports. The question then arises as to whether the guardian is in a better position to access such support, i.e. whether the statutory position of the guardian does or should signal a need for prioritised care (services) on the quid pro quo basis referred to above.

THE THERAPEUTIC MODEL OF GUARDIANSHIP AND CASE MANAGEMENT

Introduction

This view of guardianship sees the guardian as representing society's interests towards people with mental illness in two related ways: to contribute to the social control of mental illness, seen basically as a form of deviance; and to assume the role of agent in imposing therapeutic/welfare services where necessary - the impact of which is likely to make the client more socially acceptable. There is clearly a relationship between 'control' and 'management' and the social work tasks of resource mobiliser combined with that of agent of social regulation could be described together as a particular form of 'case management'.

Within the therapeutic (case management) model the imposition of hospital care and treatment does not logically stand outside the range of services that could be imposed through guardianship. There is a strong case, not pursued further in this paper, for seeing the tasks of ASWs in compulsorily admitting people to psychiatric hospitals as in many ways similar but in otherwise failing to meet other guardianship criteria derived from the other models, in particular the advocacy and enabling roles.

Theories of social control differ fundamentally according to political and ideological positions, though some common ground might be assumed to support the proposition that

the social control of the behaviour generally referred to as mental illness is the combined task of families, law enforcement agencies and the medical profession.

Discussion of the interaction between people deemed to be mentally ill and their families has already been provided; the task of this section is to concentrate on distinctive features and implications of the therapeutic model of guardianship.

The difference between the therapeutic and the parent/child models might appear self-evident. However, although the therapeutic model is not based on substituted judgement it remains firmly linked with the legal basis for guardianship. This is expressed through what Bean refers to as 'therapeutic law',⁽³⁴⁾ i.e. basic codes and ground rules, rather than formal law, which enable the professions to effectively curtail people's liberties when exercising their discretionary powers of compulsion within broad criteria laid down in the legislation.

Criteria for and Justification of the Therapeutic Model

Frolick infers that the therapeutic model of guardianship is based on the imposition of treatment, care and social services, justified by the assumption that cure may result from exposing the person to these forms of social control. The criterion is neither substituted judgement nor best interests, in-so-far as the latter applies in an individualised sense, since guardians will not necessarily know the relevant wishes of the person prior to their becoming mentally ill and cannot claim to be able to assemble the 'package' of treatment around the unique requirements of the individual. It could be said instead that this form of guardianship is justified on a generalised best interests criterion derived empirically, i.e. on previous experience with certain kinds of depression or certain kinds of mental health problem. In short, care managers impose services/treatment because there is a sufficient body of knowledge suggesting that their effect is beneficial - individually, familiarly and socially. Such impositions, however, do not necessarily over-rule the wishes of the individual or discount client's preferences.

Case Management Versus Care Management

An outline of the connection between case/care management and social work has been offered at page 169. It is particularly important for the analysis of the therapeutic model of guardianship alongside a comparison of roles of social workers in social services departments, to underline the distinction between case management and care management. This is best undertaken following a brief reference to models of case management.

Various models of case management have been identified.⁽³⁵⁾ It is outside the scope of this paper to compare these models in detail with those described as applicable to guardianship; or to single out case management models which attempt to cater specifically for the needs of people with mental illness, as has been undertaken by Onyett.⁽³⁶⁾ Broadly, however, it is assumed that models that emphasise the individual worker/individual agency basis for case management (as distinct for the joint/multi agency models or brokerage) conform most closely to guardianship principles.⁽³⁷⁾

By this model criterion the *case manager* is seen as combining his or her other tasks with a definite commitment towards recognising the needs of the individual, ensuring that these needs are met and maintaining individual contact. The *care manager*, on the other hand, whilst not acting contrary to this intent, is more likely to be concerned with management systems, i.e. ensuring that assessments take place, that purchasing arrangements are in place and that adequate provider services are available, than in pursuing a direct care relationship with the client. The significance of the change of terminology during the post-Griffiths debate on community care is not considered in detail here though it is interesting to observe that three directors of social services discussing this issue at a conference each rejected the term 'case manager' as conveying the sense of being too concerned with the management of the individual so as to appear to be 'taking over' and restricting client authority.⁽³⁸⁾ As this is frequently the position in which social work guardians find themselves, it seems honest and appropriate to refer to them as case managers, though it should be noted that the case management intention with regard to people with mental illness is not to exclude choice or impose on the person

any more than is needful in terms of diagnosed (i.e. assessed) mental illness on the basis of criteria discussed below.

The rationale for guardianship as individualised case management has its essential starting point in the research findings of Stein and Test. These stress, among other things, the need for an individualised approach, with a high level of continuity by a co-ordinator of some degree of standing, in order to ensure services are effectively delivered. Such a description could be seen to fit the credentials of the surrogate advocate who, besides his or her other tasks, keeps the needs of the client to the forefront and ensures that needs are met as best as possible without invidious comparison with the needs of other clients or with agency policies aimed at rationing resources.

Stein and Test's broad conclusion was that it is the *manner* in which services are provided rather than their face value which is most important. They stress that services for this care group should be provided in an individualised/personalised way, assertively if necessary, in order to provide a firm structure and consistency in care, on an on-going basis if needed, rather than by one-off or episodic interventions. These approaches share the characteristic of being explicit strategies for the care of mentally ill people which may be expected to both avoid inappropriate institutional care, and rejection by family or wider social rejection in the community.⁽³⁹⁾

One assumption behind the advantages of providing case management within the guardianship framework would be that the social work guardian would be able to effectively prioritise the client on behalf of the agency against competing needs of other clients. Other social workers may find it hard, if not impossible, to prioritise on the basis of need and to that extent may be constrained from providing the individualised service which they would no doubt prefer to offer. In theory, guardianship is nothing if not individualised in this sense, and private guardianship arrangements would seem to make this point explicitly in that there may not be other clients of the guardian with whom to compete.

The 'Least Restrictive Alternative' and the 'Most Beneficial Alternative'

The following brief discussion of the doctrine (or principle) of the 'least restrictive alternative' acknowledges wide-spread acceptance of the view that care and treatment of people with mental illness should take place in the most appropriate environment for that purpose (officially endorsed in S.3(2) (a) and (b) Mental Health Act, 1983); that such environments will not limit the person's freedom more than is necessary to make such care and treatment effective.

The view of guardianship as a least restrictive alternative in this general sense is tacitly accepted by a number of commentators, though more often with some qualifications. Henkel, for example, considers this to be true only where there is real scope for client choice - both as a right of access to preferred services and as a goal promoted through the skills and motivation of social workers.⁽⁴⁰⁾ This view is close to the original Gostin formulation concerned with the need for a 'facilitative' view of guardianship,⁽⁴¹⁾ as endorsed by Millington,⁽⁴²⁾ which is seen as marking the key distinction between using compulsion as an aid to the client and using compulsion 'against' the client.

Although the idea of guardianship specifically as an alternative to hospital care is popularly promoted, a basic difficulty stands in the way of evaluating this when placed alongside the discussion of definition (pages 48 to 54) in which guardianship and hospital are compared. This analysis sought to establish that the two institutions are very distinct and comparable only in two narrowly confined contexts. Firstly, it was noted that guardianship and commitment laws are mutually exclusive only as regards applicability of Sections 7 and 3 of the Mental Health Act, 1983, so that admission of patients to hospital under guardianship is sustainable under all other sections as well as with voluntary admissions. Secondly, it was indicated that an assessment of an individual client might indicate that hospital and guardianship were actual alternatives either preventively, where guardianship arrangements could avoid the necessity for admission, or on an aftercare basis, where guardianship might enable a person to be discharged from hospital sooner than would otherwise be the case.

The remainder of this discussion therefore considers the basis for comparing restrictiveness as related specifically to the situation of individuals where guardianship and hospital are realistic alternatives.

On the individual level, the idea of assembling a range of services around the care needs of a person who has previously had a long period of care in hospital, and who may well be unused to the idea of making an informed choice between one service and another, could be a formidable task in itself. Using guardianship constructively in such circumstances, could make an important difference. However, if used to reduce choices and impose services, in the name of providing an alternative to hospital, it could serve as a negation of good psychiatric rehabilitation. It nevertheless would be more realistic to think of guardianship objectives in terms of 'an alternative to hospital' for one particular client, given good assessment and a wide range of available resources, than to think of framing a policy objective for guardianship in a social services department around this goal.

Agreed practice guidance between agencies locally could no doubt be assembled to make for a clearer understanding of the role of guardianship and the availability of resources (of all kinds) to make these objectives realistic. Meanwhile one way forward may be to create multi-disciplinary assessment panels for guardianship. American experience has suggested that their legal instrument for setting guardianship in motion, namely a court hearing, is made much more effective where the court is advised by a multi-disciplinary panel of professionals who have individually and collectively reached a view on which resources the client will need in order to remain out of hospital and what degree of enforcement may be necessary to make these arrangements workable.^(43/44)

Critics of the underlying assumptions of the benefits of guardianship have suggested that though it poses in the guise of a less restrictive alternative to hospital and institutional care it can actually be imposed on individuals in such a way as to be more restrictive for the client.⁽⁴⁵⁾ This can happen in four ways:

1. The allegedly restrictive environments imposed in psychiatric hospitals can, for particular individuals, become an environment in which the client is enabled to express him/herself without being constrained by family members whose presence is unavoidable in the community.

2. The rules set down by the guardian concerning the client's behaviour and activities can be more intrusive in a personal sense than general rules governing behaviour on psychiatric admission units.*

3. As well as being more intrusive, the impositions within guardianship can be more open-ended and less sensitive about what is normally acceptable. For example, a guardian may work on an unfounded supposition that the client suffers in the company of a certain family member, and proceed to restrict or ban such company; nursing staff on a hospital unit are more likely to operate pragmatically.*

4. Guardianship measures can be used as, for example is the case in some parts of the USA, to circumvent the due process requirements for civil commitment, thus depriving clients of certain safeguards. However, the situation in the USA is likely to change when the law is modified to ensure that people do not become compulsorily admitted to hospital without indications of incompetence.

A common theme in these arguments is that while for some people, guardianship is by definition less restrictive than admission to hospital; for others, guardianship (potentially at any rate) is more restrictive, being more pernicious and open-ended. There may be an assumption behind this argument that all methods of social control that apply to deviant groups in society (but in this case focussed on the mentally ill) are unduly restrictive or oppressive in their treatment and care of these groups, being based on a punitive or semi-punitive approach. A number of arguments about the use of psychiatric hospitals as the ultimate 'sanction' for control of mentally ill people contain the notion

* The assumption in both these instances is that the authority of guardians is effectively delegated to medical authority while the person is in hospital as regards day-to-day case management. There is no evidence to support or counter this view, but see 'Definition' discussion on comparison between guardianship and hospital, pages 48 to 54.

that compulsory psychiatric in-patient care is a form of punishment, specially when linked with a means of access provided through compulsory admission.

The doctrine of the least restrictive alternative has been subject to criticisms, for example by Bachrach.⁽⁴⁶⁾ One theme from these criticisms is that the doctrine assumes a predisposition to place mentally ill people in unduly restrictive environments when in fact no such assumption is justified. Restrictive environments, especially the literally restrictive regimes of secure units and withdrawal rooms etc, are a scarce resource and ones which are expensive to run and maintain for individual clients/patients. The less restrictive the environment, the less resource intensive it tends to be, and the ultimate in least restrictive environments is ordinary life in the community, with only as much access to medical/psychiatric care as is normally obtainable through the services of the general practitioner. Manifestly, for some people higher degrees of restrictiveness are required, but this should not be equated with negative discrimination. On the contrary, their requirements for restrictive care may well coincide with resource intensive inputs of psychiatric treatment from which the person may be expected to benefit to a far greater degree than in the less restrictive environment. It would therefore be more appropriate to view this situation as a form of positive rather than negative discrimination and likewise to consider the punitive view as a misplaced assumption.

It needs to be reiterated that the position of guardianship in these debates is equivocal, depending on its meaning and position for individual clients subject to the guardianship arrangements. Clearly, for some people the restrictive element relates not to particular forms of care but to the very open-ended or potentially constraining elements that might form their particular guardianship package of care. For others, the mere existence of an arrangement whereby a guardian as a personal carer/arranger acts in the best interests of the client, means that restrictiveness will be no more or less than is needful for a client at any one time. Neither of these alternatives excludes the possibility of the client himself being involved in the negotiations, both in determining how various forms of care will be perceived in terms of both restrictiveness and preferred movements from one kind of facility to another - again assuming a personal guardian/carer acting in the client's best interests.

As a shorthand way of expressing the questioning of the thinking behind the doctrine of the least restrictive alternative, the alternative expression, the **Most Beneficial Alternative**,⁽⁴⁷⁾ has been 'coined' to make the point that restrictiveness may or may not be beneficial or needful in given circumstances and should not therefore be viewed as an inherently negative attribute.

'Net-Widening': Guardianship as a 'More Coercive Alternative'

Guardianship is criticised for its role in extending the scope of social control because of an assumption that use will involve greater resort to compulsion as against other non-coercive measures. There is no evidence from existing data in the UK of a trend in this direction, i.e. of guardianship being used in place of informal admission to hospital or of care in the community provided on a voluntary basis. The anxiety stems from the concept of 'net-widening' articulated by Van Dusen in the USA who suggests that one consequence of deinstitutionalisation will be to bring more people within the ambit of other forms of statutory control.⁽⁴⁸⁾

Conceivably, a form of net-widening could occur if increased use of guardianship was resulting from a broadening of the criteria by which guardianship applications are based. If, in particular, guardianship was to be used increasingly to impose services on individuals, whether or not the recipients were found to be mentally ill by psychiatric assessment, and were deemed instead to require guardianship on basic welfare grounds alone, this could be the outcome. This prospect relates to the situation which some describe as hospitals being used inappropriately to provide necessary care and attention for people who would be provided for better by community services but where, in the absence of statutorily enforced community care, such people have to be compulsorily admitted to hospital. In other words, compulsory admission to hospital then arises not from the particular needs of the person to be in hospital, but the need to receive care and attention in the absence of such care and attention in the community. Compulsion is required because the person will not, of their own free will, agree to enter hospital. The person may, quite reasonably argue that they should not need to enter hospital to receive care or services which should be available outside.

A further example of net-widening might occur if guardianship powers were extended to include compulsory treatment in the community, and questions about the desirability of such a development have already been discussed, see pages 144 onwards.

'Net-widening' can be criticised for an over-sensitive presumption that increasing use of compulsory powers is against the general interests of the class of people referred to as mentally ill. If all people defined by these means remained subject to compulsory powers, as generally applied prior to 1930, one would necessarily give urgent attention to the appropriateness of the services provided and ask whether the compulsory element was not related to a negative evaluation of the quality of the services by people with mental illness. It is possibly true, but difficult to test, that the extension of good quality community services would reduce the need for compulsion.* A similar argument could be advanced for the need to increase the quantity, range, accessibility and availability of all services, including hospitals, since if people with mental illness could have choice and ready access to such services without stigma or other difficulties, they would be more likely to have confidence in their efficacy and to value access to them accordingly.

Speculatively, it could nevertheless be asserted that the need for guardianship (given an ideal quality and quantity of services) would still remain since there will be people who are so uncertain or ambivalent about receiving any therapeutically intended service that refusal will occur at some stage, probably unrelated to the point at which a service might objectively be judged to have outlived its usefulness. In other words, only by asserting that people with mental illness should not be subjected to the social control of imposed services, however effective they may be, can one envisage a situation where guardianship would not be needed.

The Therapeutic Capacity of Social Services

Social services could be considered as having only an ancillary role compared with that of the health service in the care and treatment of people with mental illness. This does

* It is interesting to note however that such a view would contradict the prediction of the Royal Commission, which was that use of guardianship would increase proportionately as the range of services for people with mental illness was broadened and extended.

not imply a judgement that all health service provision is always appropriately consistent and continuous as against social services inputs of an episodic and uncommitted quality, but social services have little incentive to undertake long-term work with people in the community with chronic mental illness problems as against relatively clear cut statutory on-going responsibilities towards children and families. Possibly, newly introduced assessment arrangements in social services will be influencing or modifying this situation as and when community care policies are fully implemented.

Guardianship could be seen as challenging social services not only to provide a therapeutic input but also continuity and structure for as long as clients need them. However, taking the example of residential care staff, it may well be found that assessment criteria applied to selecting residents in the first place effectively excludes people who require therapeutic input, other than medication. It might also be true more generally that creating a guardianship relationship with a client immediately presupposes the availability of a therapeutic input, thereby acting as a further rationing device, and keeping guardianship numbers low.

The position of social workers operating special guardianship (guardianship which, for certain clients, would include compulsory treatment in the community) would fall neatly between the health service responsibility towards persons admitted to hospital and the responsibility of ASWs towards clients on guardianship, in that the sanction to enforce powers of compulsory treatment in the community will rest with the health service rather than social services, and thereby possibly challenge the idea of guardianship being a social services responsibility.

McLAUGHLIN'S 'SOCIAL WORK-ISTIC' MODEL OF GUARDIANSHIP

McLaughlin offers a critique of a 'social work-istic' model of Guardianship, which actually questions the location of guardianship within social work agencies - i.e. agencies who employ social workers to act as *de facto* guardians.⁽⁴⁹⁾ McLaughlin's criticisms are on four main grounds:-

1. There is an inherent conflict of interests, both between the needs of the client and the needs of the agency (particularly acute where funding sources are competing with each other); and the interests of one client (on guardianship) can conflict with those of other clients. Translated into social services terms within England and Wales, the implication would be that the social work guardian acting for a client in his/her best interests conflicts with agency policy or with a management approach to, for example, use of a particular scarce resource; likewise a guardian social worker providing care for one client may find that by prioritising the needs of this client he/she thereby puts these resources further out of reach of other clients whose needs may be as great.

2. Delegated guardianship authority, i.e. from heads of agencies to social workers, causes "substantial weakening of the accountability of guardians", the implication of which would be that guardian social workers see their mainline accountability being towards management rather than clients, whether or not the client is on guardianship.

3. Guardian social work is prone to discontinuity of personal relationships (i.e. exactly the opposite outcome to a basic guardianship assumption) which is predominantly due to staff turnover at social worker level in social services agencies. McLaughlin points out that if a due process was in place, the head of a social work agency would in this event have to bring his guardianship clients back to the court for the work to be reassigned, whereas in a social services department all that would happen is that the social worker's caseload would get handed over to another social worker (and given the situation known to exist in some social services departments, individual cases may not even be reallocated in this way - though hopefully guardianship cases would be).

4. Guardianship clients are said to be more likely to be subjected to institutionalised care than other clients with similar characteristics and needs, due to guardian social workers' cautious inclination towards use of protective services. In other words, where guardianship clients are at risk, a social worker is more likely to remove clients from the risk, and thereby protect him/herself from

criticism, than to allow the client to weather the difficulty in the ordinary way. Such a situation is especially likely where social workers are also the "gatekeepers to the institutions".

At first sight it is difficult to recognise the sort of problem identified in (4) above applying directly to the social services situation in England and Wales, not least because of known difficulties in arranging admission of mentally ill guardianship clients to scarce residential care resources belonging to social services. However, if one took a long enough time-span to observe these manoeuvres, and included in them access to residential care provided by the independent sector and other agencies to which social workers could gain access, there may well be an observable trend in this direction. Furthermore, there is a striking parallel between this view and current criticism of social workers involved in child protection work, namely that they may be predisposed to remove such children from their homes - not because of objective evidence of child abuse but in order to ensure the record shows them as having observed all due precautions.

In summary, McLaughlin has caricatured the guardian social worker as one who sees guardianship as a form of care management by which services can be imposed on clients, whether they are in essential need of them or not, because of the intrusion of self-protective motives on the part of social workers and/or social services management.

Echoing a number of McLaughlin's concerns from a British perspective, Millington notes that:

"The ASW is, however, an employee of the local social services authority and may find the extent to which he can exercise his independent, impartial judgement constrained by his employers if they operate a blanket policy of refusing to accept people into guardianship or if they are unable to do so [through resource constraints....] If there was a statutory requirement to provide resources for persons subject to guardianship, authorities could not refuse to accept applications [for such reasons....] Those authorities which are disinclined to accept people into guardianship are not operating in accordance with the spirit of the legislation."⁽⁵⁰⁾

More specifically, Brown points to the number of parties and interests who need to be represented in the processing of guardianship within social services as conceivably involving:

- "1. a social worker;
2. an Approved Social Worker who may or may not be the social worker involved in the case;
3. the Director of Social Services who in accordance with the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983 represents the local social services authority and when appropriate, becomes [technically] the guardian;
4. a private guardian."⁽⁵¹⁾

Brown could have gone on to mention that elected members of social services committees are required to be consulted if a guardianship order is to be discharged before expiry date. He might also have noted that in between the ASW and the director of social services is usually two or three layers of management who, whether or not formally involved, will expect to be consulted and briefed on the nature of the application and the reason why the social worker is pursuing it. He does, however, pinpoint the conflict of interest in-so-far as the client's needs are concerned in that "the local authority can in effect, be applicant, guardian and landlord [of the residential establishment within which the client is expected to reside]", and he compares arrangements in England and Wales unfavourably with those applicable in Scotland, seeing:

"benefits of having guardianship matters considered in court where the client can be legally represented. It could be argued that the English system, where applications are made to a social services department by an approved social worker, employed by the same department, with no client representation, does not promote natural justice."⁽⁵²⁾

Professional Social Work Values and Practice Issues

To many observers, guardianship raises serious ethical questions about the use of compulsion and the imposition of care in the guise of acting in the client's 'best interests'. Bedi is particularly concerned on these matters, as exemplified by the needs

of those clients whose mental health is very variable and where their capacity to decide for themselves fluctuates. His specific concern is the use of statutory powers to anticipate a situation in which the authority of guardianship will be required, He regards this use of guardianship as inappropriately pre-emptive, as when considering the position of:

"...those clients who are stable for most of the time but who have a cyclic history of unstable episodes and become difficult to get hold of or handle (sic)... After all, is one justified in taking a Guardianship order on someone who is quite stable on the chance that they may not be so at some time in the future? If the answer is yes, then is six months [the period of the order] long enough to make such monitoring effective? In addition to this, what criteria for the renewal of an order will a local social services authority accept, as a matter of policy?"⁽⁵³⁾

Bedi, anticipating greater use of guardianship to facilitate the placement of elderly people in residential accommodation, expresses misgivings as to whether this is "either professionally or morally justified". Grudgingly, however, he admits that "it is true, both historically and in the future (sic), that guardianship orders are effective in this area of social work".

Bedi appears to echo a general anxiety about the use of guardianship for elderly people (for these reasons and others) which are further discussed below under **Innovative and Controversial Uses of Guardianship**.

Basically, Bedi sees guardianship as being in conflict with certain key social work values, namely 'respect for persons' and 'client self determination'. It is true that there is a notable absence of guidance or discussion from the professional association, the British Association of Social Workers, concerning the relationship between social work values, practice principles and the role and function of a social worker acting as *de facto* Guardian for a mentally ill person.

Such guidance is on record as having been requested by a group of BASW members as far back as July 1985 when a news item in **Social Work Today**⁽⁵⁴⁾ reported on a "controversy over the use of Guardianship and social work with the mentally disordered [which] has prompted the British Association of Social Workers Special Interest Group

on Mental Health Issues to seek out members' views through an item in **BASW News**. The response identified "areas of concern among mental health practitioners" of which the following were the principle:

- "The amount of persuasion that can be used to direct clients to live in a particular place if they do not wish to co-operate."
- "The use of Guardianship for elderly mentally infirm people."
- "The granting of powers under Guardianship with very little sanction with which to exercise the powers."
- "Problems with time-delay between the Director of Social Services accepting Guardianship and the Social Services Sub-Committee endorsing it."
- "The ASW may be presented with a conflict between the necessity of acting in the best interests of the clients, and the demands of the role of Guardian and Advocate."

Representation from the professional practice divisional committee of BASW to approach MIND, MHAC and relevant Universities was sought "to establish a group to oversee research [into the use of Guardianship] and to encourage the provision of funding to monitor this section of the Mental Health Act."⁽⁵⁵⁾ No such activity has taken place.

Although BASW have held conferences and workshops on these (alongside other) practice aspects of the Mental Health Act, specific discussions related to guardianship have not been written up or reported. Contributors to BASW's most recent relevant publication confine comment on guardianship to two brief observations, describing it, on the one hand, "as a way of commanding a degree of priority [for elderly people] for both social work support and the provision of services [as an alternative to hospital]" and, on the other, as a "little known or understood [alternative to compulsory treatment orders]".⁽⁵⁶⁾

Innovative and Controversial Uses of Guardianship

A number of journal articles have focused on the particular use of guardianship for the care of elderly people, dividing their attention broadly between maintenance of elderly people at home and placement of such people into residential care straight from hospital.

Use of guardianship to assist in the maintenance of elderly people at home has drawn attention to some interesting and important practical concerns, such as the authority of the guardian to have a key to the client's front door in order to sustain appropriate access to care services. Also, discussions are offered on ways of working with clients who frequently endanger themselves and others by such means as leaving gas cookers turned on.⁽⁵⁷⁾ There is general endorsement for guardianship as a means of helping in work with clients who are demented or dementing with particular reference to lack of connection between guardianship and the Court of Protection in order for guardianship to be used as an auxiliary measure for protecting the client's affairs and property.^(58/59/60)

The placement of elderly people into Part III accommodation is criticised on ethical and policy grounds as being an abuse of the power and as, at least in some cases, being actually illegal where guardianship is used as a power to convey. It is also seen as being in contradiction of the Code of Practice injunction that guardianship should not be used in these limited ways but only as part of a total care package. There is nevertheless some counter-argument to the effect that guardianship has a definite place in preventing clients returning to uncared for situations in the community. Again, this is not peculiar to elderly people but is more often discussed with their needs in mind. By implication, there is the parallel argument that younger people, such as those suffering from schizophrenia, could also benefit from rehabilitation being put in hand through guardianship to enable more satisfactorily supervised aftercare arrangements to be sustained.

Perhaps the most telling reservation about use of guardianship for people who appear to be dementing is the one advanced by Bedi⁽⁶¹⁾ with regard to pre-emptive use. It is not to deny the prognostic skills of geriatricians and other professionals in the field, to wonder with Bedi at what point it becomes ethically justifiable to make assumptions about a client's capacity to care for themselves ceasing at a given time in the future.

Social Work Training and Skills

Following from the above, there are a number of comments in the literature about the absence of a particular training prescription in the use of guardianship. As Brown says,⁽⁶²⁾ this should necessarily avoid being separated off from skills in mental health work generally but should be clearly located within the range of skills required to work with this care group, while being firmly connected with an understanding of the appropriate use of authority and its relationship to a particular form of advocacy. Such gaps in training appear to apply both during qualifying courses and in ASW training.

Bean has pointed out that there is a vicious circle created by a lack of appropriate experience of guardianship by social workers, causing them to be reluctant to take on guardianship responsibilities.⁽⁶³⁾ Gunn observes that training deficiencies are not peculiar to social work practitioners but are also to be found among social work managers, giving rise to a generally guarded or sceptical management viewpoint.⁽⁶⁴⁾

As earlier outlined, McLaughlin (considering Canadian experience), questions the capacity of social workers to provide the necessary continuity implicit within the guardianship framework.⁽⁶⁵⁾ With continuity could probably also be linked structure and individualised care, offered in as assertive a way as is necessary for the individual, thus connecting these points with the broader observations from the findings of Stein and Test.⁽⁶⁶⁾

In short, there is a continuing question mark over the ability of social services in general and social workers in particular to function at an optimum therapeutic level to provide the necessary ingredients for an effective guardianship package. This may well apply both to specific guardianship arrangements under the Mental Health Act and casework with this care group which may carry some of the same elements, albeit on a less formalised basis - i.e. informal guardianship.

Availability to Social Workers of Policy and Practice Guidance

The combined impact of the various Codes of Practice referred to above (Chapter III) suggests that policy and practice guidance in the use of guardianship is necessary to help prospective applicants consider both positive and negative outcomes, and that the measure should be part of, or an expression of, the assembly of a care package applicable to the particular needs of the individual. Spelling out this latter prescription is tantamount to discouraging would-be applicants to apply for guardianship before having given wider consideration to the client's care needs and must receive universal applause. On the other hand, it could be seen as yet a further disincentive to put guardianship as a first option priority within a strategy for providing a range of services.

In short, there is lack of guidance on the essential question as to whether guardianship should be used to provide access to services which the client would not otherwise receive - either because of their own unwillingness or because of the authority's reluctance to prioritise access to that client. The official literature has specified that, of itself, guardianship does not automatically provide for prioritised service provision or access.⁽⁶⁷⁾ However, it might be appropriate if future guidance re-stated this in positive terms, i.e. that guardianship arrangements could be used to prioritise service provision to a client where this is justifiable in terms of client need. Brown, examining a selection of guidance documents provided by social services departments to social workers, comments that their stress on the need for available resources to be in place before a guardianship order can be considered, leads eventually "to produce a service-led approach rather than a needs-led approach".⁽⁶⁸⁾ As matters stand, however, guardians' statutory powers are framed entirely in terms of powers towards the client and are not directed towards gaining access to the agency's own resource allocation system.

Although the Codes of Practice provided by the Department of Health could take social workers some of the way towards making appropriate use of guardianship, this can only be of limited value without endorsement and development by individual local authorities. In practice this requires social services management to make plain the terms and conditions related both to the process of applying for guardianship and for the sustaining

of the order once in force. The remainder of this chapter therefore focusses on the interaction between social workers and social services management as the underwriters of guardianship, without which social workers' decisions carry little or no weight.

GUARDIANSHIP, SOCIAL WORK AND THE POSITION OF SOCIAL SERVICES DEPARTMENTS

Historical/Conceptual Problems

Social services departments have been required to adjust to the differences between guardianship under the 1959 Act and the 1983 Act but, as has already been demonstrated, the conceptual definition of guardianship was by no means made clear in 1959. Added to this, is a demonstrated uncertainty as to what concept of guardianship was involved in the thinking about the relevance of guardianship for mentally ill people in 1959 or since. Only the limitations of applying a strict parent/child model of guardianship for people with mental illness under the terms of the 1959 Act would seem to have been accepted. For instance, the failure to implement the form of 'two-tier' guardianship, suggested in the 1978 White Paper, leaves unanswered questions as to the component parts of guardianship with the independent advocacy function and the protective care function arguably accommodated uneasily within the same framework. Keeping them separate would, in Fisher's view, have enabled them to better meet the different needs of clients for control as against protective advocacy.⁽⁶⁹⁾

Social services departments were required to implement the 1983 Act whilst the alternative model formulation being put forward was by no means clear. Arguably, pre-existing notions of the role and value of guardianship for people with mental illness needed to have been understood through these changes in order to stimulate fresh thinking in applying the concept to the care of certain mentally ill people in the 1980s and 1990s. For instance, is approving a guardianship order tantamount to a finding of incompetency, as suggested by Gostin⁽⁷⁰⁾ (and as assumed by this researcher) whether in a plenary sense or in respect to the areas of life prescribable by powers specified in Section 8 of the 1983 Act? If so, are social services departments *ipso facto* in a surrogate role *vis-à-vis* the client? If the surrogate role is assumed, and additional powers become necessary in

a particular case, for example to consent to treatment on the client's behalf, might local authorities' legal advisers suggest following the untested course outlined by Hoggett⁽⁷¹⁾ whereby a court is requested to invoke Royal Prerogative authority, via committee of the person, to sanction use of compulsion?

Arguably, in the absence of a clear historical/ conceptual understanding of guardianship, social services departments have by default been expected to comprehend its implications within the narrowest sense of statutory implementation providing them at best with a static and incomplete view of its potential. They are faced with a set of powers of questionable effect with official literature emphasising a position of authority for the guardian which is difficult to justify even in purely legal terms. They have to contend with elliptical language as to the need for the client to accept the authority of the guardian in the first instance but which is also seen as a criteria for the effectiveness of guardianship.

Furthermore social services have had few incentives to develop the advocacy element within their guardianship practice, and functions of social services guardians are difficult to equate with advocates in the independent sense referred to by Wolfenberger.⁽⁷²⁾ Consequently, no readily available guidance is usually offered by social services managers to approved social workers on how to offer guardianship clients particular priority or continuity of care - requirements which social workers readily recognise as at the heart of guardianship practice.

The rare use of private guardians begs the question as to whether the private guardian is seen to be in a position to overcome some of these problems - i.e. by being independent by definition and by being able to advocate for prioritising the needs of the client. There may well be a balance of views between those who argue that private guardians would find access to the social services required to support a guardianship more difficult than a social services social worker, or whether the independent element would enable the private guardian to make demands on social services management which would be difficult, if not impossible, for the social services social worker to sustain. Apparently, only in the Scottish context has this debate been fully rehearsed,⁽⁷³⁾ but even there has not been translated into any form of official guidance.

At the root of these difficulties, social services are faced with the fact that social work has a different historical origin to guardianship, giving rise to a number of conflicting expectations. Social work with this care group arguably originated with the need to implement the Poor Law and in this respect continues to influence a social work perspective within local government which is aimed at reducing the level of dependency of mentally ill clients on these services. Guardians, on the other hand may well see themselves as providing a 'service-in-itself' and of continuing to carry the advocacy role without reference back to the needs of ratepayers to limit their financial burden.

Statutory Powers: The Legal Basis of Guardianship and Consequences of Intervention Under the Mental Health Act, 1983

Part of Chapter III (page 44 onwards) set out to show that local authorities are vested with a wide range of powers, some mandatory others permissive, to provide services and care for adults who suffer from limitations of care or from specific disabilities, of a limited or long-term time span. They have even greater obligations towards children, and it is generally accepted that child care law is more fully developed to require social services departments to intervene to protect individual children, for example to provide monies to prevent children coming into care, as well as to provide a range of services for children in need - including children with disabilities or special problems. Adult services are less well developed towards a basis for individual intervention, with the Mental Health Act providing a partial exception to this. New legislation in the form of the National Health Service and Community Care Act, 1990, arguably provides a mid-way position between an individual interventionist approach and a care group service providing approach, and puts its emphasis on individual assessment and case management.

Social services departments have a duty under the Mental Health Act, 1983, to provide a sufficient number of ASWs and there is a training prescription for ASWs over and above Diploma in Social Work (DSW). As has been indicated in various points in this thesis, ASWs are most frequently the *de facto* guardians of mentally ill people but any social services employee may be assigned this task, without any necessary regard to training qualification or experience, by virtue of the delegatory powers of the director of

social services. Technically, therefore, the ASW role in relation to guardianship could be confined to their responsibility under the Act to make applications to the director of social services to recommend that the/she become guardian of the client or, in certain cases, that a private guardian be approved. There is no requirement upon the director of social services to accept an ASW's recommendation and he/she may therefore decline any guardianship proposal. Directors of social services have only to accept the role of guardian in situations where a private guardianship arrangement has broken down due to the death or proven unsuitability of the private guardian.

In other respects the position of social services departments with regard to guardianship might appear analogous to the responsibility to act and intervene in the care of individual children. However although this level of intervention can arise with regard to mentally ill adults, there is no mandatory requirement on social services department to proceed in any particular way. A guardianship order may be declined simply because that authority does not have the resources to implement the order; this could mean either that it is not feasible to allocate the client to the guardian social worker or that the requirements of the client under guardianship might appear to include residential or day care facilities which are in short supply, or even where staff of these services have misgivings about receiving a person into their care whilst on a guardianship order. Even though, as Slater has clearly indicated,⁽⁷⁴⁾ the statutory framework of service provision applicable to social services in the care of mentally ill people is much wider than is generally appreciated, the actual incentive for social services to consistently provide services at an optimum level for any given individual, whether on guardianship or not, is very weak.

The Mental Health Act, 1983, does not lay down an expectation of service provision other than by inference, and follows the same framework as the 1959 Act, even though the latter was brought in at a time where Government policy was intended to shift towards the development of community care. In comparing the two Acts, it can be overlooked that within months of the 1959 Act a **Department of Health Circular 14/60 (Mental Health Services)** was required in order to explain to local authorities and health authorities that the Act was in fact intended to implement the Royal Commission's recommendations for the expansion of community care. Nothing comparable has followed the 1983 Act, and for most commentators the achievement of this Act was not

a further enhancement of, or a greater impetus towards, the development of community care but a general tightening up of civil rights with a more up-to-date approach to the limited use of coercion and compulsory powers generally.

There are few clear guidelines to justify intervention by means of guardianship under the Mental Health Act, 1983. The rationale for change of criterion for use from being 'in the interests of the patient' to 'in the interests of the welfare of the patient' remains obscure and no clarification has been forthcoming on whether invoking guardianship under the Act is actually or tantamount to a finding of incapacity. Consequently, neither social services managers nor ASWs are offered a way of approaching these issues in a way which would enable them to satisfactorily distinguish between the inability of the client to make appropriate decisions (e.g. on where to live) as against the needs of the agency to arrange a residential placement for a client as a way of dealing with the problems they face, for example, in implementing a rehabilitation programme.

Following publication of the White Paper **Caring For People** in 1989,⁽⁷⁵⁾ the Government set forth a consultation process to examine the implications of their proposals for the way services for adult care groups are planned, organised and delivered. This included much discussion relevant in varying degrees to guardianship, and to assessment and case/care management. However no specific reference to guardianship or linked concepts such as 'representation' have found their way into the National Health Service and Community Care Act, 1990. It may thus be assumed that the collaborative arrangements suggested will be 'tacked-on' to the care planning dialogue envisaged by the new legislation.

Without a recognised conceptual link between guardianship and case management, ambiguity remains as to the significance of the distinction between 'class' (or care group) responsibility and responsibility for individual people with mental illness. In this difficult area the courts have generally upheld the view that local authority responsibilities for service provision for mentally ill people relates to the care group as a whole and does not imply a particular responsibility to meet individual need, if there are legitimate (eg. resource) reasons for not being able to do so. Is guardianship one of these 'services', which may or may not be provided for clients according to circumstances, or does the

use of guardianship by social services departments arise from certain contingencies (defined by medical and social work recommendations following assessment) which cannot be side-stepped even when the level of demand is judged to be too high?

Guardianship and its Resource Implications

Bedi is typical of many commentators who are sceptical of the value of guardianship as a long-term alternative to hospital care without parallel growth in the scale and range of community services. The relationship between the guardianship concept and actual resource commitments to underwrite it is a constant source of concern.⁽⁷⁶⁾

There would seem to be two related views on the matter. The first of these points to the illogicality of not providing guardianship clients with some priority access to services, as the ultimate success of guardianship is seen as turning on appropriate use of community alternatives to hospital. By implication, support for Gostin's 'ideology of entitlement' is in adherence to the quid pro quo principle, whereby the availability of appropriate care and services to clients is assured on a reciprocal basis for restriction of liberty.⁽⁷⁷⁾

The second view is simpler and more practical, namely that if services are not available to clients on guardianship, this gives rise to a contradiction in the idea of guardianship being helpful to clients, as well as rendering guardians impotent to fulfil their functions.⁽⁷⁸⁾ Both points of view would seem to point to the same conclusion that guardianship, if it is to obtain credibility, needs to be seen as a means of enhancing clients' rights rather than as a threat to these rights.

On a realistic level, a number of commentators observe that there are few incentives for social services departments to help put appropriate community care facilities and services in the way of guardianship clients and a number of obvious policy reasons for not giving guardianship clients priority access to such services that exist.

The Cost of Guardianship

No systematic attempt appears to have been made to cost the implementation of guardianship - ie. whether viewed as a small part of assessments under the Mental Health Act pursued by social services, or in terms of approximate individual costs of the guardianship for a particular client borne by these agencies.

The only self-evident cost of guardianship is the administrative expense of the processing: the application and its consideration; time taken to decide and the time required to sort and deal with necessary documentation, together with the liaison arrangements with other agencies which might arise from these. After this point, the cost can only be clearly calculated in terms of the time required by the needs of individual clients from the individual *de facto* guardian, together with the time of those colleagues who the guardian requests to assist him/her. Other costs would be consequential upon actual implementation of guardianship powers, i.e. in determining place of attendance/day care/access by making services available.

Apart therefore from administrative costs, similar costs will be entailed in any substantial arrangements to provide care for people with mental illness where service provision was called for. For example, any client with a history of schizophrenia and a number of hospital admissions, is already a 'resource intensive' demand on statutory agencies, both in terms of the time required from social workers and others, as well as in providing residential and/or day care as part of the community care package. This would be so whether the client was on guardianship or not. Also, one might add, similar costings would apply whether the client could be described as being supervised by social services departments through informal guardianship as distinct from statutory arrangements.

In other words, apart from the formalities and the processing, there is little which inevitably distinguishes the cost of caring for a guardianship client from others, given a certain level of service provision/ availability/ access. Guardianship would be a more costly option only if it demanded that local authorities make services available to such clients by application of the principle behind the CSDP Act, 1970; on the contrary,

however, the official literature stresses the opposite interpretation, that no individual resource consequences flow from taking out a guardianship order.

A more precise approach to considering the cost of guardianship might be to apply the concept of opportunity cost, requiring a precise idea of what would or could constitute an alternative to guardianship. The inappropriateness of viewing hospital care in this way has already been established (pages 51 to 54) not least because the statutory basis for guardianship does not exclude application while the client is in hospital. Conceivably the scope of guardianship could be limited for the purpose of a costing exercise to community care arrangements which are statutorily formalised and structured as distinct from less formal care - i.e. social casework (or informal guardianship) accessing the required services in the ordinary way.

Detailed hypothetical costings could be attempted using this formula but these are hardly necessary to visualise a situation in which the cost of providing adequate community care for a person through informal means might actually be greater in the long run than the more formal requirements of guardianship, in that a more rigorous assessment of benefit from community care resources (residential, day care, domiciliary care) is likely to have been undertaken prior to the commencement of guardianship. Furthermore, much informal community care is offered on a 'take-it-or-leave-it' basis with little attempt to ensure that clients who become involved, for example, in a given day care programme actually sustain their attendance at this programme and gain some definite benefit. Proper monitoring and review are more likely to take place where a client is on guardianship.

In some ways, therefore, the true financial cost of guardianship is best seen as the cost of not using guardianship, and using instead some other means of providing appropriate care. It can therefore only be conjectured that anxieties from social services management about the cost of guardianship is related to the obligation to continue providing services during the period of the guardianship, as distinct from the more episodic and fragmented arrangements that may apply to those receiving informal care. If this is the case, the cost comparison is less to do with the cost of guardianship *per se*

than to do with the cost of providing thorough systematic and appropriate community care arrangements related to the needs of individuals.

If, as the Law Commission are suggesting,⁽⁷⁹⁾ health authorities were also to take on responsibility for providing guardianship, the cost could be shared between health and social services authorities, as would presumably be the case if special guardianship was introduced. There would clearly remain a serious problem in viewing the alternative to guardianship as hospital, i.e. with costs falling on another agency without that agency being party to a decision in favour of hospital rather than to pursue guardianship. The Law Commission's suggestions might help to balance costs across statutory agencies but would be unlikely to answer the question as to how realistic it is, in terms of agency accountability, to regard guardianship as an alternative to hospital.

The 'Quantity' of Guardianship Usage

The above discussions lead to the question of whether guardianship is used sufficiently or not. Viewed as a purely statutory intervention, the 'sufficiency' of usage does not arise, provided right procedures and practice are adopted in respect of each individual ASW assessment and application. However there appears to be a normative assumption that a certain level of use is appropriate for each local authority as well as for England and Wales overall.

With such an assumption in place, wide divergence between local authorities would appear to suggest misinterpretation or misunderstanding by the authorities in question. Alternatively, criticism could be targetted at authorities at respective ends of the scale, i.e. concentrating on authorities who use guardianship 'too much' or those who use it 'too little'. Clearly without a clear concept of the optimum amount of guardianship usage, such criticism merely begs the question about the objective of guardianship. Furthermore, a given authority seen as being in the vanguard of guardianship development because of consistently high numbers over a given period, may be found to be using guardianship 'inappropriately' by any reasonable standard. There have been suggestions, for example, that some authorities have unwittingly fallen into the mould of using guardianship at the behest of health authorities in a narrowly defined manner

around the task of decanting hospital populations and endeavouring to enforce alternative residential care placements, especially of older people into homes for the elderly. At the other end of the scale, an authority with a very limited record of usage, may be tentative in their approach for reasons which are adequately explained locally, i.e. due to tensions or difficulties between various groups of professionals or, more fundamentally, because of serious professional doubts about the efficacy or ethics of the use of compulsion outside hospital. Official Departmental Health guidance is arguably unhelpful to authorities in this position.

Conceivably in this situation there is appropriate concern to ensure that when guardianship is used, it does, as the MHAC suggest, demonstrate a collaborative approach between the respective agencies and is not a unilateral 'stab in the dark'. Furthermore, there is anecdotal evidence that consideration of the need for guardianship often focusses on clients who have evidenced a pattern of social 'failure' following successive admissions to psychiatric hospital and unsuccessful attempts at rehabilitation. The professionals involved in the situation feel a corresponding sense of 'failure' in their attempts to deal with the situation and a proposed use of Guardianship at this juncture would understandably be viewed cautiously in order to ensure that this does not in turn become a failure for those concerned.

The official literature contains normative statements to the effect that guardianship usage should apply to a small minority of people in the community who cannot receive care and supervision by other means, and this has been a consistent theme (except for the 1978 White Paper) since the Percy Commission Report of 1957. When taken at the level of a cautionary warning to ensure that people do not use guardianship lightly, such comments may be appropriate, but when used as a reference point to indicate the optimum use of guardianship, the position is clearly pre-emptive, if not self-fulfilling.

In the absence of a clear reference point to indicate appropriate quantity of usage, the Social Services Research Group have referred back to the official definition of the objective of guardianship from a social policy point of view as being an alternative to hospital, and have asked whether, and to what extent, guardianship is used for this purpose.⁽⁸⁰⁾ From this point of view a calculation of the appropriate amount of

guardianship would commence with some agreement on the appropriate ratio as between a given number of compulsory hospital admissions and guardianship as a 'diversion'. The SSRG comment on the adequacy of guardianship usage concludes that a ratio of 1:100 indicates that guardianship is not fulfilling the intended role.

Comment is offered elsewhere (pages 48 to 54) on the appropriateness of defining the guardianship objective in this way. However, the SSRG logic may be flawed in suggesting that guardianship *in its present form* is appropriate for use in the small minority of cases envisaged by the Government as a diversion in this sense, implying not that guardianship is necessarily inadequate as it stands (though there are arguments to this effect) but that other diversions could and should have been made available to prevent inappropriate hospital admissions. More to the point, all diversions share the same requirement, namely a level of resources which can be flexibly deployed to meet the needs of individual clients for whom social circumstances have become intolerable and for whom other forms of care and help are immediately required.

By way of recapitulation, previous discussions explored the issue of whether it is appropriate to define guardianship as an 'alternative to hospital' and concluded that although social workers would clearly see this as justifying use of guardianship for individual clients, social services management will not necessarily see this use of guardianship as implying that local authorities should (alone) be providing such alternatives. There is thus the potential for a conflict of objectives between a policy on use of guardianship and an individual social worker's objective for their client which almost certainly determines the numbers of guardianship finally agreed.

Reasons for 'Under-Use'

Although the meaning of 'under-use' is not clear, as the discussions on quantitative and normative aspects have shown, most commentators refer to under-use of guardianship and indicate that this situation requires a remedy.

The most frequently quoted reason for under-use is concerned with sanction and credibility, i.e. the argument that since guardianship cannot be 'enforced', either in terms

of authority of the guardian or in terms of service provision, it must inevitably lack credibility and can only apply to clients for whom guardianship was only marginally appropriate in any case. Inconsistencies (apparent or real) between the degrees of enforceability of guardians' powers is frequently noted, e.g. as between the power to return a person on guardianship to their place of residence but not legally to convey them there in the first place, as in the Third Biennial Report of MHAC referred to above.

From time to time guardianship has been compared unfavourably with a probation order, especially since the client's unwillingness to comply with the terms of the latter can be sufficient ground to bring the order back to the court for reconsideration.^(81/82) No commentator (so far as the researcher is aware) has advocated devising a way in which the breakdown of a guardianship order can be re-negotiated, e.g. through the assistance of a Mental Health Review Tribunal. Other reasons for under-usage are contained within Gunn's omnibus term 'inertia factors' which refers to general scepticism about the value of guardianship, both by practitioners and social services managers, added to which the latter are poorly informed about guardianship.⁽⁸³⁾

SUMMARY AND DISCUSSION

There would appear to be major obstacles in comparing guardianship and social work at a general level as these refer to different phenomena, albeit with a measure of overlap. Guardianship could best be defined at this general level as a social institution partly circumscribed by statute, whereas social work is easier to recognise as a professional activity whose context is organisational and managerial within social services rather than of the institution of professional social work in its own right.

The dictionary definitions both refer to a relationship of care but the need of the guardian's ward for protection is explicit whereas social workers' clients' needs are implicit (i.e. "individual or social problems arising mainly from mental [disability]"). The operational definition of social work implies that all clients require care and protection to varying degrees.

It is hard to overestimate the special connection between guardianship and social work in England and Wales brought about by the statutory arrangement which requires, in effect, guardians to be social workers. This might imply that social work would be the senior of the two in being able to dominate its operation and activities. Whether or not social workers can and do put a firm 'social work imprint' on to the way guardianship operates in practice emerges in Chapter V.

The existence of a small number of private guardians continues to raise awkward questions since their professional background is not prescribed and it is not known how many are trained as social workers. Moreover, there is some suggestion from developments in Scotland that private guardians exercise greater influence independently of social work agencies and indeed put pressure on local authorities to provide services. Conceivably, a private guardian could be in a position to request social services to provide social work help, and in this narrow sense, the guardian could be the 'senior partner' to the social worker.

It is also necessary to acknowledge that in a loose general sense social work can be referred to as an informal kind of guardianship while guardianship can be referred to as formal (i.e. statutorily prescribed) social work. If nothing else, these references point towards a degree of interrelationship rather than to two quite different ways of helping certain people with mental health problems. Although social work and guardianship have been shown to have elements in common, formal connections between them other than statutory requirements seem to have occurred almost through historical accident: the idea that guardians for mentally ill people should be social workers - by training, qualification, experience and employment - is not universally accepted and, in any case, seems only to apply clearly in Great Britain, and to a lesser extent in Canada.

The level of social workers' understanding of the degree to which the role of guardian is seen as appropriate and needful to meet the needs of some mentally ill people may well be extremely varied, and the empirical section is intended to clarify this point. Meanwhile the lack of incentive on the part of social services management to assist social workers in clarifying their views, through developing practice guidance and through clear articulation of the resources underwritten to make guardianship viable, does not suggest

that social services departments of local authorities are the most satisfactory milieu within which guardianship can develop securely.

In developing their quality control systems, social services have not been offered a way forward which would enable them to reach an objective view as to whether the use of guardianship in given circumstances is sensitive to the needs of clients. More important, direct quality control of interventions under the Act by way of proposing or applying for guardianship on the basis of client need is difficult to envisage given an overriding message that the guardianship option is to be discouraged wherever possible.

Guardianship can certainly be said to be a costly enterprise but it can provisionally be said that all worthwhile care and assistance for people with mental illness is costly, especially that provided for those with continual or intractable problems and for whom community care solutions are at best a precarious arrangement. Well organised and properly timed guardianship may turn out to be more economic for all concerned than episodic and un-committed social work taking place in a management context which strives mainly to avoid allocating scarce resources unless this becomes politically unavoidable.

As matters stand, however, responsibility for guardianship rests squarely with social services and it would seem that Age Concern were correct in considering guardianship as basically a 'social services order'.⁽⁸⁴⁾ The evidence points to the fact that social services have not come to terms with conceptual difficulties and conflicts within the guardianship idea - particularly surrogacy and advocacy - which might mean that they are unable to provide assurances that they are willing to offer guardianship as a service to clients, i.e. as a means of enhancing the level of care needed for a particular mentally ill person.

Social services management are, in practice, the only ones able to determine the actual numbers - i.e. to make the key decisions - while their responsibility for developing the right professional climate within which appropriate guardianship decisions are made is far from clear. They have not been helped by the level of guidance forthcoming from the Department of Health following the 1959 Act while guidance forthcoming following

the 1983 Act has been equivocal in this respect. The quantity of guardianship is seen as derived both from the uncertainties of social workers and the ambiguity surrounding the need for it felt by social services managers and others. Again, the empirical section aims to test out these assumptions.

There is widespread acceptance that the redefinition of the guardianship criterion in the 1983 Act has not clarified the situation or made for more ready or appropriate usage; in fact, the significance of the change of terminology (from 'in the interests of the patient' to 'in the interests of the welfare of the patient') is a source of continuing doubt.⁽⁸⁵⁾

Finally, a number of commentators have observed that there are frequent administrative delays in the take-up of guardianship caused by uncertainties, prevarication or general dilatoriness on the part of social services management (at various levels). This may well start from the situation described by Gunn, with social services managers poorly informed about guardianship and anxious about its significance for their budgets and policies.⁽⁸⁶⁾ Whatever the reason, as noted in the MHAC Second Biennial Report referred to above, there is a much longer time lag between a decision to accept or decline a guardianship order than a decision related to the admission to hospital of a person under compulsory powers, which presumably conveys further doubts about the 'alternative to hospital' concept even when applied to individual circumstances of assessed clients.

An interim conclusion is that there remains a highly ambiguous position in terms of social services' responsibilities to provide services to people with mental illness when the status of guardianship as a service in its own right is by no means clear. Meanwhile directors of social services are left in the invidious position of exercising a 'stewardship' over guardianship usage, a form of 'guardianship over guardianship'. In other words, they have been clearly shown to be the accountable party, but accountability goes further than local authority level for nationally determined policies and legislative requirements. A further question, therefore, arises as to whom directors of social services are accountable for their stewardship of guardianship and how does central Government assist directors of social services in accounting for that stewardship?

The second interim conclusion is that when guardianship is subjected to close conceptual analysis as in the three model approach of Frolick,⁽⁸⁷⁾ the functions of advocacy, casework and case management, as shared concerns between guardianship and social work, stand out as promising and worthy of further attention.

Despite some pressing agendas on the research front there would seem to be no more important area to focus on than social workers' attitudes to guardianship, especially as it effects their advocacy, case worker and case management roles, and how these are influenced, on one hand, by management restraints and, on the other, by the range of clients with mental illness problems who present themselves to social workers.

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CHAPTER V

SURVEY OF SOCIAL WORKERS' VIEWS

AND GUARDIANSHIP CASES

This chapter concentrates on the empirical part of this research, namely a survey of social workers' attitudes to guardianship and of details of their guardianship cases. There are three main parts: (1) DESIGN, which considers the research questions and methodology, (2) PRESENTATION AND STATISTICAL ANALYSIS, and (3) INTERPRETATION OF FINDINGS. The assembled data provides the basis for answering the research questions in the following chapter (Chapter VI - Conclusions).

PART ONE: RESEARCH DESIGN

THE RESEARCH QUESTIONS

The first part of this section discusses the relationship between the research questions, the research subjects and the means chosen to address the questions.

To address the question:

'What are social workers' views on guardianship?'

it was decided to undertake a survey of attitudes of a group of social workers, each of whom had some experience as guardians of clients with mental illness. Views of social workers' managers were also sought. These were drawn from two agencies for purposes of comparison. Consequently the first consideration was to select and gain access to agencies which fulfilled these conditions, on the basis explained in Chapter I, page 20.

It was then decided that the second question:

'Which clients do social workers choose for guardianship?'

The questionnaire used is located in Appendix H, from which it will be seen that the range of questions divides into three sections:

- Objectives and uses of guardianship
- Role of social worker compared with role of guardian
- Possibilities for future development

With regard to the **Social Workers' Guardianship Clients Questionnaire**, the objective was to trace the decision-making process and to relate this to the circumstances of the case. The viewpoint on the case remained essentially that of the social worker and no external review of data or opinions expressed was undertaken with, for instance, social work managers. Occasionally, alternative versions of the facts emerged during discussion with the social worker, in which case the questionnaire answers were modified accordingly. In a few cases the client turned out to be shared with another social worker and a composite picture was arrived at by discussing the case with both social workers. In one instance this produced a three-way discussion between the researcher and two social workers, both with different line managers, and the researcher had to be reconciled to having two rather different versions of the client's story and prospects.

Guardianship Cases and Vignettes as Substitutes

Vignettes are client pen-pictures based on 'live' guardianship cases encountered during the research pilot. Fictional names were used to differentiate these cases. The value of the vignette presentations put to social workers was as substitute cases, particularly necessary in interviewing social workers with limited guardianship experience.

The three vignette cases (see Appendix C), presented social workers with a range of information and decision-making options and their attention was drawn to parts of the narrative where differences of opinion would be likely to emerge. For the task of collecting research data, only one key decision was recorded, namely whether, in all the

circumstances of the case, social workers could see any place for guardianship in taking case management forward.

The result of this part of the survey, to which a total of 16 respondents contributed, registered that a place for guardianship could be found for 'Geoff Baxter' by 7 out of 14 respondents, by 5 out of 16 respondents in the case of 'Audrey Cummings' and by 6 out of 12 in the case of 'Joan Humphreys'. The quantitative aspects of this data is discussed under 'Vignettes and Cases', page 238.

Case Status Differences: Original and Revised

Case status distinctions from (I) to (VI) were intended to show how cases differed according to the stage of decision-making reached: from being considered by a social worker as a basis for a proposal to management to being endorsed by his/her Director of Social Services. As shown in Table 2, page 243 the basis for simplified groupings is that cases in old Categories (V), (IV) and (III), joined into new category [2], share the characteristic of not having reached the stage of being formally agreed by a director of social services at the time of the research fieldwork, whereas cases in Categories (II) and (I), joined into new Category [1], have been thus endorsed.

The main use made of the distinction between Categories [1] and [2] is to be found in Chapter VI (Conclusions) where Category [2] clients are judged to represent the specific choice of guardianship for clients by social workers as distinct from the choices of their managers or other parties - see page 338.

Managers' Views

An attempt was initially made to ascertain differences in attitudes of social workers' managers included in the survey population but this proved difficult to achieve. None of the managers in practice wanted to be seen to speak on behalf of the agency on matters which they regarded as largely hypothetical and instead contributed in their individual capacities. One manager in particular felt the need to dissociate herself from her own management position and offered instead to provide comments on the vignettes as if she

were a social work practitioner. Essentially, therefore, managers approached the research from different stand points over which the researcher had no control, which inevitably produced uneven results. Given the small number involved, it was not appropriate to discuss individual differences in attitude with the four managers concerned, either as a basis of comparison with each other or with individuals or groups of social workers.

The Research Samples of Cases and Social Workers

Size of Sample: Guardianship Cases

This research concerned 41 guardianship cases divided into categories, i.e. status groups: **Old Status Categories (I) to (V)**, (five stages of decision-making, from social workers' initial suggestions to final management endorsement) and **New Status Categories [1] and [2]**, (cases agreed by management (Category [1]) and those not agreed at the time of the research, but already decided upon by social workers (Category [2])).

The relationship between the categories and the number in each is shown in Table 3, page 243. The following discusses size of samples in the categories compared with such national figures as are available or can be approximated.

There were four guardianship cases currently in force [Old Category (I)] at the time of the research: three in Westminster and one in Kensington and Chelsea. This compares with a national average of approximately 1.1 cases per local authority. The latter figure has been calculated on the basis of 130 guardianship cases concerning mentally ill people in force ('Continuing') as at mid-1987 (the period during which the research field work was being undertaken), for a total number of local authorities in England and Wales of 117. However, this is known to be an under-estimate since a number of local authorities had not sent returns to the Department of Health. This would suggest that the research sample of cases was between 3% and 4% of the national total.

The nine lapsed cases in the sample (Old Category (II)) were acquired on the basis of available data on clients for whom guardianship had been used by the two agencies in the past. There is no guarantee that this was an accurate figure: in some instances clients who had, for example, moved out of a borough could have been lost from the sample,

who had, for example, moved out of a borough could have been lost from the sample, and clients whose guardianship had lapsed much earlier than the research field work could well have been overlooked. Approximately, one might assume that the ratio between live and lapsed cases overall in the sample should have been 1:3, giving a national total estimate of 390, of which this research considered 9 cases, ie 2.3%.

With regard to cases in New Category [2], the overall ratio of this group to Old Category (I) is 7:1 (28:4). By this measure the number of cases in New Category [2] nation wide is 910, giving a sample size of 3%. However, wide variation between the two social services departments must be taken into account which, if extrapolated, would give an estimated total number of cases ranging from 2730 (Kensington and Chelsea: 21 New Status Category [2] cases and one Old Category (I)) to 303 (Westminster: seven clients in New Category [2] compared with three clients in Old Category (III)).

Size of Sample: Social Workers

Even more difficult to calculate satisfactorily is the sample size in relation to numbers of guardian social workers. The simplest approximation, suggests that 23 social workers concerned with 41 guardianship clients (of various categories) in the research populations, gives a social worker to case ratio of nearly two cases (of all categories) for each social worker. Extrapolating the 23:41 ratio nationally (the combined picture of both social services departments in this sample) would give a total of approximately 1346 social workers - approximately 6% (5.85%).

It is of note that there is an inverse ratio between numbers of social worker research subjects and guardianship cases as between the two agencies: **Overall ratio = 27:41; Kensington and Chelsea = 11:24; Westminster = 16:17.**

Ratio of Social Workers to Managers

It will be noted that there is an imbalance between the two agencies in the ratio of social workers to managers. Some allowance therefore needs to be made for the fact that the management voice, as reflected in the data obtained, has been over-represented in

Kensington and Chelsea (Overall ratio of social workers to managers = 6:1; Kensington and Chelsea = 4.5:1; Westminster = 7:1).

Vignettes and Cases

The ratio of vignettes completed to cases also requires comment. Fewer vignettes (14) were completed in Kensington and Chelsea but this social services department produced the largest number of cases (24). On the other hand, Westminster produced fewer cases (17) but a relatively high number of vignettes (10). For an average of 2 cases per social worker in Kensington and Chelsea (24 cases for 11 social workers), the 14 vignettes completed bring the total of cases to 38, giving a **combined social worker to case ratio of 1:3**. Thus some parity was achieved, though this should not be understood as implying that the completion of vignettes was regarded as a full equivalent to making a decision about an actual case - discussed on pages 234/5.

Randomness

The research field-work was confined to two agencies, and numbers of **guardianship cases and social workers** was determined by the maximum available data in both agencies.

For guardianship cases, each available example in the various categories was collected to provide a total population sample from both agencies (with the exception of one case where details were unobtainable due to the move of a client out of borough).

For social workers, numbers were determined **entirely by the numbers of cases** and the allocation of social workers to those cases. Thus, although the collection of data about cases and about social workers' attitudes related entirely to information from social workers, the preliminary stage was concerned with ascertaining cases and identifying the social workers (past or present) allocated to those cases.

From the standpoint of populations located in 117 agencies across the country, the sampling of neither cases nor social workers was fully random. Within the research agencies, however, choice was predetermined by method of sample collection of cases and was 'blind' in respect of the social workers linked with those cases. A fair measure of randomness was thus achieved given the limitations of methodology and those of the nature of the total research populations of cases and social workers concerned.

Statistical Significance and Analysis

It was not considered appropriate to declare a given level of statistical significance as a bench mark upon which to judge results prior to the research fieldwork as no obvious basis for establishing such a reference point presented itself. Probability thresholds of .05, .01 and .001 are referred to where applicable.

The initial assembly of tables contained as many categories and sub-categories as seemed of interest or relevance to the researcher, and for the most part these have been retained as of interest in their own right, despite small numbers in many of the cells. Wherever possible, however, the data has also been reassembled into 2 x 2 tables to maximise the numbers in each cell and to undertake the Chi-Square tests of association. One degree of freedom applied to each of the tests shown in the tables in this chapter and in Chapter VI.

The SPSS Manual* says that "...for the Chi-square distribution to be a good approximation of the distribution of the statistic...expected values must not be too small", and goes on to explain that:

"While it has been recommended that all expected frequencies be at least 5, recent studies indicate that this is probably too stringent and can be relaxed...."

In hope of improving the approximation in the case of a 2 x 2 table, *Yates' correction* for continuity is sometimes applied. Yates correction for continuity involves subtracting 0.5 from positive differences between the observed and expected frequencies (the residuals) and adding 0.5 to negative differences.

* M J Norusis, *SPSS/PC+ V 2.0 Base Manual*, Chicago: SPSS Inc, 1988

An alternative test for 2 x 2 tables is based on the hypergeometric distribution. The exact probabilities of obtaining observed results if the two variables are independent and the marginals fixed are calculated. This is called *Fisher's Exact Test*. It is most useful when the total sample size and the expected values are small. SPSS/PC+ calculates Fisher's Exact Test when the sample size in a 2 x 2 table is 20 or less*.

Each table and statistical analysis is accompanied by the Chi-Square test of association and the level of probability from the applicable test result(s). All hypotheses are two-tailed. The null hypothesis applicable to tests of association on social workers' views was that the fact that they are employed by different social services departments was not significant for the purpose of these comparisons. For the guardianship cases, the null hypotheses were that there was no significant difference between them in the characteristics identified according to whether they were: (1) drawn from this research population or from that of other identified research; (2) of different diagnoses; (3) in Category [1] or [2]; or whether they were Kensington and Chelsea or Westminster cases.

Processing of Data

Section A: Details on Clients

1. Readily quantifiable data (e.g. ages, gender, ethnicity), was aggregated and reassembled in frequency tables.
2. Non-readily quantifiable data was divided into:
 - (i) Material susceptible to retrospective categorisation and second stage quantification (e.g. purposes of guardianship) which was then handled as in A.1 above.

* Because the SPSS system used to process the research data in this study confines use of Fisher's Exact Test to sample sizes less than 20 and does not use this test for sample sizes over 20 which include cells of expected frequencies less than 5, this researcher has used Fisher's Exact Test for all 2 x 2 tables where these conditions pertain: i.e. sample sizes less than 20 and/or cells with expected frequencies less than 5. Where Fisher's Exact Test is not used, i.e. not shown in the tables, this conveys that the sample size is above 20 or that there are no cells with expected frequencies less than 5. However, for information and comparison, Chi-square and Yates correction probability figures are retained where there are cells with expected frequencies of between 3.5 and 5. This is in response to the above mentioned suggestion that the 5 minimum is too stringent - personal communication from Ms Susanah Brown, Department of Statistics and Mathematical Sciences, London School of Economics.

- (ii) Material not quantifiable in this context was used to aid in completing client profiles (e.g. history of previous social work involvement).

3. Analyses were undertaken as follows:

Analysis I - Cross-Tabulation: Differences by Client Status Categories [1] and [2]

All variables were related by case category differences in this analysis.

Analysis II - Cross-Tabulation: Difference between the 2 Social Services Department.

All variables were explored in relation to this distinction and the diagnostic and 'medical influence' variables produced distinguishable patterns discussed in the findings.

Analysis III - Cross-Tabulation: Diagnosis of Guardianship Clients

A critical distinction was assumed to apply between guardianship for people suffering from schizophrenia and those suffering from dementia. The diagnostic variable therefore received attention and this distinction was used to prepare cross-tabulations along the following client characteristics:

- Age Range
- Client Living Arrangements
- Level of Family Support
- Objectives of Guardianship
- Problems in Achieving Guardianship Objectives
- Case Status
- Differences Between two Social Services Departments.

Section B, C and D: Social Workers' Views

1. This data was in readily quantifiable form when collected and was therefore aggregated and reassembled into frequency tables.

2. The five point Likert scale (giving +2, +1, 0, -1 and -2 weighting of response) was reordered into +1, 0 and -1 categories for the purposes of providing frequency tables and cross-tabulations.
3. Analysis of data employed the distinction between **the Two Social Services Departments** (the Agencies) as the key variable throughout.

Points on Presentation of Social Workers' Views

- * Material in the section following the statistical summary represents responses to sections of the questionnaire directed at obtaining social workers' attitudes to guardianship across the two social services departments.
- * The data is presented in the form of:
 - Commentaries indicating the extent of agreement with the statements.
 - Bar charts showing the balance of opinion between pro, con and neutral (undecided etc) responses to the statements.
 - 2 x 2 tables and statistical analysis of differences between social workers in the two agencies.
- * Some of the questionnaire items have been merged where little or no difference of response was obtained. Conversely, some questions have been split in two where different meanings for part of the questions became apparent during the interviews.
- * Reference to 'social workers' includes social work managers unless otherwise indicated.

RESEARCH POPULATIONS AND QUANTITATIVE DATA:

RESEARCH SUBJECTS: SOCIAL WORKERS AND MANAGERS

TABLE NO. 1

	Kensington and Chelsea	Westminster	Total - both Social Services Departments
Social Workers	9	14	23
Managers	2	2	4
Totals	11	16	27

GUARDIANSHIP CLIENTS: DECISION-MAKING CASE STATUS GROUP
DISTINCTIONS - ORIGINAL AND REVISED

TABLE. 2

Original Case Categories	Revised Case Categories
I IN FORCE	(1) CASES AGREED BY MANAGEMENT
II LAPSED	
III) AT VARIOUS STAGES OF IV) OBTAINING MANAGEMENT AGREEMENT	(2) CASES CHOSEN BY SOCIAL WORKERS - NOT AGREED BY MANAGEMENT AT THE TIME OF THE RESEARCH
V SERIOUSLY CONSIDERED BY SOCIAL WORKERS	

GUARDIANSHIP CLIENTS: NUMBERS IN STATUS CATEGORY GROUPS - ORIGINAL AND REVISED

TABLE. 3

Left Hand Entries	Kensington and Chelsea	Westminster	Total/ - both Social Services Departments	Right Hand Entries
Old Status	V 21) 21 x [2]	V 6) 7 x [2]	V 27) 28 x [2]	New Status Differences by
Differences by Category (V - I)	IV 0) III 0) II 2) I 1) 24	IV 1) III 0) II 7) I 3) 17	IV/III 1) II 9) I 4) 41	
				Groups [2] and [1]

VIGNETTES (See Note 3, pages 234/5)

TABLE. 4

	Kensington and Chelsea	Westminster	Total both SSDs
'Geoff Baxter'	5	9	14
'Audrey Cummings'	6	10	16
'Joan Humphries'	3	9	12
Total in each Social Services Department	14	28	Total Return 42

PART TWO: PRESENTATION AND STATISTICAL ANALYSIS

SOCIAL WORKERS' VIEWS ON GUARDIANSHIP - WHOLE POPULATION

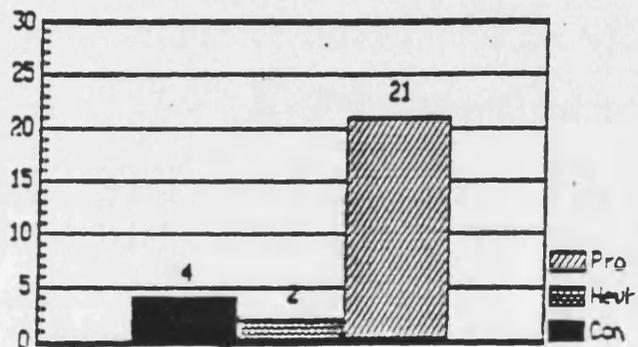
USE OF GUARDIANSHIP

Social workers (N = 27 unless otherwise indicated) were asked to respond to a number of statements about the nature of guardianship, its purposes, and suitability for clients in particular circumstances, and the resulting data is summarised below:

GUARDIANSHIP PROVIDES:

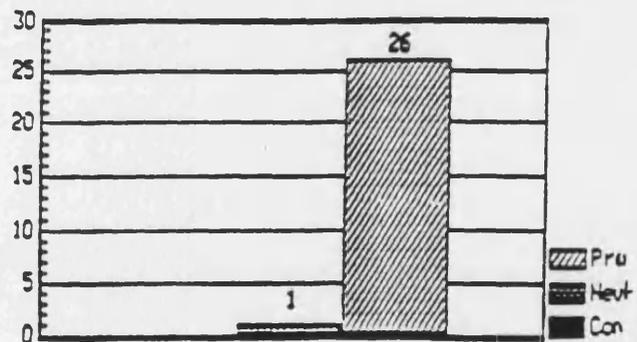
1. Protective Care

This statement was supported by three-quarters (21) of the social workers.



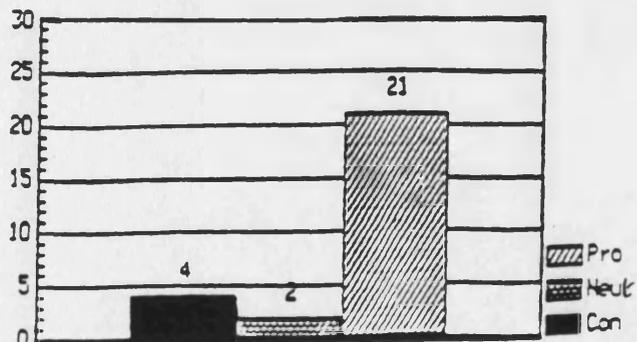
2. Structured Care

This statement provided 96% favourable response - 26 social workers.



3. Continuity of Care

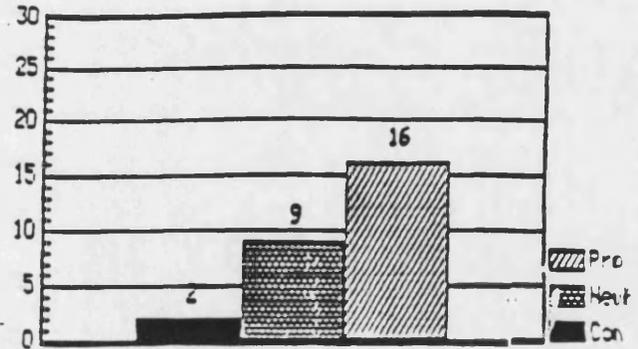
Twenty-one (78%) social workers supported this view of guardianship.



GUARDIANSHIP PROVIDES:-

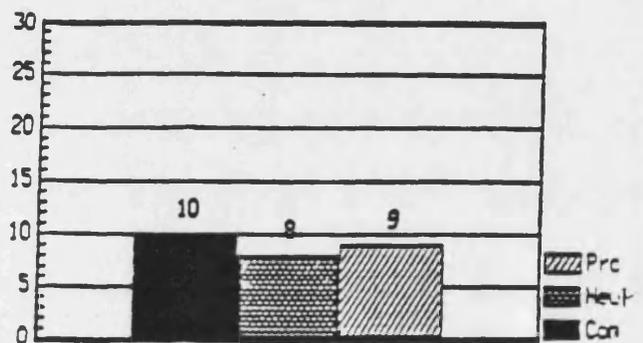
4. Reinforcement of Authority

This view of guardianship was supported by 16 (60%) social workers.



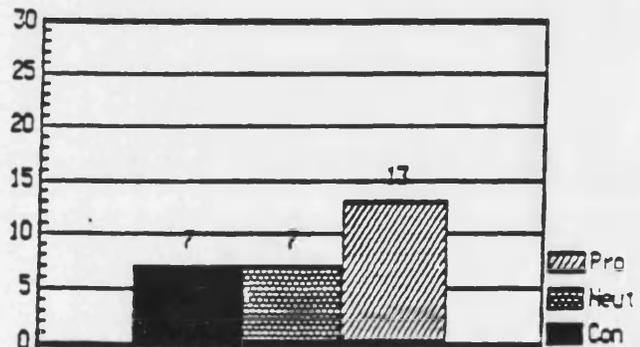
5. Priority Access to Services

One third of social workers (9) supported this view, and 10 were against it.



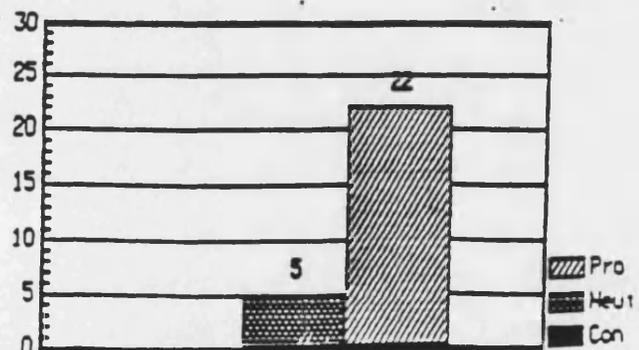
6. For Recognition of Need

This role for guardianship was supported by 13 (48%) of social workers.



7. A Stabilising Influence

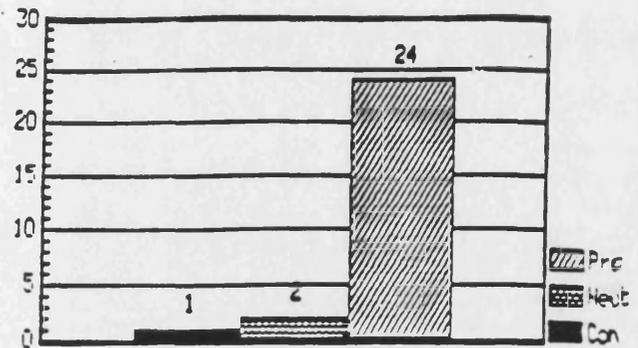
Twenty-two (82%) social workers view guardianship in this way.



GUARDIANSHIP AS SURROGACY AND THE IMPLICATIONS

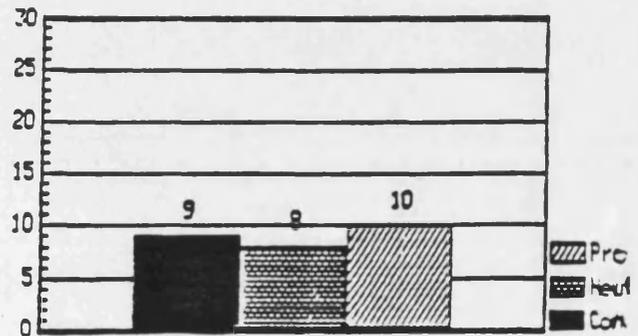
8. A Basis for Substituted Judgement

Twenty-four (89%) social workers support this view of guardianship.



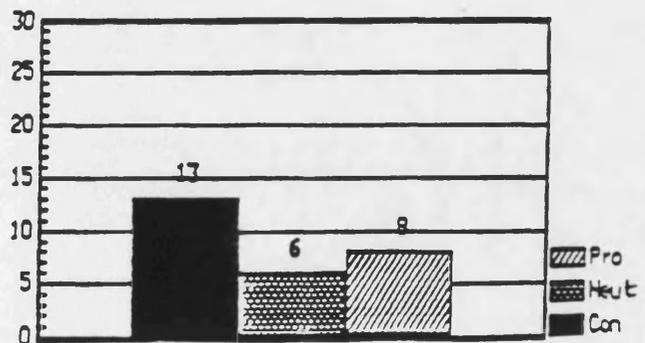
9. Pre-emptive Use - 1st Example: Anticipating Need

This view was supported by 10 (37%) of social workers and a third of the social workers were against the notion.



10. Pre-emptive Use - 2nd Example: Onset of Dementia

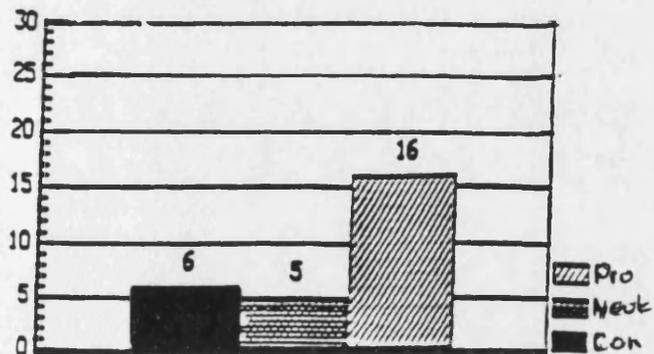
Eight (30%) of social workers supported this view but 13 (48%) were against it.



GUARDIANSHIP OBJECTIVES

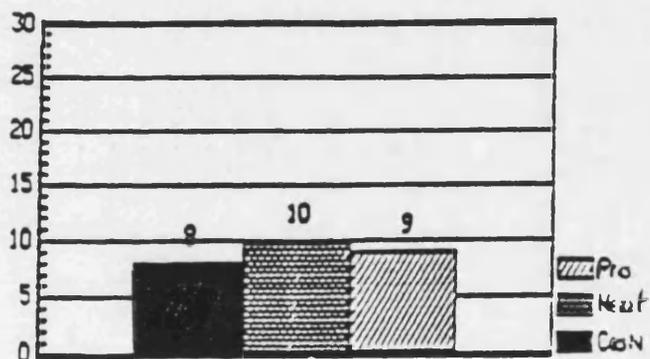
11. To Facilitate Change and Growth in a General Sense

This view of guardianship was supported by 16 (60%) of social workers.



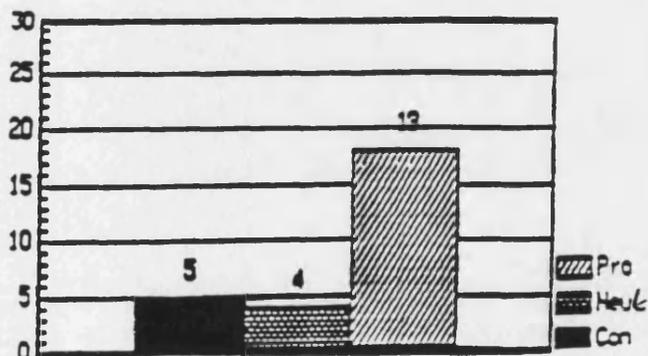
12. Specific Expectations - to Develop (a) Emotionally and (b) Psychologically

Nine social workers (33%) supported these views and 8 (30%) were against them.



13. Specific Expectations (c) - to Develop Behaviourally

In this case 18 of social workers (67%) supported this view.

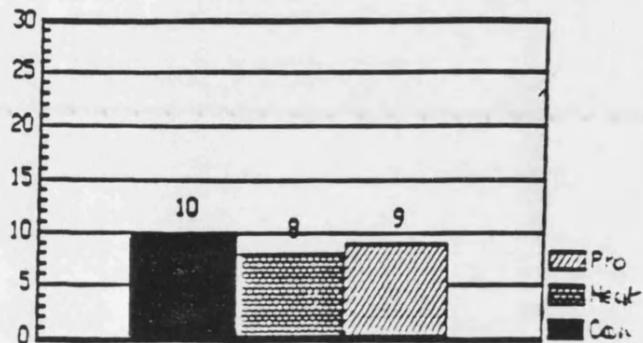


DIFFERENTIAL USE

Suitability of Guardianship
for Particular Kinds of
Mentally Ill people, ie:

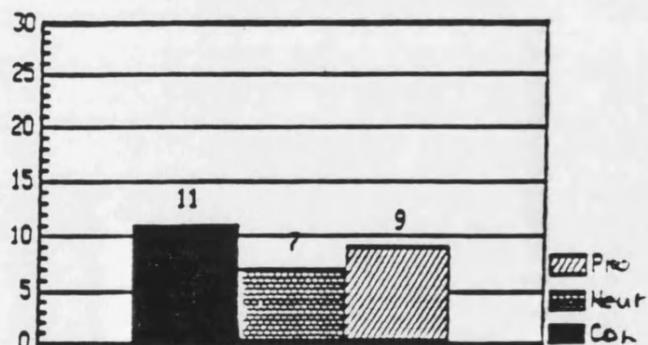
14. For Depressed Clients

Nine social workers (33%)
supported this view and 10
(37%) were against it.



15. For Clients with 'Compliant' Personalities

This view was supported by a
9 (33%) social workers, but
11 (41%) were against it.

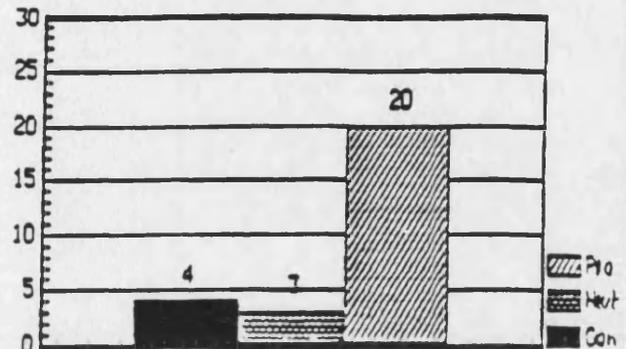


DIFFERENTIAL USE

Circumstantial/Contingent

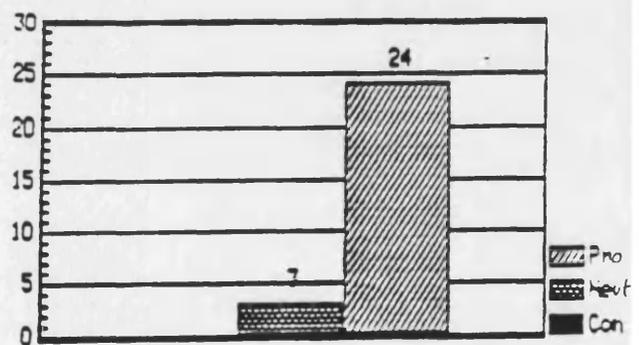
16. Use in Client Situations of Social Vulnerability

This view was supported by 20 (74%) of social workers.



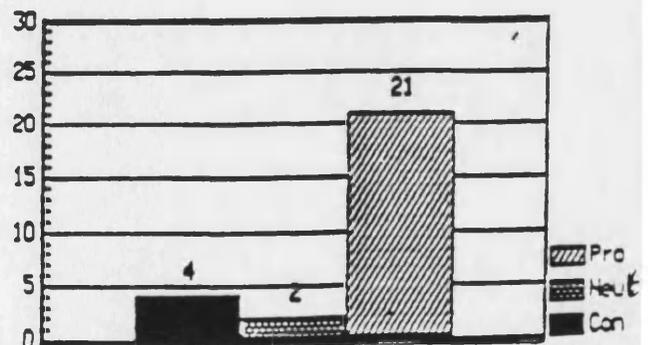
17. To Enforce a Particular Type of Authority

This produced 89% agreement from 24 social workers.



18. Use for Firming Up Aftercare

Twenty-one (78%) social workers agreed with this statement.

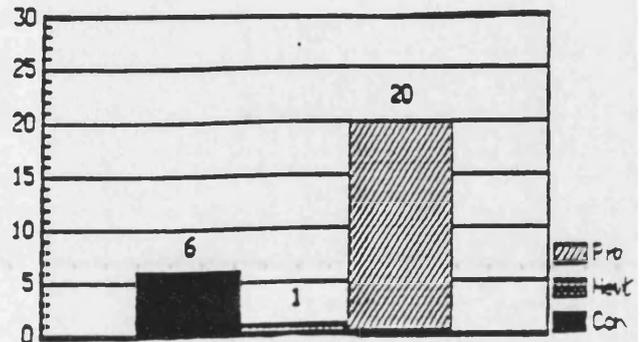


ESSENTIAL POWERS

Use to enforce powers for determining:

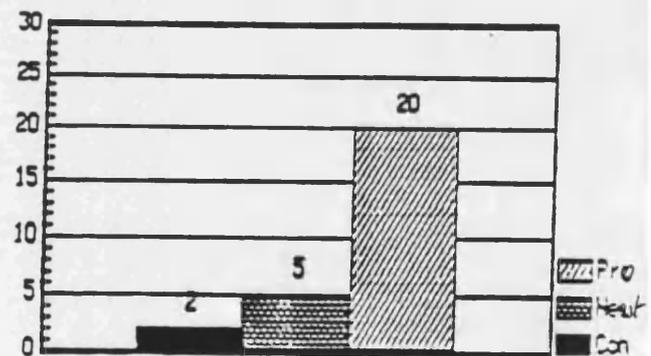
19. Access

Twenty (74%) social workers supported this use of guardianship.



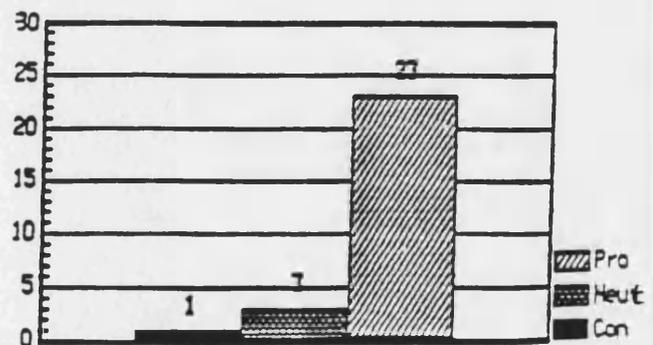
20. Attendance

Twenty (74%) of social workers supported this statement.



21. Place of Residence

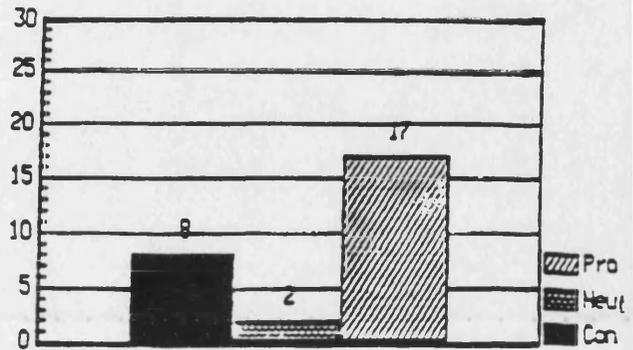
This view was supported by 23 (85%) of social workers and only 1 disagreed.



CONTAINMENT AND RESTRAINT

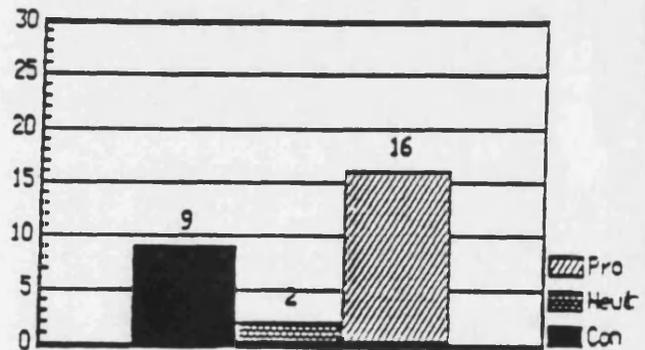
22. Containment

This use of guardianship in enforcing one or more of the essential powers was supported by 17 (63%) social workers, with 8 (30%) disagreeing.



23. Physical Restraint

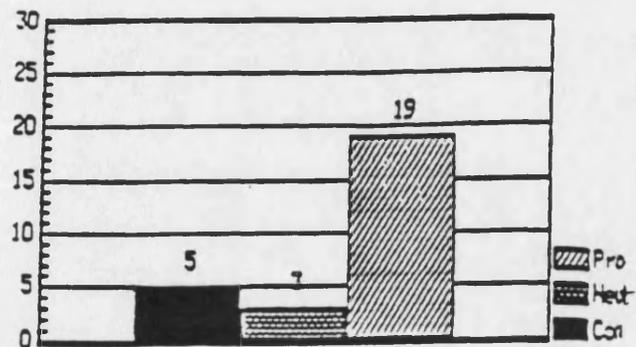
Sixteen (60%) social workers accepted in principle that they might need to be involved in the physical holding or restraining of a person under guardianship, 9 social workers (33%) being against such involvement.



GUARDIANSHIP AND RESIDENTIAL CARE PLACEMENTS

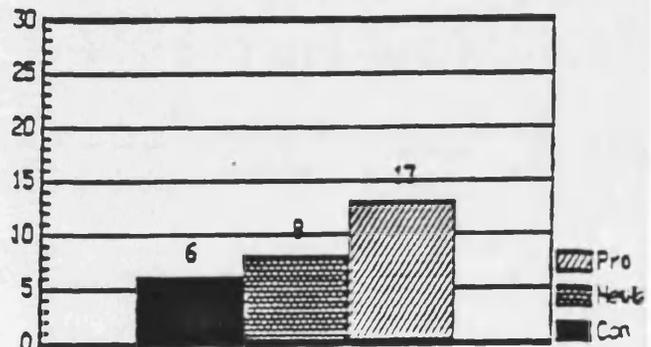
24. Means of Facilitating Residential Placement

Nineteen (70%) of social workers saw the use of guardianship in this way and 5 (19%) were against this.



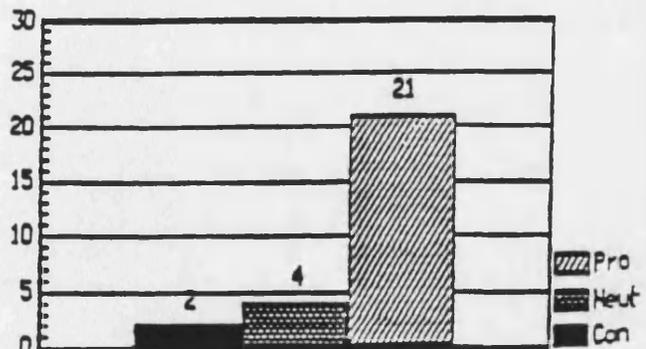
25. Justification for Detention

Thirteen (48%) social workers regarded it as ethically justifiable to detain people under guardianship in residential care and 6 (22%) disagreed.



26. Adaptation of Regimes

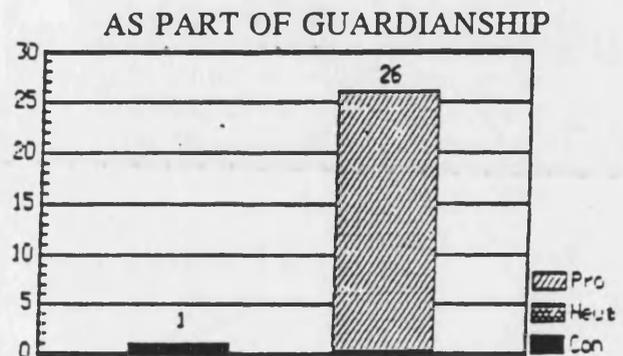
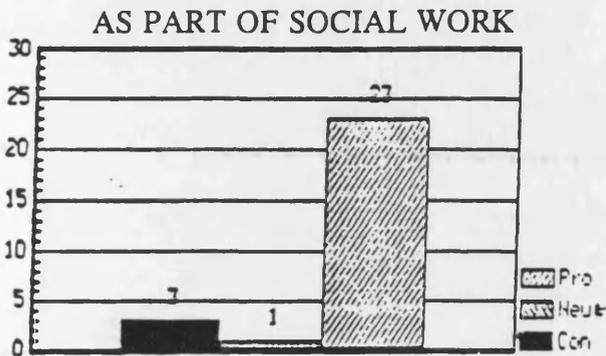
Twenty-one (78%) social workers thought it appropriate that the regimes of residential units should be adapted to meet the particular needs of residents on guardianship, and only 2 (7%) were against this idea.



COMPARISON OF SOCIAL WORKERS' AND GUARDIANS' ROLES:
SIMILARITIES AND DIFFERENCES ON FOUR KEY DIMENSIONS AND THE
QUESTION OF COMPATIBILITY

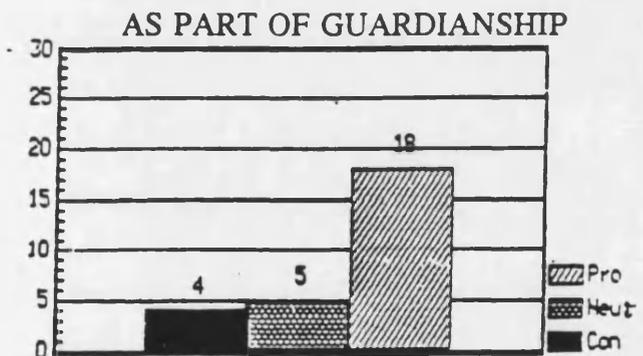
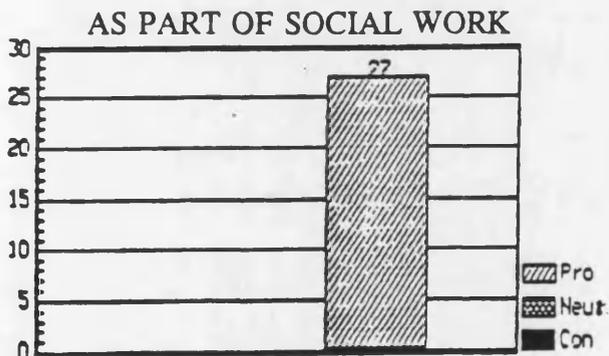
27. Basic Caretaking

Twenty three (85%) social workers viewed this as part of the social work role whereas 26 (96%) social workers saw this as part of guardianship.



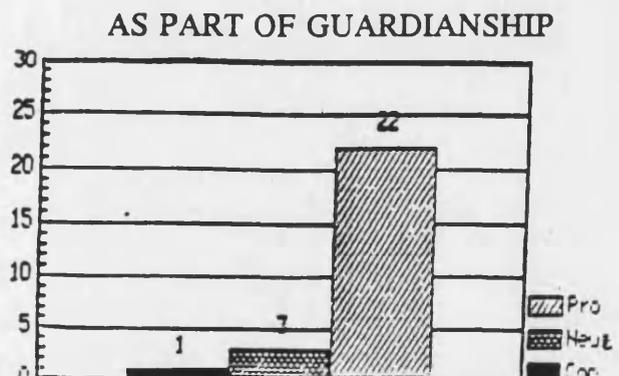
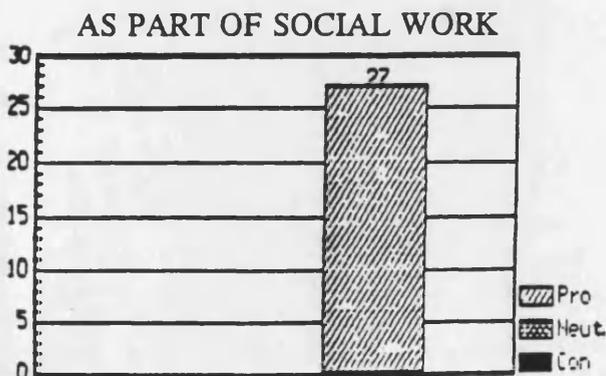
28. Enabling

All social workers saw this as coming within the social work role, but only two-thirds of social workers saw it as part of guardianship.



29. Advocacy

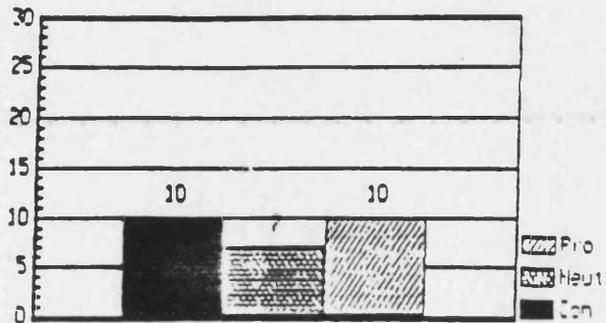
This view of social work received 100% agreement whereas 22 (85%) of social workers saw it as part of guardianship.



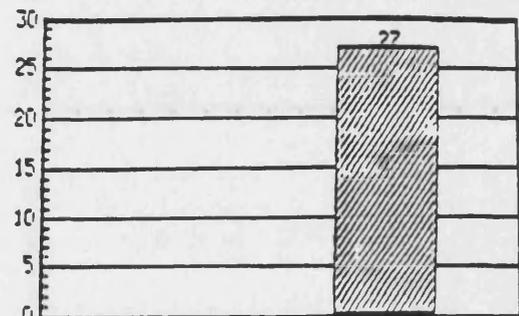
30. Surrogacy

Only 10 (37%) of social workers support this view of social work, with the same number against it. All social workers see this as part of guardianship.

AS PART OF SOCIAL WORK

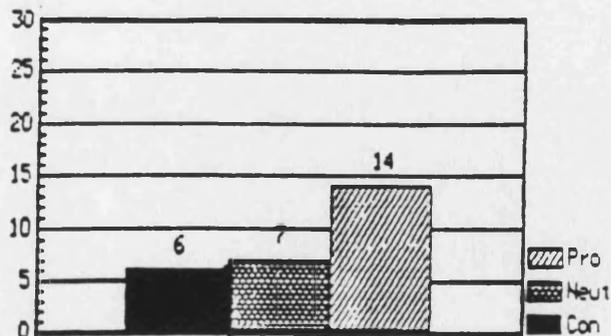


AS PART OF GUARDIANSHIP



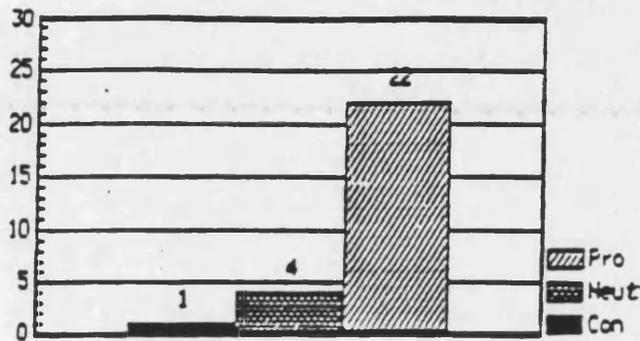
31. Guardians' Functions Incompatible with Social Work

Fourteen (52%) social workers stated that there was an incompatibility of function between guardians and social workers. The differences were seen in various ways but the most frequently mentioned was in the surrogate role itself.



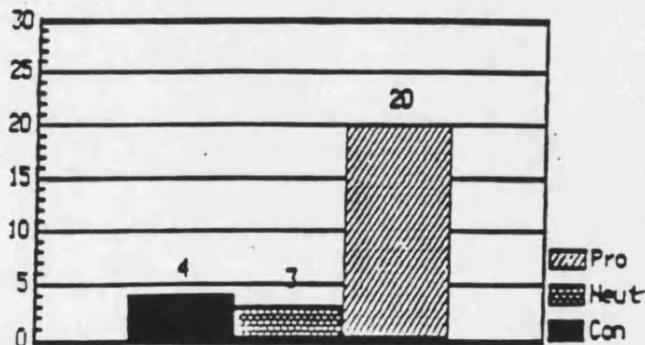
32. Informal Guardianship

Twenty two (82%) social workers saw their work with mentally ill people as being appropriately described as a form of voluntary or informal guardianship, and the most common similarities pointed to were: client characteristic of poor motivation (15%); similarity of 'contract' between client and workers (16%); and in a high level of client vulnerability (26%).



33. Other Social Services Department
Employees as Guardians

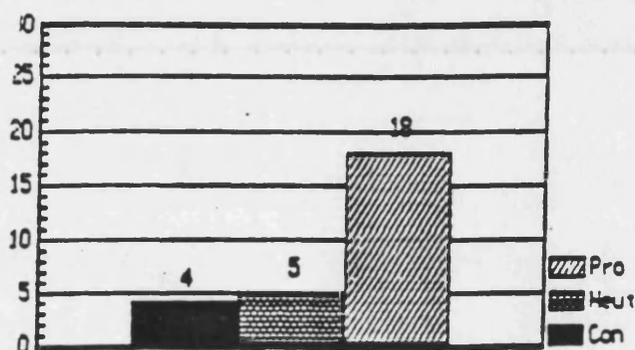
Most social workers (20) thought that guardianship could be provided by non-ASWs and by social workers other than level 3/4. Some thought that residential care staff could fulfil the role.



34. Guardians Outside Social Services

Two-thirds of social workers thought that people outside social services could fulfil the guardian's role, the majority looking to representatives of voluntary agencies such as MIND as suitable.

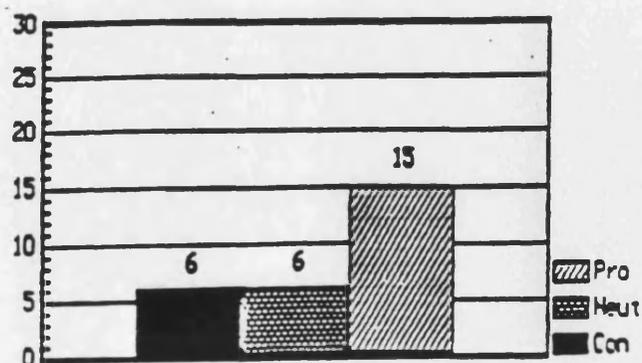
Eleven (41%) social workers thought that non-social services department employees would find the advocacy role easier within guardianship than would social workers, but a third of social workers considered that they would find this role harder.



35. Guardian as Family Member

Fifteen (56%) social workers agreed that the guardian could be a member of the client's family.

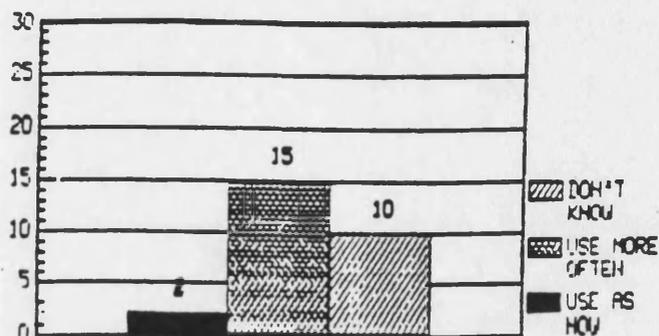
Only 4 (15%) social workers considered that they should be members of the same household - and half the social workers definitely disagreed with this proposition.



FUTURE PROSPECTS AND PROBLEM AREAS

36. Extended Usage

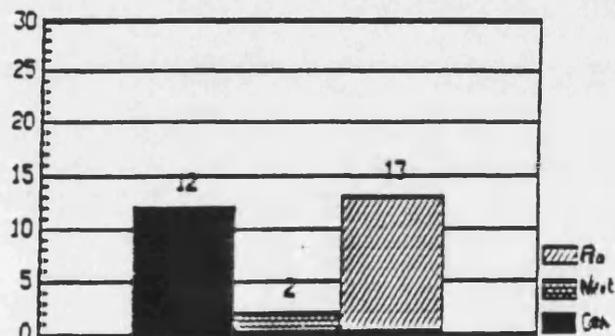
Fifteen (56%) social workers thought that guardianship should be used more often, but 10 social workers felt unable to give a definite answer to this question.



REASONS FOR UNDER-USE (which would need to be addressed if optimum use were to be achieved):

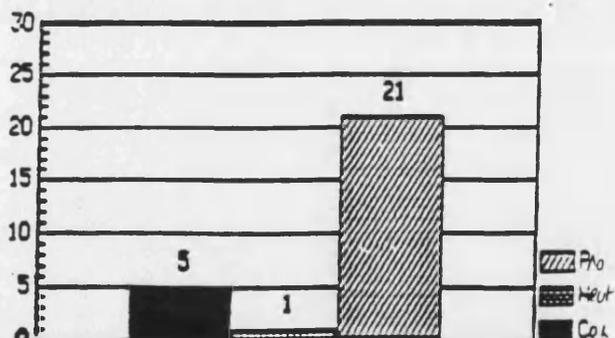
37. Demand on Social Service Resources

Thirteen social workers (48%) thought that guardianship makes demands on social services resources. Twelve social workers (44%) thought this was not a reason for underuse.



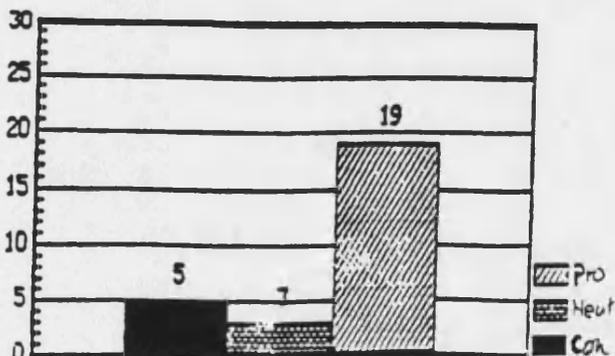
38. Concern with the Use of Coercion

Twenty-one social workers (78%) thought that this concern exists whereas 5 (19%) disagreed.



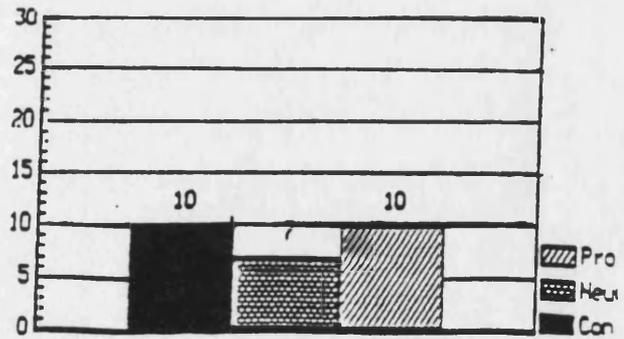
39. 'Toothless Wonder' (Insufficient Power)

Nineteen social workers (70%) thought there was truth in the statement that guardianship carries insufficient powers to be considered as a serious alternative to hospital.



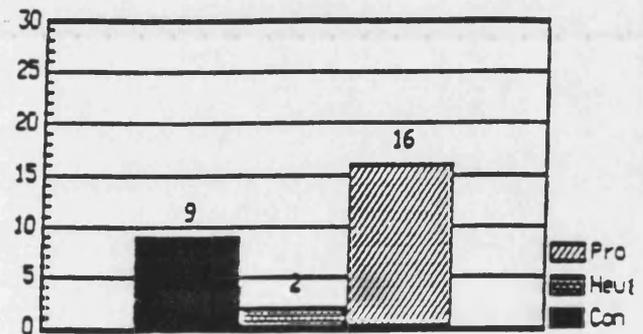
40. Civil Liberties

Social workers were evenly divided as to whether guardianship represents an unacceptable infringement of civil liberties with 10 social workers (37%) representing each point of view.



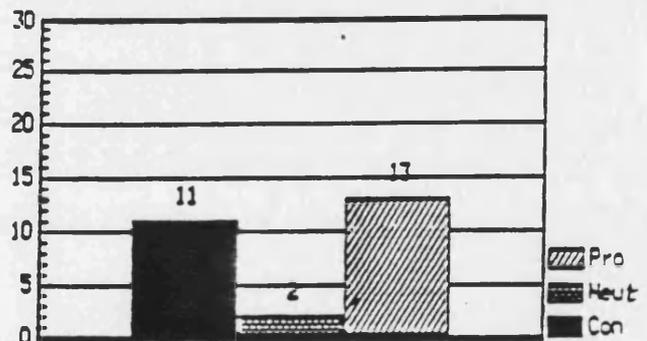
41. Fear of Abuse of Authority

Sixteen social workers (59%) thought that guardianship carries with it the risk of abuse or misuse of authority, but 9 (33%) social workers thought otherwise.



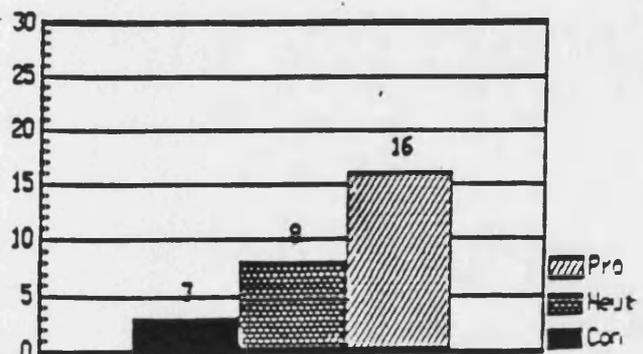
42. Inappropriate Assumption of Responsibility for Adults

Thirteen social workers (58%) agreed that this was a feature of guardianship of some concern, while 11 (41%) thought otherwise. (N = 26 social workers)



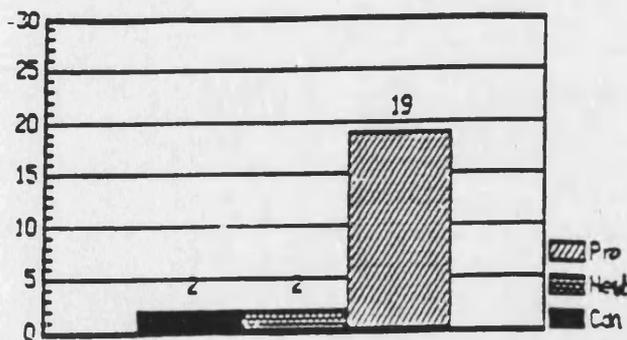
43. Need for Change

Sixteen social workers (59%) considered that changes are needed in guardianship to make it more effective, but only 8 social workers (30%) considered that more powers were needed.



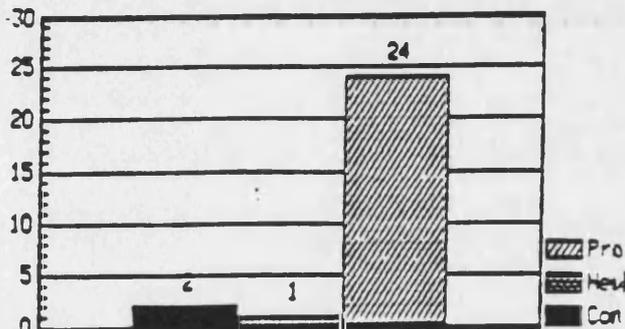
44. Adjustment to Meet Individual Requirements

Nineteen social workers (70%) felt that guardianship powers should be tailored to meet the expressed needs of individual clients. (N = 23 social workers)



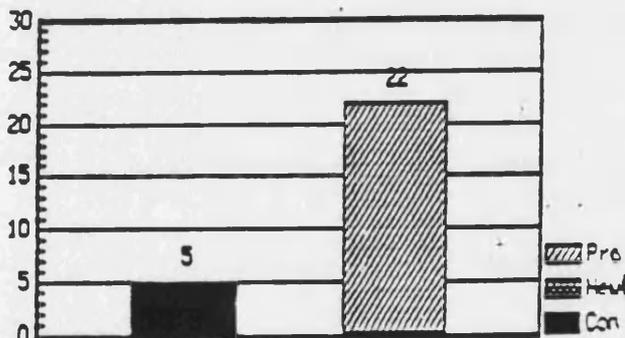
45. Package of Care

Twenty-four social workers (89%) thought that guardianship should include a requirement to develop packages of care in the community based on individual assessment.



46. Resource Consequences

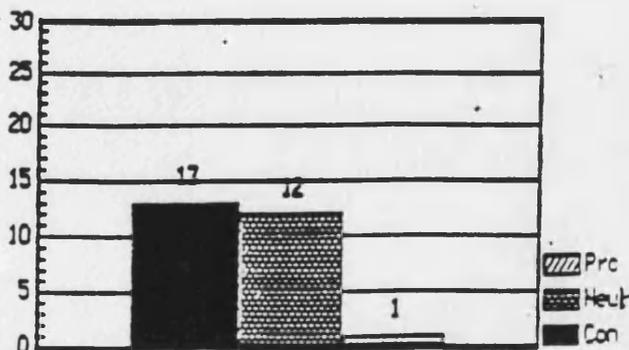
Twenty-two social workers (82%) consider that statutory agencies should fund the resource consequences of guardianship.



47. Guardianship Budget

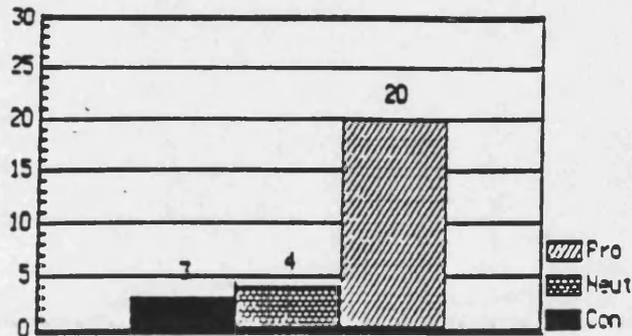
Only one social worker agreed that social work guardians should be accountable for an allocated budget sufficient to meet the particular needs of his or client and 13 social workers (50%) disagreed with this proposition.

(N = 26 social workers)

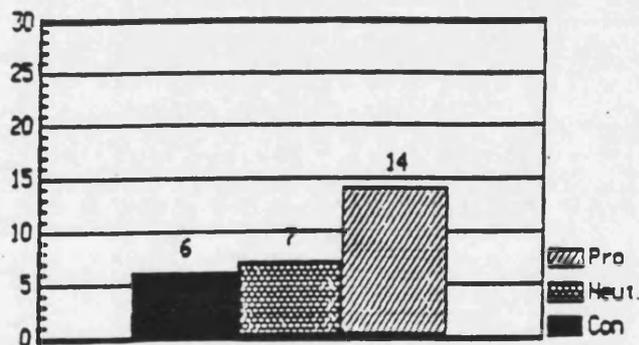


Compulsory Treatment in the Community

48. Twenty social workers (74%) believed that a power to provide compulsory treatment in the community was needed.



49. Fourteen social workers (52%) considered that this should be provided for within 'special' guardianship. Only 4 social workers (15%) considered that it should be provided outside the present guardianship framework, and 14 social workers (52%) clearly disagreed with the latter view.



50. Powers of Detention Sixteen social workers (59%) felt that these powers should be made explicit; 3 social workers (11%) felt that the position should be left as it stands; and only 2 social workers agreed with the view such powers should be outlawed.

COMPARISON OF SOCIAL WORKERS' VIEWS IN THE TWO SOCIAL SERVICES DEPARTMENTS

The following presentation draws on statistical analyses of comparisons of views between the two groups of social workers, in the same sequence as the presentations on pages 244 to 260.

Tables 93 to 146 in Appendix F give the detailed results. For the purpose of statistical analysis, the 3 x 2 tables showing 'con', 'neutral' and 'pro' responses to the propositions have been collapsed into 2 x 2 tables with 'con' and 'neutral' responses combined. The tables presented below, were selected to highlight similarities and differences which emerged from the analyses.

Main Characteristics of Guardianship i.e. 'What guardianship Provides'

Of these seven key guardianship characteristics:

PROTECTIVE CARE
STRUCTURE
CONTINUITY
REINFORCEMENT OF AUTHORITY
PRIORITY ACCESS TO SERVICES
RECOGNITION OF NEED
STABILISATION

only CONTINUITY evidenced any difference between the agencies, (see Table over page).

Guardianship Characteristics of Continuity

There was less certainty about the concept of CONTINUITY in Westminster, where 68.8% of social workers supported these views compared with 90.9% of social workers in Kensington and Chelsea.

Continuity

Table No. 5

	K & C	W'min	Row Totals
Con/Neut	1	5	6
Pro	10	11	21
Column Totals	11	16	27

Fisher's Exact Test

p = .350

Minimum Expected Frequency = 2.4

Guardianship as Surrogacy and the Implications

Surrogacy as SUBSTITUTED JUDGEMENT proved a less acceptable idea in Westminster, where 81.3% supported the view compared with 100% support in Kensington and Chelsea.

Surrogacy/Substituted Judgement

Table No. 6

	K & C	W'min	Row Totals
Con/Neut	0	3	3
Pro	11	13	24
Column Totals	11	16	27

Fisher's Exact Test

p = .248

Minimum Expected Frequency = 1.2

The view of guardianship as APPROPRIATELY USED PRE-EMPTIVELY, i.e. anticipating clients' needs, was less popular in Kensington and Chelsea, where 27.3% social workers supported the view, compared with 43.8% in Westminster.

Pre-Emption

Table No. 7

	K & C	W'min	Row Totals
Con/Neut	8	9	17
Pro	3	7	10
Column Totals	11	16	27

Chi-Square Value = .759 p = .384

Yates' Correction Value = .217 p = .641

Fisher's Exact Test p = .448

Minimum Expected Frequency = 4.1

GUARDIANSHIP OBJECTIVES (Items 11-13)

The view of guardianship as a FORMALISED RELATIONSHIP TO FACILITATE CHANGE IN THE CLIENT was more popular in Kensington and Chelsea, with 72.7% support compared with 50% support among Westminster social workers.

Formalised Change

Table No. 8

	K & C	W'min	Row Totals
Con/Neut	3	8	11
Pro	8	8	16
Column Totals	11	16	27

Chi-Square Value = 2.123 p = .3135

Yates' Correction Value = 1.2795 p = .946

Fisher's Exact Test p = .4015

Minimum Expected Frequency = 4.48

Similarly, Westminster social workers gave less support (81.3%) to guardianship used to ENFORCE AUTHORITY for a particular purpose, compared with 100% support in Kensington and Chelsea.

Enforce Specific Authority

Table No. 9

	K & C	W'min	Row Totals
Neut	0	3	3
Pro	11	13	24
Column Totals	11	16	27

Fisher's Exact Test p = .248

Minimum Expected Frequency = 1.2

DIFFERENTIAL USE (Items 14-18)

Use of guardianship to meet needs of SOCIALLY VULNERABLE CLIENTS was less well supported by Westminster social workers (62.5%) compared with 90.9% support in Kensington and Chelsea.

Social Vulnerability

Table No. 10

	K & C	W'min	Row Totals
Con/Neut	1	6	7
Pro	10	10	20
Column Totals	11	16	27

Fisher's Exact Test p = .183

Minimum Expected Frequency = 2.9

ESSENTIAL POWERS

Using guardianship to gain ACCESS TO CLIENTS in their place of residence was well accepted by social workers in Kensington and Chelsea with 100% support, compared with 56.3% support in Westminster.

Access to Client

Table No. 11

	K & C	W'min	Row Totals
Neut	0	7	7
Pro	11	9	20
Column Totals	11	16	27

Fisher's Exact Test

p = .0216

Significant at the .05 level

Minimum Expected Frequency = 2.6

Similarly, the power to require ATTENDANCE of guardianship clients was less well supported by social workers in Westminster, with 62.5% compared with 90.9% support in Kensington and Chelsea.

Attendance Power

Table No. 12

	K & C	W'min	Row Totals
Con/Neut	1	6	7
Pro	10	10	20
Column Totals	11	16	27

Fisher's Exact Test

p = .183

Minimum Expected Frequency 2.9

CONTAINMENT AND RESTRAINT (Items 22 and 23)

Use of PHYSICAL RESTRAINT within guardianship was not well supported by Kensington and Chelsea social workers (45.5%) but more Westminster social workers (68.8%) accepted this idea.

Physical Restraint

Table No. 13

	K & C	W'min	Row Totals
Con/Neut	6	5	11
Pro	5	11	16
Column Totals	11	16	27

<u>Fisher's Exact Test</u>	p = .264
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Minimum Expected Frequency = 2.0

SECTION C - COMPARISON OF SOCIAL WORKERS' AND GUARDIANSHIP ROLES Items 27-31

The ENABLING view of guardianship received support from 81.3% social workers in Westminster, but from 45.5% of social workers in Kensington and Chelsea, viz.:

Guardianship as Enabling

Table No. 14

	K & C	W'min	Row Totals
Con/Neut	6	3	9
Pro	5	13	18
Column Totals	11	16	27

Chi-Square Value = 3.759 p = .053

Yates' Correction Value = 2.320 p = .128

<u>Fisher's Exact Test</u>	p = .0969
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Minimum Expected Frequency = 3.7

The view that guardianship involved actions **INCOMPATIBLE WITH SOCIAL WORK** (good social work practice) was supported by 62.5% of Westminster social workers but only by a 36.4% of Kensington and Chelsea social workers, viz.:

Incompatible with Social Work

Table No. 15

	K & C	W'min	Row Totals
Con/Neut	7	6	13
Pro	4	10	14
Column Totals	11	16	27

Chi-Square Value = 1.784 p = .182

Yates' Correction Value = 0.890 p = .345

Minimum Expected Frequency = 5.3

Asked whether social work with mentally ill people could sometimes be viewed as a form of **INFORMAL GUARDIANSHIP**, 87.5% of Westminster social workers agreed, compared with 72.7% in Kensington and Chelsea.

Informal Guardianship

Table No. 16

	K & C	W'min	Row Totals
Con/Neut	3	2	5
Pro	8	14	22
Column Totals	11	16	27

Fisher's Exact Test p = .370

Minimum Expected Frequency = 2.0

Questions as to whether social services department's staff other than ASWs should be guardians (OTHER EMPLOYEES) indicated much greater support for the proposition from Westminster: 81.3% compared with 63.6% support from Kensington and Chelsea social workers.

Other Social Services Employees

Table No. 17

	K & C	W'min	Row Totals
Con/Neut	4	3	7
Pro	7	13	20
Column Totals	11	16	27

Fisher's Exact Test

p = .391

Minimum Expected Frequency = 2.9

FUTURE PROSPECTS AND PROBLEM AREAS (Items 36-49)

37.5% of Westminster social workers considered guardianship should be USED MORE while 81.8% of Kensington and Chelsea social workers supported this view, viz.:

'Extended Use'

Table No. 18

	K & C	W'min	Row Totals
As now or more	9	8	17
Less	2	8	10
Totals	11	16	27

Chi-Square

Value = 2.830 p = .093

Yates' Correction

Value = 1.630 p = .202

Fisher's Exact Test

p = .124

Minimum Expected Frequency = 4.1

63.6% of Kensington and Chelsea social workers thought guardianship should be regarded as a CLAIM ON THE AGENCY'S RESOURCES but only 37.5% Westminster social workers supported this view.

Resource Demand

Table No. 19

	K & C	W'min	Row Totals
Con Neut	4	10	14
Pro	7	6	13
Column Totals	11	16	27

Chi-Square Value = 1.784 p = .182

Yates' Correction Value = .890 p = .345

Minimum Expected Frequency = 5.3

Only 18.2% Kensington and Chelsea social workers thought guardianship problematic as necessarily an INFRINGEMENT OF CIVIL LIBERTIES, whilst Westminster social workers were evenly divided on this, viz.:

Infringement of Civil Liberties

Table No. 20

	K & C	W'min	Row Totals
Con/Neut	9	8	17
Pro	2	8	10
Column Totals	11	16	27

Chi-Square Value = 2.830 p = .093

Yates' Correction Value = 1.630 p = .202

Fisher's Exact Test p = .124

Minimum Expected Frequency = 4.1

No Kensington and Chelsea social workers felt guardianship POWERS SHOULD REMAIN UNCHANGED while 18.8% Westminster social workers supported the status quo, viz.:

Guardianship Powers Should Stay the Same

Table No. 21

	K & C	W'min	Row Totals
Con/Neut	11	13	24
Pro	0	3	3
Column Totals	11	16	27

Fisher's Exact Test

p = .248

Minimum Expected Frequency = 1.2

Asked whether POWERS TO DETAIN SHOULD BE OUTLAWED, no Westminster social workers supported this view, but two (18.2%) Kensington and Chelsea social workers agreed with it, viz.:

Detention Powers: 'Outlaw Them'

Table No. 22

	K & C	W'min	Row Totals
Con/Neut	9	16	25
Pro	2	0	2
Column Totals	11	16	27

Fisher's Exact Test

p = .157

Minimum Expected Frequency = .8

All Kensington and Chelsea social workers supported the view that guardianship should imply availability of a PACKAGE OF CARE for the client, but three (18.8%) of Westminster social workers could not support this view, being opposed to, or uncertain about, guardianship being used to prioritise services for guardianship clients, viz.:

Package of Care

Table No. 23

	K & C	W'min	Row Totals
Con/Neut	0	3	3
Pro	11	13	24
Column Totals	11	16	27

Fisher's Exact Test

p = .248

Minimum Expected Frequency = 1.2

SOCIAL WORKERS' GUARDIANSHIP CASES

(1) AGGREGATED DATA

The following provides information from Section A of the questionnaire completed by social workers, which related to a total of 41 guardianship cases. The sequence of characteristics follows that of the original questionnaire. These attempt to draw out the main distinguishing features and comparisons. Detailed tables supporting the observations provided below are to be found at Appendix G.

Section 1 gives a brief profile of guardianship clients. This refers only to items susceptible to analysis and to comparison with other studies. The reference studies are two produced by members of the Social Services Research Group, referred to as the **Barnes (1990)** and **Fisher (1991)** studies respectively, and a number of small-scale studies. The reference studies are summarised and referenced in Appendix A.

Sections 2, 3 and 4 of the analysis examine results of cross-tabulations of variables within the present research, considering **Diagnosis, Category Status Groups and the Two Social Services Departments (the Agencies)** as reference points in the respective sections.

Section 1 Guardianship Clients: a Brief Profile

Ages of Guardianship Clients

- Ages of 40 clients were obtainable, and these ranged from 18-91.
- Main age groups were 80+ with 11 clients (27.5%), and 61 - 80 with 10 clients (25%).
- Clients aged 60+ formed 55.3% of the total, and 65+ clients, 45% of the total. These latter figures compare with the **Cheshire (1988)** and the **Fisher** studies, with 58% and 47% respectively for these same age groups.

Comparing the breakdown by age groups of this research population with that of the Barnes study, shows differences between ages of clients referred for guardianship and those referred for all kinds of Mental Health Act assessment. This applies to some extent to age group 44-54 but much more so to age group 75+, as shown below:

Ages of Clients

Table No. 24

	Ages 44-54	Other Ages	Row Totals
This Study	1	39	40
Barnes	1279	8125	9404
Column Totals	1280	8164	9444

Chi-Square Value = 4.18898 p = .0407

Yates' Correction Value = 3.29512 p = .0695

'Nearly' significant at the .05 level

Minimum Expected Frequency = 5.4

Ages of Clients

Table No. 25

	Ages 75+	Other Ages	Row Totals
This Study	13	27	40
Barnes	976	8428	9404
Column Totals	989	8455	9444

Chi-Square Value = 20.78957 p = .0000

Yates' Correction Value = 18.49704 p = .0000

Fisher's Exact Test p = .0136

'Nearly' significant at the .01 level

Minimum Expected Frequency = 4.2

Gender

Gender
Table No. 26

	Male	Female	Row Totals
This Study	14	27	41
Barnes	856	1217	2073
Column Totals	870	1244	2114

Chi-Square Value = 0.84787 p = .3572

Yates' Correction Value = 0.57846 p = .4469

Minimum Expected Frequency = 16.9

Two-thirds (65.9%) of guardianship clients in the sample are female, roughly similar to most previous guardianship research findings (See page 355). The above table compares this sample finding with the 'Alternative Care' (i.e. alternative to hospital admission) group in the **Barnes** study in which the referral of female clients formed 58.65% of the total.

Marital Status

Marital Status
Table No. 27

	Single	Other Status	Row Totals
This Study	27	13	40
Barnes	3599	5336	8935
Column Totals	3626	5349	8975

Chi-Square Value = 12.25381 p = .0005

Yates' Correction Value = 11.14941 p = .0008

Significant at the .001 level

Minimum Expected Frequency = 16.2

Two-thirds (65.9%) of guardianship clients were single, a very different finding to that of the **Barnes** study in respect of all referrals from mental health assessments, in which single clients formed 40.3% of the total.

Ethnicity

Ethnicity of Clients

Table No. 28

	W.I./A-C.	Other Groups	Row Totals
This Study	2	39	41
Barnes	91	1905	1996
Column Totals	93	1944	2037

Fisher's Exact Test

p = .711

Minimum Expected Frequency = 1.9

Three-quarters of guardianship clients (31 = 75.6%) were British/English. Different classifications make comparison with the Barnes study difficult, but concentrating on West Indian/Afro-Caribbean groups compared with others shows the very similar picture, indicated in the table above.

Diagnosis

Overall, 19 (47%) of guardianship clients in this sample were diagnosed as schizophrenic, 12 (29%) suffered from dementia, 7 (17%) were suffering from depression or manic-depression, with the remaining 3 (7%) clients diagnosed as suffering from other conditions.

Comparison with the Barnes study using the nearest equivalent diagnostic distinctions are at Tables 29 and 30 on the next page. Comparing schizophrenia and dementia as between this research and that of the Barnes study, shows similarity in proportions of people with schizophrenia but marked difference in the proportion of dementia sufferers in this research population.

The other studies referred to in Appendix A provide a variable pattern between schizophrenia and dementia with a range between 65% dementia (the Leeds (1990) study) and 43% schizophrenia (in the Cheshire study). It is interesting to note that the figure

for people suffering from schizophrenia in this study compares with 14% people suffering from schizophrenia described as 'Alternative Care' and with 27% described as avoidably admitted to hospital ('potentially diverted' from hospital) in the Barnes study.

Diagnosis: Schizophrenia

Table No. 29

	Schiz- ophrenia	Other Diagnosis	Row Totals
This Study	19	22	41
Barnes	2371	3041	5412
Column Totals	2390	3063	5453

Chi-Square Value = 0.10591 p = .7448

Yates' Correction Value = 0.2805 p = .8670

Minimum Expected Frequency = 18.0

Diagnosis: Dementia

Table No. 30

	Dementia	Other Diagnoses	Row Totals
This Study	12	29	41
Barnes	359	5053	5412
Column Totals	371	5082	5453

Fisher's Exact Test p = .0107

'Nearly' significant at the .01 level

Minimum Expected Frequency 2.8

Family Support

Twenty (49%) of guardianship clients experience a negligible amount of family support, and for only 5 (12%) of clients is such support regarded as substantial.

Living Arrangements

Twenty-nine (70%) of guardianship clients live alone, 7 (17%) with nuclear family and 5 (12%) in residential care.

Admissions to Psychiatric Hospitals

Information on numbers of hospital admissions was available on 29 clients. Of these, 16 (55%) have had one or more compulsory admissions and 8 (27%) have had one or more voluntary admissions.

Social Work Objectives

Social work strategy prior to guardianship consideration aimed at a range of psycho-social and service-providing objectives but insufficiency of persuasion to accept help was the single most frequent reason to look to guardianship.

Purposes of Guardianship (i)

Individually defined purposes divided between 23 (56%) where the authority/control is the main objective and 18 (44%) where the main objective is enhanced levels of care.

Purposes of Guardianship (ii)

With guardianship purposes defined in terms of *residential service provision*, 23 cases (56%) involved a residential placement - but for 5 (12%) of these clients the requirement consisted of regularising a pre-existing residential arrangement.

Purposes of Guardianship (iii)

Purposes related to *gaining access/arranging attendance* for care form small percentages of the remainder, the largest group of which concerned regularising rather than arranging care. There were three for whom attendance for out-patient treatment was the issue.

Purposes of Guardianship (iv)

Objectives of guardianship were deemed *realised or realisable* in half the cases. The distinction between Categories [1] and [2] is obviously of particular significance here - see Table 43 on page 288.

Influence of Medical Colleagues

In answer to the question: 'Was medical opinion influential in your decision about guardianship in this case?' 'Yes' answers applied in 22 (58%) cases.

Asked whether this medical influence was for or against guardianship, social workers said that medical views favoured guardianship in 14 (64%) of these 22 cases.

Section 2 Diagnoses and Other Variables

Diagnosis and Age

Ages and proportions of clients across the full range of diagnostic groups are indicated in Table 62. Schizophrenia is the diagnosis of 68% people who were less than 60 years of age while dementia is the main diagnosis of 53.3% people aged 60 or over.

Looking only at schizophrenia and dementia as in the table below provides percentages of 100% and 64.7% respectively for these age groups.

Diagnosis and Age

Table No. 31

	Schiz- ophrenia	Dementia	Row Totals
0-60	13	0	13
61+	6	11	17
Column Totals	19	11*	30

Chi-Square Value = 13.282 p = .000

Yates' Correction Value = 10.641 p = .001

Fisher's Exact Test p = .0317

Significant at the .05 level

Minimum Expected Frequency = 4.8

Looking at other age groupings is also indicative in judging respective weighting between schizophrenia and dementia in the sample groups.

* Age of one client with dementia not known

Diagnosis: Living Arrangements and Family Support

Looking at different living arrangements and family support for clients in the various diagnostic groups in Tables 63 and 64 suggests that similar living patterns pertain as between people suffering from dementia and schizophrenia. For both groups, people living alone form about two-thirds of the samples while the proportion of those in residential care compared with other arrangements is about 1/6 for both groups. No people suffering from dementia were closely supported by family but a quarter of those suffering from schizophrenia obtained such support.

Diagnosis and Hospital Admissions

The overall pattern of diagnosis and compulsory hospital admissions confirms experience that people with schizophrenia are much more subject to compulsory admissions to hospital than those with dementia, as shown in the simplified table below. 72.7% of people suffering from schizophrenia had had three or more admissions. No clients with dementia had been compulsorily admitted.

Diagnosis and Compulsory Hospital Admissions

Table No. 34

	Schiz- ophrenia	Dementia	Row Totals
2 or Less	3	12	15
3 or more	8	0	8
Column Totals	11	12	23

Chi-Square Value = 13.38182 p = .0003

Yates' Correction Value = 10.36779 p = .0013

Fisher's Exact Test p = .0337

Significant at the .05 level

Minimum Expected Frequency 3.8

Diagnosis: Social Work and Guardianship Objectives

The main reason for considering guardianship following unsuccessful attempts to pursue social work objectives was failure to persuade clients to accept help - referred to as Insufficiency of Persuasion. Looking at how this applied to the two main diagnostic groups shows similar patterns but was slightly more of an issue with people with dementia: 75% (Table 36) compared with 63.2% (Table 35).

Schizophrenia and Social Work Objectives

Table No. 35

	Schiz- ophrenia	Other Diagnoses	Row Totals
Pers. Insuffic	12	12	24
Other Probs.	7	9	16
Column Totals	19	21	40

Chi-Square Value = 0.15038 p = .6982

Yates' Correction Value = 0.00418 p = .9485

Minimum Expected Frequency = 7.6

Dementia and Social Work Objectives

Table No. 36

	Dementia	Other Diagnoses	Row Totals
Insuffic/Pers.	9	15	24
Other Probs.	3	13	16
Column Totals	12	28	40

Chi-Square Value = 1.60714 p = .2049

Yates' Correction Value = .83829 p = .3599

Fisher's Exact Test p = .297

Minimum Expected Frequency = 4.8

Guardianship objectives related to the implementation of one or other of the three main powers, as between residential placement, day care provision or obtaining access (i.e. various aspects of service provision in the broadest sense) are compared by diagnostic groups in Table 65. This indicates that the residential requirement applied to half of the clients suffering from schizophrenia and for three quarters of the clients suffering from dementia.

Section 3 Case Status Category Groups and Other Variables

Category Status and Age of Clients

Main differences in age *vis á vis* category status emerge in categories 80+, and in the 31-50 group, as indicated below. In the former, 80+ clients formed 15.4% of the Category [1] group and 33.3% of Category [2].

Case Status and Age

Table No. 37

	Category [1]	Category [2]	Row Totals
80 or above	2	9	11
-80	11	18	29
Column Totals	13	27	40

Chi-Square Value = 1.41789 p = .2338

Yates' Correction Value = 0.66054 p = .4164

Fisher's Exact Test p = .286

Minimum Expected Frequency = 3.6

The 31-50 age group is made up of 38.5% of Category [1] and 18.5% of Category [2]

Cases Status and Age

Table No. 38

	Category [1]	Category [2]	Row Totals
31-50	5	5	10
Other Ages	8	22	30
Column Totals	13	27	40

Fisher's Exact Test p = .246

Minimum Expected Frequency = 3.3

Category Group and Gender

Table 66 shows the breakdown between male/female clients in the two categories, indicating no appreciable difference and suggesting that there is no relationship between gender and the distinction between cases decided upon by social workers and those finally endorsed by management.

Category Group and Marital Status

Table 67 shows the different marital status groups between the two status groups. It indicates that the largest group from both categories are single people and that there is no significant difference between single status and the category distinctions.

Category Group and Ethnicity

Table 68 shows distinctions between the main ethnic groups and case status differences. Collapsing the ethnic group categories into 'British' and 'non-British' as in the Table below gives a clearer picture in which the first group form 61.5% of Category [1] clients and 82.1% of Category [2].

Ethnicity and Case Status

Table No. 39

	Category [1]	Category [2]	Row Totals
British	8	23	31
'Non-British'	5	5	10
Column Totals	13	28	41

Fisher's Exact Test

p = .241

Minimum Expected Frequency = 3.1

Category Group: Living Arrangements and Family Support

Table 69 indicates the distinction between living alone, living with nuclear family and living in residential care. Two further tables (Tables 70 and 71) collapse these categories in order to show how 'living alone' and 'living in residential care' relate to the category group difference compared with other living arrangements. These indicate that people living alone form two-thirds of each groups, and that those living in residential care form a seventh of Category [1] and one tenth of Category [2] cases. Table 72 shows levels (i.e. the amount) of family support to clients, and that no notable difference between the categories is evident.

Category Group and Diagnosis

Table 73 shows the breakdown of diagnostic groups alongside the two status category groups. There is no statistically significant distinction between diagnostic groups and the categories. This remained the case even when groups were collapsed to show only schizophrenia and dementia compared with other diagnoses in relation to the categories, as indicated in Tables 74 and 75.

Category Group and Hospital Admissions

Tables 76 and 77 show the number of admissions for each client and the distinctions between the two status category groups, for compulsory admissions and voluntary admissions respectively. The following regrouped table indicates proportionately more compulsory admissions in Category [1], i.e. 80%, compared with 42.1% in Category [2].

Compulsory Admissions and Case Status Categories

Table No. 40

	Category [1]	Category [2]	Row Totals
None	2	11	13
1 or More	8	8	16
Column Totals	10	19	29

Chi-Square Value = 3.804 p = 0.051

Yates' Correction Value = 2.426 p = 0.119

Fisher's Exact Test p = .114

Minimum Expected Frequency = 4.5

Category Group and Social Work Objectives

Regarding reasons prompting guardianship consideration, Insufficiency of Persuasion to receive help was the majority answer for both status category groups, but proportionately more so in Category [2] cases.

The following table shows Insufficiency of Persuasion compared with other reasons given for the two categories, and indicates that the factor applied in 71.4% of Category [2] cases and 33.3% of Category [1] cases, viz.:

Social Work Objectives and Case Status Categories

Table No. 41

	Category [1]	Category [2]	Row Totals
Insuffic. Pers	4	20	24
Others	8	8	16
Column Totals	12	28	40

Chi-Square Value = 5.079 p = .024

Yates' Correction Value = 3.616 p = .057

Fisher's Exact Test p = .0367

Significant at the .05 level

Minimum Expected Frequency 4.8

Category Group and Guardianship Objectives

- Individually Defined

Guardianship objectives which had been defined in terms of individual client requirements for authority/control or enhanced care show no notable difference between the two groups in this respect.

Category Group and Guardianship Objectives - Service Provision

With regard to guardianship objectives defined in service provision terms, Category [1] clients are over-represented in the sub-group 'Regularisation of Residential Care' and the table below highlights that distinction. The percentages are 30.8% and 3.6% respectively between the categories in the sub-groups. Table 78 looks in detail at guardianship objectives between the two categories.

Guardianship Objectives and Category Status

Table No. 42

	Category [1]	Category [2]	Row Totals
Reg.Res.Care*	4	1	5
Other Objectives	9	27	36
Column Totals	13	28	41

Fisher's Exact Test

p = .0284

Significant at the .05 level

Minimum Expected Frequency 1.6

* Regularisation of residential care placements

Category Group and Realisability of Guardianship Objectives

With regard to the realisability of guardianship objectives divided between the two categories, there is a clear link between objective realisability and Category Status [1], which is clarified in the table below. Possibly social workers considered that 'realisability' was actually being demonstrated in Category [1] cases. Realisability applied in 72.7% of category [1] cases and 33.3% of Category [2] cases.

Realisability of Guardianship Objectives and Category Status

Table No. 43

	Category [1]	Category [2]	Row Totals
Realisable	8	9	17
Not Clear or unlikely	3	18	21
Column Totals	11	27	38

Chi-Square Value = 4.906 p = .027

Yates' Correction Value = 3.442 p = .064

Fisher's Exact Test p = .0367

Significant at the .05 level

Minimum Expected Frequency = 4.9

Category Group Differences and Medical Influence

Tables 79 and 80 show answers to the two research questions in this section, namely:

(1) Was there medical influence? (2) If so, in which direction?

The answer to question (1) was 'yes' for 9 Category [1] clients and 13 Category [2] clients. In answer to question (2), medical opinion favoured guardianship in 9 Category [1] cases and 5 Category [2] cases. 'Yes' answers formed 75% of Category [1] clients and 50% of Category [2] clients shown in Table 44. 'Favoured' answers formed 100% of Category [1] clients and 41.7% of Category [2] clients in Table 45.

Medical Influence - 'Was there?'

Table No. 44

	Category [1]	Category [2]	Row Totals
'No' or 'Not Clear'	3	13	16
Yes	9	13	22
Column Totals	12	26	38

Chi-Square Value = 2.10511 p = .1468

Yates' Correction Value 1.20445 **p = .2724**

Minimum Expected Frequency = 5.1

Medical Influence - 'Which Way?'

Table No. 45

	Category [1]	Category [2]	Row Totals
'No' or 'Not Sure'	0	7	7
'Favoured'	9	5	14
Column Totals	9	12	21

Fisher's Exact Test **p = .0712**

'Nearly' significant at the .05 level

Minimum Expected Frequency = 3.0

Section 4 Differences Between the Two Social Services Departments (the Agencies) Compared with Other Variables

The Agencies and Ages of Clients

Information on ages of clients for the two agencies is presented in Table 81. This shows that the main distinctions arise in age categories 81+, and in combined groups below 50 years of age compared with 51 or above. 51+ clients form 78.2% of Kensington and Chelsea cases, and under 50 clients form 64.7% of Westminster cases.

The Agencies and Clients' Ages

Table No. 46

	K & C	W'min	Row Totals
-50	5	11	16
51+	18	6	24
Column Totals	23	17	40

Chi-Square Value = 7.51918 p = .0061

Yates' Correction Value = 5.83546 p = .0157

Significant at the .05 level

Minimum Expected Frequency = 6.8

81+ clients form 43.4% of cases in Kensington and Chelsea. Clients under 80 form 94% of cases in Westminster.

The Agencies and Clients' Ages

Table No. 47

	K & C	W'min	Row Totals
-80	13	16	29
81+	10	1	11
Column Totals	23	17	40

Chi-Square Value = 6.930 p = .008

Yates' Correction Value = 5.172 p = .023

Fisher's Exact Test p = .0119

'Nearly' significant at the .01 level

Minimum Expected Frequency = 4.7

The Agencies and Diagnosis

Table 84 shows the different diagnostic groups for the agencies and indicates that schizophrenia and dementia are both major diagnostic groups in Kensington and Chelsea. In Westminster, schizophrenia is the main group and there is very little sign of interest in the use of guardianship for people suffering from dementia in Westminster. Dementia sufferers form 45.8% of the Kensington and Chelsea cases and 5.9% of the Westminster cases. Clients with schizophrenia form 33.3% of the Kensington and Chelsea cases and 64.7% of the Westminster cases. The following tables isolate the two main diagnostic groups.

Diagnosis and Agency - Dementia

Table No. 49

	K & C	W'min	Row Totals
Dementia	11	1	12
Other	13	16	29
Column Totals	24	17	41

Chi-Square Value = 7.672 p = .006

Yates' Correction Value = 5.864 p = .015

Fisher's Exact Test p = .0643

'Nearly' significant at the .05 level

Minimum Expected Frequency = 5.0

Diagnosis and Agency - Schizophrenia

Table No. 50

	K & C	W'min	Row Totals
Schizophrenia	8	11	19
Other	16	6	22
Column Totals	24	17	41

Chi-Square Value = 3.93883 p = .0472

Yates' Correction Value = 2.77821 p = .0956

Minimum Expected Frequency = 7.9

The Agencies and Living Arrangements

Table 85 shows the main living arrangement distinctions and indicates little difference between the agencies. However, looking only at 'Living Alone' emphasises that this was more a factor in Kensington and Chelsea - 79.2% compared with 58.8% in Westminster.

The Agencies and Living Arrangements

Table No. 51

	K & C	W'min	Row Totals
Alone	19	10	29
Other	5	7	12
Column Totals	24	17	41

Chi-Square Value = 1.989 p = .158

Yates' Correction Value = 1.128 p = .288

Fisher's Exact Test p = .184

Minimum Expected Frequency 5.0

The Agencies and Family Support

Table 86 shows the amount of family support which guardianship clients are estimated as receiving by their social workers. This indicates that the majority of guardianship clients in both agencies receive a negligible amount of family support and conversely that those with a close family relationship form a small minority. Differences between the agencies are small.

The Agencies and Hospital Admissions

The available data on guardianship clients in respect of hospital admissions was limited and provided information on 31 clients regarding compulsory admissions and on 29 voluntary admissions. Data on compulsory admissions to hospital in the agencies is provided at Table 87. This indicates that 64.7% of clients in Kensington and Chelsea experienced no compulsory admissions compared with 14.3% in Westminster, and the effect of this difference is emphasised in the table below comparing those who have had no hospital admissions with those who have had one or more.

Hospital Admissions and the Agencies - Compulsory

Table No. 52

	K & C	W'min	Row Totals
None	11	2	13
One or More	6	12	18
Column Totals	17	14	31

Chi-Square Value = 8.01551 p = .0046

Yates' Correction Value = 6.07857 p = .0137

Significant at the .05 level

Minimum Expected Frequency = 5.9

A similar but less pronounced pattern of clients' voluntary admissions is evident in the distribution between the agencies in Table 88. This is emphasised in the table below which compares those who have no admissions with those who have had one or more. The former represent 84.2% clients in Kensington and Chelsea and 50% of clients in Westminster.

Hospital Admissions and the Agencies - Voluntary

Table No. 53

	K & C	W'min	Row Totals
None	16	5	21
One or More	3	5	8
Column Totals	19	10	29

Fisher's Exact Test p = .0834

Minimum Expected Frequency = 2.8

The Agencies and Realisability of Social Work Objectives

A retrospective analysis was undertaken of social workers' views on the limitations of social work in care and service providing for their clients prior to considering guardianship as an option. Of three broad reasons why social work alone was insufficient to provide care as between 'Insufficiency of Persuasion', 'Inability to Enforce Care' and the 'Excessively High Level of Supervision Required', the main reason given was that persuasion was insufficient. The balance of numbers is shown in the table below indicating that this was particularly an issue in Kensington and Chelsea (70.8%) compared with Westminster (43.8%).

Social Work Objective Realisability and the Agencies:

Insufficiency of Persuasion

Table No. 54

	K & C	W'min	Row Totals
Insuffic. Pers.	17	7	24
Other	7	9	16
Column Totals	24	16	40

Chi-Square Value = 2.93403 p = .0867

Yates' Correction Value = 6.07857 p = .1665

Minimum Expected Frequency 6.4

The Agencies and Guardianship Objectives

Objectives of guardianship were considered on two dimensions: the distinction between individual client focused objectives and service providing objectives.

Individual Client Focused Objectives

These divided broadly between the requirement for more authority or control as distinct from providing the client with an enhanced level of care. The distinctions are reflected in the following table, from which it will be seen that authority and control was generally more of an issue for social workers in Westminster - 70.6% compared with 45.8% in Kensington and Chelsea.

Client Focused Guardianship Objectives In The Agencies

Table No. 55

	K & C	W'min	Row Totals
Authority/Control	11	12	23
Enhanced Care	13	5	18
Column Totals	24	17	41

Chi-Square Value = 2.47609 p = .1156

Yates' Correction Value = 1.57295 p = .2098

Minimum Expected Frequency 7.5

Service Providing Objectives

Service providing objectives related to the three guardianship powers, i.e. determining place of residence, gaining access and ensuring attendance, are reflected in the categorised groupings in Table 89. By far the most common objective of guardianships in both agencies was concerned with residential care and the similarity between the two agencies is reflected in Table 56 below - 66.7% in Kensington and Chelsea and 70.6% in Westminster. Differences between the agencies emerged in respect of the regularisation of residential and day care placements, which was much more of an objective in Westminster, as indicated in Table 57 - 41.2% compared with 8.3% in Kensington and Chelsea.

Guardianship Objectives in the Agencies - All Residential Placements

Table No. 56

	K & C	W'min	Row Totals
All Res. Placements	16	12	28
Other	8	5	13
Column Totals	24	17	41

Chi-Square Value = .07067 p = .7904

Yates' Correction Value = .0000 p = 1.000

Minimum Expected Frequency = 5.4

Guardianship Objectives in the two SSDs: Regularising

Table No. 57

	K & C	W'min	Row Totals
Regularising (all placements)	2	7	9
Other purposes	22	10	32
Column Totals	24	17	41

Chi-Square Value = 6.26528 p = .0123

Yates' Correction Value = 4.49493 p = .034

Fisher's Exact Test p = .028

Significant at the .05 level

Minimum Expected Frequency = 3.7

A distinction in service providing objectives was also evident between residential placements and the regularisation of an existing residential placement. The former mainly concerned Kensington and Chelsea with 66.7% compared with 41.2% in Westminster. Regularisation is not an objective in any Kensington and Chelsea case whereas these form 22% of Westminster cases.

Guardianship Objectives in the Agencies: Residential Placement

Table. No 58

	K & C	W'min	Row Totals
Res. Placement	16	7	23
Other Objective	8	10	18
Column Totals	24	17	41

Chi-Square Value = 2.62537 p = .1052

Yates' Correction Value = 1.69237 p = .1933

Minimum Expected Frequency = 7.5

Guardianship Objectives in the Agencies Regularising Residential Placements

Table No. 59

	K & C	W'min	Row Totals
Reg.Res.Placement	0	5	5
Other Objective	24	12	36
Column Totals	24	17	41

Fisher's Exact Test p = .0826

Minimum Expected Frequency = 2.1

Guardianship Purpose Realisability

As to how achievable (or for existing guardianship cases - actually achieved) were guardianship's objectives for each of the clients concerned, Table 90 indicates the pattern between the agencies and shows that achievability receives a slightly higher evaluation in Westminster - 52.9% compared with 43.5% in Kensington and Chelsea.

The Agencies and Medical Influence

In this section two questions were asked in respect of each guardianship client:

(1) Was there medical influence? (2) If so, in which direction?

Tables 91 and 92 show the answers to these questions and the following two tables regroup the data, to demonstrate more medical influence in Westminster and a more favourable view of guardianship by medical colleagues in respect of guardianship clients. 'Definitely Yes' was the answer in 45.9% Kensington and Chelsea cases compared with 70.6% in Westminster.

Medical Influence in the Agencies: 'Was There?'

Table No. 60

	K & C	W'min	Row Totals
Definitely Yes	11	12	23
Other	13	5	18
Column Totals	24	17	41

Chi-Square Value = 2.47609 p = .1156

Yates' Correction Value = 1.57295 p = .2098

Minimum Expected Frequency = 7.5

The following table shows 'favoured' to be the answer in 54.5% of Kensington & Chelsea cases and 75% of Westminster cases.

Medical Influences In the Agencies: 'Which Way?'

Table No. 61

	K & C	W'min	Row Totals
Favoured	6	9	15
Other responses	5	3	8
Column Totals	11	12	23

Chi-Square Value = 1.059 p = .304

Yates' Correction Value = 0.349 p = .555

Fisher's Exact Test p = .400

Minimum Expected Frequency = 3.8

SOCIAL WORKERS' GUARDIANSHIP CLIENTS:

(2) CASE EXAMPLES AND ILLUSTRATIONS

The following notes on guardianship clients are presented in an abbreviated format reflecting the often limited information available to the researcher from social workers or from case records.

Case A (Status Category V)

This 42-year-old woman suffers from schizophrenia, and had entered hospital annually since 1977, sometimes compulsorily. At the time of the suggestion for guardianship, the client was in hospital under a Section 3 order and the intention was to improve on previous after-care arrangements by ensuring a planned programme of rehabilitation in an appropriate residential unit.

The proposers wanted to prescribe where the client could reside, and how often her mother should visit, etc. There was also a day care activity plan which it was hoped guardianship would help to consolidate. The client lacked motivation to pursue her own rehabilitation plan and in particular to resist the over solicitous attentions of her mother. No social work action had previously been effective in either of these directions.

Management had not given any suggestion of support for the social workers' submission and the case 'lay on the files' in a limbo/unresolved situation. The social worker expressed diffidence because he considered he was receiving conflicting messages about management support for guardianship.

Case B (Status Category V)

A 81-year-old woman, living alone, has shown evidence of psychotic behaviour but has so far managed to survive at home, albeit in a neglectful state, refusing to eat food, to clean herself or her flat, or to go out shopping. She now suffers from malnutrition.

The social worker had been trying for over a year to gain proper access to her and this only succeeded when client confused identity of social worker with that of her daughter, but the client would otherwise refuse all access.

Social worker's team leader had suggested guardianship as a means of providing structure for the care of the client at home and to enable her to stay physically healthy, by allowing home helps and district nurses to gain access.

The proposal had not proceeded beyond this stage because the social worker had understood that senior management "did not want guardianship orders". The client eventually required hospital admission and died in hospital.

Case C (Status Category V)

This 86-year-old woman suffers from dementia and has been 'battered' by her older sister who insists on holding her money and taking over her management without ensuring proper care. Client was not eating properly and suffered injuries. She was too frightened of her sister to agree to do anything to safeguard her welfare.

Social workers wanted her to move into a home for the elderly but she was too confused and over-influenced by her sister to be able to express an independent decision.

Guardianship could have been used to place her into Part III accommodation and to help to resist the overtures of the sister. In the event the sister was judged to be mentally ill and was compulsorily admitted to hospital, thereby removing the source of the difficulty on a temporary basis. The sister will soon be out of hospital and the whole problem could re-emerge. (Possibility of client entering home for the elderly while the sister is in hospital -apparently difficult because of the non-availability of places in homes for the elderly.)

Case D (Status Category V)

This client is 26, from a mixed Afro-Caribbean/Irish-American background, and has a long history of violent episodes (possibly psychotic) which have taken him in and out of hospital. However, between times he is manageable in the community provided he can be closely supervised and almost 'bullied' to take his medication.

No family member or friend is in a position to do this because they have separated from him due to his violence. However, he does respond to persuasion from professionals provided they can get access to him and are persistent enough.

The object of guardianship therefore would be to get him to take his medication regularly and for him to attend a depot clinic. There have been indications that if social workers persist, they can always eventually get in to see him.

The social worker was very serious about the task of preventing this person yet again requiring hospital care but spoke in dismissive terms about the prospect of management agreeing a guardianship in this case. It is true that it would be a radical departure for most social services departments to take on management in the community of someone with such obviously high levels of disturbance and aggressive behaviour.

It is also noted that client has a very close relationship with his mother but the two of them cannot live together because of his violence. For similar reasons he has broken up with his girlfriend and no longer sees his daughter.

Case E (Status Category IV)

This 28-year-old Jewish woman has been placed in residential care in a hostel in Kent. The diagnostic picture is unclear but she has been labelled 'mentally handicapped' and also as having a 'personality problem'.

The idea of guardianship came from the client's father who thought that it would act as a reinforcement to the authority position of the head of care at the hostel. In the short run, this was aimed at reducing absconding (or more specifically to give the head of care authority to get her client returned to care after absconding). More generally it was hoped that this would stabilise the client's situation at the hostel, as well as helping to make the relationship between her and family more manageable.

Previous rehabilitation plans from a mental handicap hospital into residential care had not worked out well.

Case F (Status Category I)

This 72-year-old single woman was on guardianship at the time of the research. It commenced in October 1986 having first been proposed in July 1986. It is interesting to note that the Principal Officer (Mental Health) in the agency had recommended against guardianship and had written to the social worker discouraging her from pursuing it any further. However, the Mental Health Review Tribunal looked at the case and recommended guardianship in place of Section 3.

The client has suffered from manic depressive illness from the time she was 18 and has had at least 20 hospital admissions and relies on major tranquillisers. She is unable to cope with housework etc., and cannot support her common-law husband who is equally disabled.

There was common agreement that something additional was needed to enable this person to remain at home if she was not to continue to neglect herself severely. The client refused entry to all forms of home care and to the CPN.

Objective of guardianship was described as:

"to provide firm boundaries and a plan of care which the client was unable to provide for herself because of her lack of insight and inability to see or accept consequences of her action".

Guardianship has worked to enable access of services and to enable a suitable residential placement to be made. The client no longer cohabits but former common-law husband has also become more accommodating since the guardianship order.

Case G (Status Category II)

An 82-year-old single woman has been suffering from severe dementia for at least the last five years and has been on the receiving end of intense domiciliary care (14 home help visits per week) plus by-monthly 'Network Meetings'. The Court of Protection are also involved.

As dementia progressed the care task became harder and a decision was reached that the client needed to enter residential care. However, she was unable to express cooperation or otherwise.

Guardianship was used to place client in residential care where she settled well and the guardianship order was then allowed to lapse.

There is an interesting link between guardianship and Court of Protection, but no details are provided. Objective of guardianship was said to be:

"to ensure that the client is living in a safe secure environment where she will be cared for and the element of risk is reduced."

The reason for guardianship being allowed to lapse was stated thus:

"the client was settled and happy in residential care and was not considered to be likely to leave".

Medical opinion was said to be influential in suggesting that the client was at risk in the community and likely to deteriorate.

Case H (Case Status V)

A woman of 85, with no psychiatric history, is now suffering from dementia with 'severe short-term memory loss'. Client's mental health deteriorated rapidly following death of spouse in 1981. Client has substantial wealth and guardianship objective was to 'give local authority the right to engage a full-time carer on client's behalf' - i.e. funded from proceeds of husband's estate. Eventually the client was persuaded to accept help voluntarily and the case was not put to management.

There was a view expressed both by medical colleagues and social workers that guardianship should not be pursued because "client would be happier and more cooperative if she felt she had retained some remaining level of control over her life". By implication, the pursuit of guardianship would be seen as removing all control from client. No notion of quid pro quo or of a partial or limited approach here.

Case I (Case Status II)

This is a single woman of 73, separated from her family, who had previously lived in Ireland and Canada. She has had a number of paranoid psychotic episodes since 1985 and some physical health problems (admitted into general hospital because of hypothermia).

Eventually discharged from psychiatric hospital under guardianship in December 1986 in order to be placed into a specialist residential unit (not clear in which sense this unit was specialist) because neither Part III accommodation nor sheltered accommodation was seen as appropriate. There was medical support for placement under guardianship.

Guardianship was lapsed once client was 'settled in'.

Case J (Case Status II)

This single woman of 49 suffering from schizophrenia had been admitted to hospital at least every other year. Community care efforts were "unable to stabilise her for any length of time".

"Regular sustained social work involvement" did not begin until the commencement of the guardianship order. The guardianship brought about some cooperation and stabilisation.

Guardianship lasted four years. It had been judged successful: no more hospital admissions since.

Case K (Case Status II)

A 37-year-old man living apart from family with a number of long hospital admissions. On discharge, drifted and experimented with drugs.

He received statutory after-care after a Section 3 admission, and social worker tried to prevent reversal to his previous life-style.

It was felt that some structure and support would outweigh the curtailment of client's liberties. Aim of guardianship was to "try to win over the confidence of the client and help him feel more relaxed about our motives". It was expected that guardianship would "give structure and boundaries that were clear to work on client".

Guardianship was accepted by the agency's senior management but they did not positively endorse it. Neither did they provide any reason for allowing guardianship to lapse.

Case L (Case Status V)

This woman of 69, diagnosed as suffering from schizophrenia, is married with children but separated from family for many years. She has regular in-patient care and her history of illness dates back to 1949.

Many attempts have been made to provide a stable care situation for her on discharge from hospital but all have failed:- nursing home, old peoples home etc. She rapidly becomes disenchanted with the placement and takes herself off.

Guardianship was seen as a means of securing a 'package' of after-care for client to include accommodation and day care, therapeutic occupation and psychiatric follow-up. But "no suitable community placement could be found" before she discharged herself from hospital. She was readmitted to another hospital before the guardianship application could be made.

Some enthusiasm for guardianship by medical colleagues is present but a view prevails that situation changes too rapidly for guardianship arrangements to be put in hand. Latest decision by medical team is to delay further action until client is placed in a new community facility which is just about to be opened.

Case M (Case Status V)

This 85-year-old unmarried woman lives alone with only occasional family contact and suffers from dementia.

Community care arrangements were working reasonably well with social worker dealing with client's finances, visiting regularly in conjunction with a community care assistant, Meals on Wheels and DNO.

The social worker advised use of guardianship in order to be able to place the person in Part III accommodation, on the basis that the client was disorientated and "unable to give informed consent". By implication this applied also to the risky aspect of managing client's finances.

The request for Part III accommodation was linked with the idea that the 'power of return' would be valuable to deal with absconding due to client's mobile 'life-style'. Management declined to support this recommendation saying that it was an "inappropriate use of guardianship". Consequently a formal proposal was not submitted.

Case N (Case Status V)

This widow of 85 has a daughter living close-by who appears to feel she has 'failed' in caring for mother as she becomes more uncommunicative and withdrawn.

Client refuses community services (home care etc.) and entry into Part III accommodation. The role of guardianship was to:

1. assume power to direct client to live in Part III accommodation;
2. remove responsibility from daughter, thus relieving guilt/stress, and to break dead-lock [referring to daughter's inability to gain access to services for her mother].

It is particularly notable that the agency's homecare management "refused to enter [the client's home] without express consent". The guardianship application was declined on the grounds that residential care staff were strongly opposed to this use of guardianship. Social worker appears to think that there was a management 'bottom line' position that made residential care more acceptable under guardianship than home care. He appears therefore not to have pursued as far as he might the notion that home care could be 'imposed' on client - though he may well also have had practical difficulties very much in mind. His view was simply that community care was not working, mainly because client refused to consent to anything. He also refers critically to the inflexibility of home care management and the situation of EMI clients 'falling between NHS and local authority responsibilities'.

Case O (Case Status V)

This schizophrenic man of 59, with very little family contact, is described as a 'Barnardo's boy'.

Some major psychotic episodes appear to have provided quite traumatic hospital experience in the two previous years and further hospital admissions were predicted. He relies on major tranquillisers, attending out-patient clinic for injections plus oral medication. Social worker feels that his social adjustment is precarious and that he requires occupation, social contact and day care.

Role of guardianship was to direct client into day care attendance but in the event this idea was merely 'talked about'.

Also a practical matter intervened: the social worker identified a departmental policy affecting the decision not to pursue this case, namely the:

"Necessity of providing report for consideration by management before making application meant that social worker would not propose unless there is a high chance of success (because of extra work involved)."

In other words, the management 'advice' on the case in response to a report was not seen as supportive but as an 'extra chore'.

Case P (Case Status I)

A 55-year-old single woman has two sisters who offer some continued interest and concern but appear determined that main responsibility shall fall on social services, apparently to avoid assuming financial responsibility.

Client suffers from manic depressive psychosis and has been in and out of hospital many times since 1975. After discharge client tends to withdraw and refuse contact with medical and social services staff. Thus 'community care' has not been possible in a true sense.

Follow-up from hospital has become more of an issue since she has been subject to Section 117 as a Section 3 patient. At last discharge she was described as "clearly a very vulnerable client at risk of death through self neglect". These factors in combination appear to have encouraged management to accept the guardianship.

Management did not say on what grounds they accepted the guardianship but the following were listed:

- To prevent need for further admission by close monitoring and supervision;
- To accommodate client in supportive environment;
- Allowing a hostel to be stipulated as place of residence;
- By ordering attendance at day hospital and medical appointments;
- By allowing access to client against her expressed wish.

A good deal of medical support was expressed for guardianship as "the only measure left".

Case Q (Case Status V)

This is a 91-year-old widow of Polish origin, whose remaining family live in USA/Canada. She has no history of hospital care until admitted to an acute unit in a confused self-neglected state by Section 2 in 1987. Community services were becoming ineffective for at least a year beforehand when she began to refuse help and stopped eating properly. In other words, she was allowed to deteriorate to the point where hospital care was inevitable.

The diagnosis of senile dementia is supported by the fact that she has "little insight" and already believes she is in an old people's home.

It was not thought appropriate for her to be discharged home (!) and a proposal for Part III was put forward. The social worker met resistance from the Part III panel because client was "not able to consent" and client went instead to a 'long-stay NHS resource'.

In other words, guardianship was not used because the avenues open to a client in this situation were excluded in advance. She went to hospital unnecessarily and went into an NHS residential unit because social services management declined to have her in residential care unless consenting.

No clear idea of management thinking about this.

Case R (Case Status II)

An 84-year-old Swedish woman, widowed for many years with no known relatives in England suffers from 'progressive dementia'. Community care arrangements have been operating since 1982 (initial referral), consisting of Home Care, Meals on Wheels, CPN. Court of Protection are also involved and the social worker has not been happy about the Court's ability/intent to operate in the client's best interests (unspecified).

Guardianship is therefore seen as a means of:

1. reducing possible exploitation by others;
2. protecting rights of individual to remain in own home;
3. if necessary, assisting with long-term care needs - i.e. to place in residential care if and when necessary.

Social worker saw guardianship as a means of acquiring additional authority which would give her some 'clout' in dealing with Court of Protection and in formulating a long-term care plan. Some interesting views on the use of guardianship here, especially regarding authority and the ability draw up care plans.

Case S (Case Status V)

This is a 78 year old woman, widowed, who lives with her daughter. The client has had a history of hospital admissions because of paranoid schizophrenia. She accepts community care reluctantly being very much against 'professionals'.

Motivation for guardianship seems to have come from her daughter. According to the social worker the daughter saw guardianship as a means of getting her mother out of her flat (? into residential care).

There are a number of unanswered questions in this case but it is interesting to record:

1. The idea was for the daughter to be the guardian and therefore to be given powers (to determine place of residence).
2. The arrangement would explicitly involve a person losing (i.e. being removed from) their own home in favour of a residential or hospital solution.

3. Management considered (quite rightly) that the whole idea had not been properly thought out and were extremely wary of going along with the daughter's view of the situation.

Case T (Case Status I)

This guardianship case is in force and concerns a man of 63 of Polish/Jewish origin, divorced, with a history of paranoid schizophrenia with a grandiose and violent aspect.

He has been in and out of hospital since 1972 and was discharged from a Section 3 order in 1986 - Section 117 - to after-care of day hospital but stopped attending. guardianship seen as a means of enforcing attendance and to ensure that continued care and attention does not gradually fade into the background (so that he does not 'fall out' of the system).

The social worker has indicated that management agree with his view, that guardianship is to provide "authority over client and an obligation to provide continuing community care". It is interesting that none of the discussion up to this point referred to priority access to care/services.

Case U (Case Status V)

This case is interesting in that two social workers were involved from both the research agencies. The original (Kensington and Chelsea) social worker moved (to Westminster) but was persuaded to come back to talk to the researcher about the case. Broadly speaking she was in favour of guardianship but the succeeding social worker was not.

The first social worker was working more as a self-styled 'relationship therapist', whereas the social work successor was more practical in approach.

Diagnosis is obsessional neurosis and client has had a leucotomy and much hospital treatment - still continuing.

The guardianship idea was to impose some form of control over his hazardous life style. For example, he never throws anything away and his flat has become a health hazard. Guardianship may have enabled social services to have moved the client out, at least while the flat was cleaned up etc.

No plan was drawn up and eventually the matter was dropped.

PART THREE: INTERPRETATION OF FINDINGS

Introduction

The following discussion looks overall at social workers' perspectives on guardianship, social work and guardianship clients, and seeks to explore connections within the findings between expressed views and recorded experience of work with the clients. The application of guardianship models (see Chapter IV) as a framework for analysis of social workers' views of guardianship and social work is tested. The task of answering the research questions by reference to two key variables - the differences between the agencies and between Categories [1] and [2] clients - is deferred to Chapter VI (Conclusions).

The data and analyses upon which the results are based, presented in numbered bar charts and commentaries from page 244, are referenced below by result number and page number.

(1) SOCIAL WORKERS' PERSPECTIVES ON GUARDIANSHIP AND SOCIAL WORK

Key guardianship concepts already defined include structure, continuity, surrogacy, enabling and advocacy. The assumption here is that these characteristics would be present to varying degrees in considering any particular guardianship model. Added to these were 'authority' and 'protective care' which the researcher had initially assumed to be essential elements rather than contingent attributes.

On this basis the researcher concluded that guardianship contains the notion of surrogacy and protective care exercised by someone in 'authority', and that whichever model of guardianship one examines, the elements of surrogacy, authority and protective care will be paramount. The influence of different models and different circumstances of client needs will effect the balance between these elements at any given point in time.

Some comment is required on three findings related explicitly to authority elements in guardianship, the first two of which were somewhat obliquely worded. Wide endorsement of the use of guardianship to provide particular kinds of authority (89%) [Result No.17, page 249] is interesting but begs the question of what kind of authority was envisaged, thereby possibly giving social workers undue scope for investing guardianship with whatever form of authority with which they could most readily sympathise or identify. On the other hand the notion that guardianship would serve to reinforce an existing authority base received luke-warm support (60%). [Result No.4, page 245].

Taking these two findings together, suggests that social workers might feel that guardianship is useful to the extent that it can impose its own form of authority rather than for use in parallel with social work (as itself a form of authority). A number of clues support this interpretation, in that social workers were less comfortable acknowledging the authority position of social work as, indeed, the authority of others - e.g. heads of residential units, where reinforcement of authority to detain was the example given for social workers to discuss. The third reference to authority (discussed below) considers possible risk of abuse or misuse within guardianship - a concern felt by 59% of social workers. [Result No.41, page 258].

The level of support for these elements or concepts of structure, continuity [Findings Nos. 2/3, page 244] and surrogacy, [Result No.30, page 254], which ranged from 78% to 100% agreement, suggests a high level of recognition among social workers of the importance of these elements. It was perhaps disappointing that continuity achieved the least endorsement (78%), given the presumption that guardianship assists the client and those concerned with his or her needs by being offered in a continuous and persistent way. Some social workers might regard this as a difficult goal to achieve, a situation which may require particular attention in the future.

There was modest endorsement for enabling [Result No.28, page 253] as being part of guardianship compared with social work itself. The idea of guardian social work being less enabling than ordinary social work perhaps gives rise to some concern.

Turning to the consequential effects of guardianship, the findings indicate substantial endorsement for the ideas that guardianship should contain a package of care (89%) and that statutory agencies should accept responsibility for resourcing guardianship (82%) [Results Nos. 46/7, page No 259], both of which seem essential if guardianship is to obtain a sympathetic and appropriate place within social services' policies and objectives. Finally, the idea of individualised powers within guardianship, intended to touch both upon a possible way forward for developing guardianship sympathetically to clients' needs, and a means of suggesting realistic changes in the way guardianship is organised and enacted, gave a moderately optimistic endorsement of 70% [Result No. 44, page 259].

Protective care had been seen by the researcher as an essential part of guardianship rather than a related concept. However this may have been shown to be misjudged in view of the fact that only three-quarters of social workers supported protective care as being part of guardianship [Result No.1, page 244]. Conceivably, the protective element is the one which can convey an inappropriately paternalistic stance which marks guardianship out as being insufficiently adjusted to more recent thinking about the relationship between professionals and clients.

DESPITE THESE MISGIVINGS, CASES (B), (C), (R) AND (S) ILLUSTRATED FIRM INTENTION TO USE GUARDIANSHIP IN WAYS WHICH ARE CLEARLY PROTECTIVE OF THE CLIENT, i.e. PROTECTION FROM UNHELPFUL AUTHORITY, FROM RELATIVES AND FROM CLIENTS' OWN SELF-DESTRUCTIVE BEHAVIOUR.

IN CASE (B): this old person was neglecting herself to the point of near starvation, and the authority of guardianship to provide protection could have been brought in to enable services to reach the client.

IN CASE (C): the sister of the client was said to be intruding on the client's affairs in an aggressive and unhelpful way. Guardianship could have been used to resist the sister's overtures.

IN CASE (R): the social worker felt the need to acquire additional authority in her dealings with the Court of Protection, and saw the protective aspect of guardianship in this light.

IN CASE (S): the position was that the intentions of the client's daughter were equivocal and the authority of guardianship thus contained an ambiguity: whereas it could have been instrumental in pursuing the daughter's apparent intent in removing her mother from her home, it could equally well have been used to protect the client from this very contingency. The case also illustrates the uncertainty in statutory guardianship about the role of relatives *vis-à-vis* the guardian.

Models Used as Basis for Further Interpretation of Findings

Substituted Judgement

The substituted judgement model of guardianship is seen primarily as the legal expression of surrogate advocacy. In this sense it is a 'service-in-itself' rather than being seen as access to, or the imposition of other services, and links to the idea of a person or agency speaking on behalf of the needs of the person. Some of the practical expressions of these concerns rest on the use of: Court of Protection; representation and agency; and (by implication) private guardians - particularly associated with the advocacy role - activities only indirectly related to functions of social services departments. Consequently relatively few questions in the empirical study were directed at testing views on these attributes and functions.

The basic concepts of protection, structure and continuity of care, together with the authority element, clearly apply to this model of guardianship and have been widely endorsed.

The issue of guardianship being seen as a means of recognising clients' needs, reasonably ascribable to a substituted judgement notion, [Result No. 6, page 246] received support from less than half the social workers, for reasons to do with the fact that social workers see themselves as having already achieved the task of ascertaining clients needs and giving appropriate recognition to them. To then suggest considering use of guardianship for this purpose could be seen as questioning social workers' effectiveness.

Pre-emptive use of guardianship [Findings Nos. 9/10, Page 246] also relates to the substituted judgement model, since this pre-supposes a situation in which the needs of clients can be anticipated, derived from information about their past and their likely needs while they were suffering from mental illness as well as when recovered from mental illness. Again, however, this received relatively little support, from only one-third of social workers. Similarly with the pre-emptive use of guardianship where the onset of dementia could be predicted, where nearly half of social workers expressed views against this. It is likely that this line of questioning provoked anxieties from a civil liberties point of view.

The high level of support for an advocacy view of guardianship (85%) [Result No. 29, page 253] appears substantial though the specifically surrogate nature of advocacy was not specified. It is conceivable that advocacy is a term which social workers would like to associate with guardianship though not altogether realistically. Also, the view was placed alongside a comparative statement about the advocacy role in social work, which received 100% support. There is, therefore, a sizeable minority of social workers who would see advocacy within social work but not within guardianship and this differentiation would clearly need to be attended to if guardianship was further extended in the future.

There is some scope for seeing the substituted judgement model of guardianship linked with guardianship functions provided by persons other than ASWs and this was tested in relation to: current social services department employees other than social workers; guardians outside social services; and guardians as family members. [Results Nos. 33/4/5, pages 255/6]. With reservations, these views were endorsed and linked with the advocacy question as regards the proposition that people outside social services could fulfil the guardians' role, where a substantial minority (41%) thought that non social services department employees would find the advocacy role easier within guardianship than would social services social workers. Given the notion that the substituted judgement model of guardianship is about the enhancement of civil rights rather than their denial, it is interesting to see that social workers were evenly divided as to whether guardianship represents an unacceptable infringement of civil liberties.

Conceivably, different attitudes to civil liberties and justifications for statutory intervention would have 'coloured' these responses - as distinct, for example, from direct experience of guardianship and its effect on clients.

The substituted judgement model of guardianship is also expressed in the services provided by the Court of Protection but guardianship of the estate was not a focus of this study. Other connections (i.e. representation, agency and appointees) go beyond a social services focus. Guardianship within the substituted judgement model is not seen as being subsumed within wider social work functions or other service provision aspects of the social services operation.

The Parent/Child Model of Guardianship - Surrogacy within Social Case Work

Within this model of guardianship, there is an analogy with parental functions and a comparison with quasi-parental functions within social work, concerned with basic care-taking and the enabling role.

The first area touching on the relevance of this model is the view of guardianship as a stabilising influence, clearly implying that the impact on the client is expected to be beneficial in reducing unpredictable and unhelpful actions by or towards the client in favour of greater equilibrium. A response of 82% social workers in favour of this guardianship characteristic may support these views [Result No. 7, page 245].

The main thrust of the model directs attention towards developmental aspects of facilitation and this gets some support from the findings with 60% of the social workers supporting the view that guardianship should facilitate change in growth in a general sense [Result No. 28, page 253]. When the nature of the change is more specific, results divided to show only modest support for emotional and psychological growth as an objective (from one third of social workers) while two-thirds of social workers thought that behavioural change was a reasonable expectation.

Differential use between varieties of clients [Result Nos. 14/15, page 248] fits well within the parent/child model of guardianship but was not particularly well supported, possibly because of the examples chosen. The researcher had anticipated that social workers would feel comfortable with the notion that guardianship was appropriate to protect the interests of clients suffering from depression as such clients are often unable to 'speak out' for themselves and fail to argue for their rights through lack of volition to do so.

Nevertheless, only one-third of social workers were sympathetic to this argument and only a similar proportion were prepared to support the idea that guardianship would serve the needs of people with 'compliant personalities'. Obviously, there was potential for 'mixed messages' in this question, as revealed during the actual interviews, where a number of social workers associated this with exploitation of people who were unlikely to question or resist having guardianship orders made out on them.

Some social workers nevertheless identified with the underlying view in the question that guardianship helped to protect people whose personalities predisposed them to exploitation by others. This model of guardianship lends itself to expressions of misgivings about adopting a surrogate role compared with much of social case work which might even actively avoid assuming this position. Consequently, it is appropriate here to link with findings indicating concern about guardianship as an abuse of authority, supported by 59% of social workers, and a view of 58% of social workers that guardianship gives rise to concern as an inappropriate assumption of responsibility for adults [Result Nos. 41/2, page 258].

CASE (S) PROVIDES A CLEAR, IF UNUSUAL, ILLUSTRATION OF POTENTIAL ABUSE OF AUTHORITY WITHIN GUARDIANSHIP. THIS CONTRASTS WITH CASES (A) AND (E) WHICH INVOLVE LEGITIMATE USE OF AUTHORITY.

IN CASE (S): the potential for abuse had the daughter been made the guardian of her mother is clearly illustrated, as the daughter's intentions were equivocal, and may have been directed towards removing her mother from the family home for reasons connected with the daughter's needs rather than her mother's.

IN CASE (A): use of authority would seem to be legitimate and related to the client's care needs in protecting the client from the intrusion of the mother and in prescribing an effective form of day care.

IN CASE (E): the head of the hostel already had *de facto* authority (as head of care) and it seemed reasonable on the face of it for this authority to be reinforced through guardianship in respect of an individual resident.

There are clear connections between social work values and objectives implicit in these results especially with those which justify the view that different standards of intervention and protection should apply towards children and adults, irrespective of their situations and capacities to look after themselves. Distinctive legislation and different priorities in organisation within social services, between child care services and adult services, reinforce the view that different values or objectives should apply. There is clearly no easy way of comparing the use of guardianship for children and guardianship for adults who suffer from mental illness.

The Therapeutic Welfare Model

This model of guardianship emphasises the imposition of services and is therefore particularly concerned with the effectiveness and enforceability of coercion towards the objective of removing the client from their problematic situation or making radical changes to the terms and conditions by which services are delivered.

The basic coercive element in guardianship could be seen to apply to 'holding' the client in a given situation long enough for therapeutic endeavours to be effective and this would logically lead to circumstances where occasionally physical containment or restraint of a client would be justified. The position in law is not completely clear on this but advice from the Department of Health tends to rule against such practical measures. Nevertheless, within the questionnaire, 60% of social workers were willing to see a role for containment and their own involvement in the physical restraint of a client under guardianship, which may indicate that social workers would be less sensitive to civil liberty concerns than with the prospect of making arrangements work, provided they think that these arrangements ultimately meet client's need.

Many of the questions within this area dwelt on the known association of guardianship with facilitation of residential placements, probing some concerns in this area. Most (70%) social workers are reconciled to guardianship being used for this purpose but less than half would see this as justifying clients' detention in residential care. Instead (perhaps) 78% of social workers looked to residential care situations to adapt their regimes to suit the requirements of people on guardianship [Results Nos. 24/5/6, page 252].

CASE (I) ILLUSTRATES A PLACEMENT OF A CLIENT UNDER GUARDIANSHIP INTO RESIDENTIAL CARE FROM HOSPITAL, WHILE CASES (M) AND (N) SHOW ATTEMPTS TO PLACE CLIENTS FROM THE COMMUNITY INTO OLD PEOPLE'S HOMES THROUGH GUARDIANSHIP - IN EACH CASE WITHOUT MANAGEMENT SUPPORT.

IN CASE (I): a person suffering from dementia required specialist care following a period in a psychiatric hospital. The progress of the case demonstrates that where clients lack volition, and specialist facilities are required, guardianship can legitimate the placement arrangements, provided the move is supported by management in social services and medical authority.

IN CASE (M): in contrast to Case I, there is a failure to gain management support for a residential care placement. Although social services management's sanction for this move would seem to be less likely than for a corresponding move from hospital to residential care, it is less clear as to the reasoning behind this.

IN CASE (N): authority was required to deal with conflicting pressures relating to the client's care needs. Conceivably the client could have been cared for at home but home care staff would not intervene without the client's consent. Consequently, social workers saw the only alternative as being residential care and the guardianship order as necessary to facilitate this. Again, lack of clear management sanction in this situation confuses the issues.

Use of guardianship to justify containment and physical restraint [Results Nos. 22/3, page 251] received moderate support from two thirds of social workers, perhaps surprising considering social workers' professional commitment toward preserving clients self-determination.

Less than half of social workers (48%) thought that the demand on social services resources would be a reason for not using guardianship [Result No.37, page 257] and social workers frequently stated in discussion that one could not disassociate the provision of services within guardianship and the setting aside of some resources to make these facilities available.

Finally, on the ethical aspects of this model, most (78%) social workers acknowledged that use of coercion was an aspect of concern in guardianship [Result No. 38, page 257]. On the other hand, the majority (70%) of social workers thought that guardianship contained insufficient powers judged by its potential role as an alternative to hospital [Result No. 39, page 257].

Compulsory treatment in the community is not part of guardianship as arrangements stand at the moment, but the therapeutic model of guardianship clearly contains the prospect of imposed therapy and therefore has to acknowledge that these questions are still very much of general concern. Looking at the findings, shows that the majority (74%) of social workers believe that a power to provide compulsory treatment in the community is needed, and most social workers look to 'special' guardianship to accommodate this arrangement. Very few, (15%), look to the possibility of providing compulsory treatment in the community outside the guardianship framework, which supports the notion that this model has direct relevance to many of the objectives which are of concern to social workers at the moment. [Result Nos.49/50, page 260].

The comparative and context definition of guardianship offered in Chapter II was intended to show that a wide range of statutory powers were available to social workers to facilitate care and service provision for clients with mental illness, and that it was assumed in this study that these powers would be known and available to social workers alongside the possibility of using statutory guardianship. No attempt was made in the

empirical part of the study to test this assumption, but it is deduced from the case studies that, with the exception of section 117 and Court of Protection, very few social workers were considering the use of wider statutory powers either as an alternative to, or alongside, statutory guardianship.

This finding is hardly surprising since social workers working with this care group are not inclined to see the use of legal powers as a means of developing client autonomy. They are more likely to anticipate the opposite effect and, instead, to rely on their own skills and the help of others, together with whatever volition the client can bring to the situation, to achieve satisfactory results in therapeutic terms. No empirical evidence is available to confirm or otherwise whether this approach is successful.

(2) SOCIAL WORKERS' VIEWS ON GUARDIANSHIP CLIENTS

This section discusses social workers' views on guardianship clients, illustrated from the selection of individual case profiles, commencing on page 300.

Specific Client Characteristics

In summary the evidence points to a decision by social workers to apply for guardianship as being associated with the following characteristics of clients:

Diagnostic Distinctions

Contrary to the picture conveyed by other studies, **people with schizophrenia** featured most often in guardianship consideration, usually linked to the 'downward spiral' of the care problem referred to below, namely that in-patient treatment for this group of people often appears to have a deteriorating long term effect on community care prospects. Also, help with maintaining these clients on medication is valued even if there is no strictly legal power to enforce this; and community nurses, for instance, maintaining clients with depot injections, appear to be better supported when faced with client reluctance if a guardianship order is in place. Decisions about how far and in what way to pursue a client who is determined not to receive depot injections remains an unresolved problem.

Clients with dementia pose particularly difficult problems and sometimes social workers are faced with a decision about guardianship which has been partly pre-empted by the involvement of the Court of Protection and/or particular family members seeking to ensure protection of family property. Decisions about the possibility of a guardianship working in tandem with the Court of Protection have been noted, and the ability of the social work guardian at least to pursue a meaningful dialogue with receivers, and involve family members, has often been influential.

IN CASE (G) ALL EVIDENCE POINTED TO A CONSTRUCTIVE LINK BETWEEN USE OF GUARDIANSHIP AND COURT OF PROTECTION TO PROVIDE A SAFE, SETTLED AND STABLE WAY OF LIFE FOR THIS WOMAN SUFFERING FROM DEMENTIA. ON THE OTHER HAND CASE (R) INTERESTINGLY SUGGESTS THAT SOCIAL SERVICES SHOULD ADOPT GUARDIANSHIP IN ORDER TO MAKE A STAND AGAINST THE COURT OF PROTECTION AND TO PROTECT A CLIENT FROM THE COURT.

Social Isolation

The absence of effective social support in the community was a frequently noted factor in influencing a guardianship decision, though instances were rare where the reasoning about guardianship involved a consideration of it providing a substitute family situation - either directly or indirectly - other than in a residential care placement. On the other hand, decisions to go ahead with intensive domiciliary care programmes, which required a level of access to a person's home, not normally acceptable without guardianship, could be seen as a form of family care; understandings arrived at about direct access to the home, resemble in some way the assumptions which family members make about each others' willingness to receive guests with minimal formality.

Other Demographic Factors

The aggregated data on guardianship clients provided by social workers indicates that, overall, decisions towards guardianship are biased towards women, most of whom are single, living alone, and experiencing a minimum of social support from a family or others.

Authority and Enhanced Care

Apart from decisions influenced by the need to place people in residential care, other decisions arose from a perceived need to impose authority or control, or to seek to achieve enhanced levels of care for a person.

A NUMBER OF CASES ILLUSTRATE GUARDIANSHIP BEING USED TO ACHIEVE AN ENHANCED LEVEL OF CARE, INCLUDING CASES (D), (T) AND (U).

IN CASE (D): the enhanced level of care required involves much closer supervision than is commonly offered, linked with a more assertive approach than is usually seen as desirable towards people with mental health problems. The justification for this within guardianship relates to demonstrations from experience that firm intervention actually counters the client's aggressive and anti-social actions, not least towards his own family.

IN CASE (T): the enhanced level of care refers specifically to a perceived obligation on the part of social services 'to provide continuing community care', an unusual concession given a general management resistance to accepting resource consequences of guardianship.

IN CASE (U): a new social worker saw her client's needs in more practical terms as requiring a degree of control over a hazardous lifestyle which, if continued, would immobilise the client entirely within his home, surrounded by the accumulation of every conceivable item and giving rise to a health hazard. Such clients require persistent monitoring and supervision which could be seen as generally intrusive for many clients but is possibly acceptable within a guardianship relationship.

Ethnicity

Clients from ethnic minority backgrounds are slightly more likely to have guardianship applications agreed by management, but not when their behaviour is as challenging as in Case D. (see overleaf)

CASE (D) SUGGESTS THAT UNUSUALLY AGGRESSIVE BEHAVIOUR IN THE COMMUNITY MIGHT BE BETTER HANDLED WITHIN GUARDIANSHIP FOR A CLIENT FROM AN ETHNIC MINORITY BACKGROUND, WHERE THE GUARDIAN IS IN A POSITION TO ACT AS INTERMEDIARY AND CREATE AN ATMOSPHERE OF UNDERSTANDING ABOUT THE CULTURAL ASPECTS OF THE CLIENT'S BEHAVIOUR.

Clients' Situations and Guardianship Use

A range of client situations prompted decisions by social workers to consider or apply for guardianship. The following were the most common patterns.

The Downward Spiral

For a number of clients the experience of hospital admission had left them progressively less well and less fitted to survive in the community on each occasion. Therefore, each discharge from hospital was more problematic and the risk that community care services would not be able to sustain the person and attempt to maintain or improve their lifestyle was greater. A number of social workers referred to the 'downward spiral' by which a client's situation and lifestyle tended to deteriorate with each successive period in hospital. This has given rise to a need for more intensive forms of community care, which clients sometimes resented and could actually avoid. This was frequently followed by some kind of case discussion (formal or otherwise) between social worker and other professionals involved to decide strategy.

One of the reasons given for prompting serious consideration of use of guardianship was recognition that persuasion (encouragement, cajolement or whatever) was itself insufficient to ensure that clients would accept help. In other words, normal practice methods had 'failed'.

Consequently decision-making in some instances was centred around the determination that future attempts at providing community care must not also 'fail' - i.e. become a failure both for the client and for the care team - since an accumulation of failures in this sense would have a compounding effect on reducing clients' prospects of survival. In

some instances the idea of using guardianship to prevent further failures unfortunately associated guardianship itself with the idea of failure and, for some social workers, a guardianship order pursued had signified to them a failure in, or demeaning of, the relationship between social worker and client.

A NUMBER OF CASES ILLUSTRATE TO VARYING DEGREES THE PRESENCE OF THE 'DOWNWARD SPIRAL' ELEMENT. CASE (O), IN PARTICULAR, PROVIDES CLEAR EVIDENCE OF THIS WHILST INDICATING THAT MANAGEMENT COULD NOT BE PERSUADED OF THE VALUE OF GUARDIANSHIP TO HALT THE PATTERN OF DECLINE.

Placement and Containment Needs

For other clients there was a clear need for professionals to know whether they could and/or should continue to exercise persuasion in terms of a care arrangement, usually residential but sometimes day or domicilliary, to attempt to ensure that the care package was supported by continued professional encouragement and backed up as much as possible by legal sanction. This mainly applied, as do most guardianship orders anyway, to placement in residential care and/or to sustaining that placement, enabling residential care staff, for example, to know that they have some additional rights in discouraging a resident from leaving the place of care. Day care was less often subject to these sorts of arrangement, though the accommodation of day and residential care in combination was often an additional factor. Domicilliary care, on the other hand, frequently involved one or more of the care team needing to know whether they had additional rights to pursue care into the client's home so that they could, for example, hold a front door key and thereby gain access on an as-and-when basis to pursue cleaning work or simply to supervise the client.

It should be added that all the above arrangements had, as far as possible, been negotiated with the client even though at the end of the day a client may have expressed a preference for some other form of surveillance. Enabling home care staff to enter a house to undertake cleaning work was frequently mentioned as an influential factor towards making a guardianship decision since continued neglect of person and/or home

was one of the most commonly indicated problems, which often left care staff feeling unable to be effective in caring and, in some cases, in saving life, simply because they were unsure of whether they had sufficient legal sanction to pursue the client further.

CASE ILLUSTRATIONS OF PLACEMENT INTO RESIDENTIAL CARE HAVE ALREADY BEEN PROVIDED IN THE EXAMPLE OF CASE (E), GUARDIANSHIP WAS SEEN AS REINFORCING EXISTING AUTHORITY TO CONTAIN A CLIENT IN RESIDENTIAL CARE WHILE CASE (N) SUGGESTS THAT HOME CARE MANAGEMENT IN A SOCIAL SERVICES DEPARTMENT CAN BE AS RESISTANT AS THEIR COUNTERPARTS IN RESIDENTIAL CARE WHEN BEING ASKED TO AGREE TO IMPOSE SERVICES ON A CLIENT.

A minority situation faced some social workers in residential care arrangements which appeared to be on the verge of breakdown because the head of the residential unit felt insufficiently empowered to apply constraints to the client to prevent a pattern of absconding. This was the origin of the notion of guardianship to reinforce authority, where the assumption would be that a head of unit working in tandem with a legally appointed guardian could have his or her authority reinforced. This idea did not gain great favour but applied adequately in certain particular circumstances described to the researcher. More frequently, guardianship was decided upon as legitimisation for a residential care placement, sometimes against the wishes of the residential care staff. In these situations, social workers were having to decide not only in terms of the needs of the client but also in those of the 'needs' of residential care staff to avoid being seen as imposing what was, in their view, unacceptable levels of coercion or direction.

Need to Re-negotiate Terms of Service Delivery

A common denominator of influence affecting social workers' decision-making, was a consensus emerging from discussion with other professionals that renegotiation of the terms on which a client should be cared for and treated in the community was necessary. Whether or not this arose from pressure from a particular source, such as an individual consultant psychiatrist, there was often the idea of consensus arrived at by common

appreciation of the difficulties of sustaining the client in the community and an agreement that some drastic new thinking was necessary, even if this did of necessity have to put to one side the client's expressed wishes. Sometimes clients' wishes were in conflict with each other, and guardianship could be used to support what appeared to be the most cherished against a lesser wish.

IN AN EXAMPLE CONSIDERED DURING THE PILOT STUDY, THE CLIENT RESENTED HOME CARE STAFF ENTERING AND DOING WORK IN HER HOME. EVEN MORE SO SHE RESENTED THE IDEA OF HAVING TO BE REMOVED FROM HER (VERY NEGLECTED) HOUSE AND TO ENTER HOSPITAL TO DEAL WITH NECESSARY PHYSICAL HEALTH CHECKS AND MAINTENANCE. THE GUARDIANSHIP ARRANGEMENT EFFECTIVELY IMPOSED A HOME CARE SOLUTION ON THE CLIENT THEREBY PREVENTING HER NEED TO ENTER HOSPITAL, RELYING ON THE ORDER TO GAIN AND TO FACILITATE ACCESS TO THE CLIENT'S HOME ON A SEMI-PERMANENT TWENTY-FOUR HOUR BASIS

Views of Management

A fairly passive, if not acquiescent, reaction by social workers to management views was notable since, for many social workers, the decision in favour of guardianship could not be sustained without management support while they, on the other hand, lacked the experience of guardianship to be able to justify their views to managers.

IN CASE (K): the difficulties of providing adequate supervision for people with drug problems and unsettled lifestyles are fairly obvious, and the social worker wanted positive sanction from management to use guardianship to create structure and boundaries for the client. This was not forthcoming.

IN CASE (A): the social worker felt that guardianship could be used to support more positive aspects of the client's lifestyle and help provide occupation and social contact. However, management failed to support the social worker's request for sanction and seemed (from the social worker's view) to put departmental procedures forward as an obstruction.

IN CASES (A), (B), (M) and (N): (discussed in previous sections): there were also varying degrees of management ambivalence towards supporting suggestions for guardianship.

Occasionally it was management who argued for guardianship to be considered and/or pursued when, for example, consultant psychiatrists exerted pressure on senior management in social services for some action to be taken and social services management translated this request for action into guardianship as a formal intervention.

IN CONTRAST TO CASE (K), CASES (P) AND (T) ILLUSTRATE THE WILLINGNESS OF MANAGEMENT TO INTERCONNECT GUARDIANSHIP WITH USE OF STATUTORY AFTERCARE (SECTION 117), WHILE CASE (F) SHOWS THE INFLUENCE OF AN OUTSIDE BODY, THE MENTAL HEALTH REVIEW TRIBUNAL, ON A PREVIOUS MANAGEMENT DECISION AGAINST THE USE OF GUARDIANSHIP.

IN CASE (K): the client's manifestly heavy and demanding care needs were seen as justifying both the Section 117 after-care plan and the guardianship measure in tandem.

IN CASE (F): the Mental Health Review Tribunal intervened in this case to recommend that guardianship should be used 'to provide some boundaries and a plan of care' for a woman of unstable social circumstances who had also some responsibility for care of her husband. The reluctance of social services management to see this case as a prospect for after-care is notable and a long-term hospital treatment order had been sought by social services as an alternative. The guardianship arrangement appeared to be working well.

CHAPTER VI

CONCLUSIONS

This chapter is divided into the following sections:

- RE-APPRAISAL OF, AND SYNOPSES OF ANSWERS TO:
 - RESEARCH QUESTION 1: SOCIAL WORKERS' VIEWS
 - RESEARCH QUESTION 2: WHICH CASES SOCIAL WORKERS CHOOSE
- OVERALL CONCLUSIONS:
 - THE SITUATION FACED BY SOCIAL WORKERS
 - MAIN DIFFERENCES BETWEEN THE AGENCIES
 - SOCIAL WORKERS' VIEWS OF MANAGEMENT
 - THE POSITION OF SOCIAL SERVICES DEPARTMENTS AND OTHER AGENCIES
 - CIVIL RIGHTS AND CHOICE
 - CONSENT TO TREATMENT
 - QUANTITY OF GUARDIANSHIP USE
 - RESOURCE ALLOCATION AND CARE MANAGEMENT
 - 'VERDICT' ON GUARDIANSHIP.

THE RESEARCH QUESTIONS

Before looking again at the research questions in turn, some assessment is required as to whether the questions have been adequately addressed: has the data obtained from social workers through questionnaires and interviews given an accurate picture of social workers' perspectives on guardianship and their decisions about individual cases; and, what were the main limitations in the survey methodology?

'What are Social Workers' Views of Guardianship?'

Material provided by social workers in answer to this question is judged to have given as full a picture as could have been obtained within the limits of the resources and the methods available. The limitation would seem to be that most of the questions were

pitched at a general level and did not provide as many bridges with social workers' own cases as had been hoped for. In other words, a gap existed between social workers' views of guardianship in general and the way in which their thinking related to individual cases. The 'Interpretation of Findings' section at the conclusion of the previous chapter has attempted to make connections in an overall sense, necessitating some conjecture and surmise which cannot fully compensate for understanding the direct bearing of attitudes on decisions or actions taken.

Given these limitations, the research question is judged to have obtained the data sought, and the research question is now answered so far as this data will allow. In so doing, this provides us with a social workers' perspective 'definition' of guardianship, which is then compared with other definitions considered in Chapter II. This synopsis is drawn from data outlined in Part Two, Sections 1, 2, 3 and 4 and the Interpretation of Findings sections of the previous chapter.

This question was addressed by considering: social workers' perspectives on key guardianship concepts; comparison of guardianship with social work; and identification of social workers' main problem areas within guardianship and possibilities for further development.

The overall findings constituted an endorsement of the most important guardianship concepts - structure, continuity, consistency - and tended to confirm that other attributes - protective care, authority and, most important of all, surrogacy, especially expressed as advocacy, were best described as essential guardianship elements, rather than contingent aspects which might vary from situation to situation.

Social workers see the objective of guardianship 'use' as assisting in caring and providing services for clients. It is accepted as a means of achieving change in clients' social situations. The three components of the 'essential powers' are endorsed but containment and physical restraint are also accepted as part of guardianship. Generally, placement in residential care through guardianship is not seen as problematic provided clients are not detained by physical force.

Social workers see the similarities and differences between guardianship and social work along four selected indicators, as follows:

Basic Care-taking: as being more part of guardianship than social work;

Enabling: as being more within social work than guardianship;

Advocacy: as being more associated with social work than with guardianship;

Surrogacy: was associated with guardianship by all social workers, but was only associated with social work by a third of social workers.

Incompatibility between social work and guardianship because of the surrogacy factor was felt by just over a half of social workers who see the clearest distinction between guardianship and social work as mainly revolving round this issue. A dislike of exercising surrogacy within social work may be one of the factors which limits the extent of the effectiveness of 'informal guardianship'. On the other hand, social workers saw the need to legitimise the use of surrogacy and saw formal guardianship as effectively embodying this. This, however, did not make them more ready to use guardianship since they could not turn their backs on their social work principles whilst acting in this role. The real decision was not between guardianship and social work, but between 'guardian social work' and 'non-guardian social work'.

Social workers' were not set against use of coercion *per se*, though this was seldom of the kind which envisaged physical force. Instead, social workers explained that guardianship has been used to 'renegotiate' the terms by which they made services available to clients, whether or not the client actively sought them or would have chosen them on his/her own volition. Short of physical force, some social workers were prepared to use restraint, for example to contain someone in residential care who would otherwise leave against their own best interests. On the other hand, social workers were unhappy about using guardianship pre-emptively, i.e., where circumstances might be expected to change, as with a client showing early signs of dementia.

Social workers see guardianship as needing to change to fit into current concepts of care for certain groups of mentally ill people in the community. They considered that the power to arrange compulsory treatment in the community is necessary for some clients and that this should be provided within the guardianship framework rather than outside it. Alongside this they saw the need for guardianship to move towards a more individualised pattern where the particular needs of clients would be recognised at the assessment stage, thereby possibly leading to some form of limited guardianship which extended only to the specific powers needed for that client. In this way the extent of coercion would be limited to the client's particular situation and would amount to a re-negotiation of the basis upon which services are provided to clients.

Social Workers' Perspectives Compared with Other Definitions

Social workers clearly recognise guardianship as a social institution, and as a much wider concept than a term used to describe actions taken under Sections 7/8 of the Mental Health Act, 1983, i.e. the **statutory definition**. Implementation of these sections of the Act does not necessitate an appreciation of the range of core concepts or of different models of guardianship. In fact no theoretical or conceptual underpinning of the idea of guardianship has been found in the official literature and very little elsewhere, as applied to the situation in England and Wales. Most of the concepts examined during the empirical work were derived from making a series of assumptions, based on concepts discussed in the American literature, about ideas of good practice in meeting the needs of people with mental illness and about the historical view of guardianship.

Social workers seemed to have little information on the origins of guardianship or appreciation of a **historical definition**. Although historical knowledge was not sought from social workers in this research, it would seem that most social workers would date the origin of statutory guardianship from the 1959 Act, or even, possibly the 1983 Act. Social workers have tended to see the institution of guardianship for people with mental illness as having no historical roots beyond proposals put forward in the Royal Commission Report, whereas the historical chapter in this paper has hopefully established a connection between forms of guardianship evolved within the Patria Potesta ideology

of Roman culture, and guardianship which has survived in various forms to the present day, linked by the idea of the Crown as ultimate trustee of people with mental illness - a 'guardian of guardians'.

Generally, social workers' experience supports the **process definition** point that changes in clients' circumstances and attitudes arising from guardianship are likely to be gradual rather than immediate, linked with the time taken to undertake fundamental re-negotiations in the basis for social worker-client relationships.

Most social workers seemed to have a limited appreciation of the **service-providing context definition of guardianship** as related to a range of statutory obligations of local authority social services departments towards people with mental illness.

Main Differences Between the Two Social Services Departments

Social workers' attitudes to Guardianship differ between the agencies mainly as follows:

Main Guardianship Concepts

There was less support for continuity in Westminster.

Guardianship and Surrogacy

The link between guardianship and surrogacy as substituted judgement was less acceptable in Westminster while the pre-emptive implication of surrogacy received less backing in Kensington and Chelsea.

Guardianship Objectives

Kensington and Chelsea social workers found it more reasonable to view guardianship as a formalised relationship which would facilitate change in clients.

Differential Use

Westminster social workers were less enthusiastic in seeing guardianship as applicable to socially vulnerable clients or as providing enforceable authority for particular purposes to do with meeting clients' needs.

Essential Powers

The use of guardianship to gain access to a client at his/her home or to require a client's attendance (e.g. at a day centre) was well accepted in Kensington and Chelsea but not so in Westminster.

Containment and Restraint

Westminster social workers said they would be much more ready to resort to physical restraint when necessary within guardianship than their Kensington and Chelsea counterparts.

Social Work and Guardianship

Westminster social workers were more ready to see an enabling role for guardianship but these social workers were also more disposed to see guardianship as incompatible with good professional social work practice, while yet being more inclined to describe some social work as akin to informal guardianship. Westminster social workers were also more disposed to accept non-ASWs (within the agency) as guardians.

Future Prospects/Problems

Kensington and Chelsea favoured more use of guardianship, seeing it as involving a package-of-care claim on the agency's resources. However, they acknowledged a problem with guardianship and civil liberties, while declining to support the view that guardianship powers should remain unchanged. No Westminster social worker supported

the view that residential powers should be curtailed, but these social workers were much more reluctant to define guardianship as implying a package-of-care commitment by the agency.

'Which clients do social workers select for Guardianship?'

This question was difficult to answer in a number of ways. Given the fact that Category [1] clients had been subject to applications by social workers as needing guardianship, the researcher initially viewed all cases as having been 'chosen' (i.e. selected) as suitably and appropriately placed on guardianship. However, experience showed that it was not clear in practice which Category [1] cases would have been chosen by social workers had they been able to decide and act autonomously. Although some undoubtedly would have done, it was concluded that other cases represented a management decision which had reached that stage because of other pressures (e.g. medical views) over and above those of social workers' recommendations. However, to have eliminated these cases from the survey would have had the effect of losing the opportunity to compare these groups of cases as representing two sets of choices, i.e. Category [1] being managers' choices and Category [2] cases as social workers' choices. By the expediency of retaining these two groupings the data could therefore be compared and tests for association carried out.

Before proceeding to make this comparison, it was noted that there was an imbalance of the proportions of clients in Categories [1] and [2] between the two social services departments. Category [2] clients form 86.5 % of the total in Kensington and Chelsea but only 41.2% in Westminster, compared with an overall percentage of Category [2] clients of 68.3%. The null hypothesis would be that there was no significant difference between the agencies in the relationship between Category [1] and Category [2] clients. Table 147 on the next page shows that the difference is significant at the .01 level and the hypothesis can therefore be rejected. This result would appear to confirm a closer connection between social workers' recommendations and management acceptance of recommendations in Westminster compared with Kensington and Chelsea and could indicate a different relationship between the two categories in terms of the decision-making systems in the two social services departments.

Category Status Groups and The Two Agencies

Table No 149

	K & C	W'min	Row Totals
Category Group [1] Cases	3	10	13
Category Group [2] Cases	21	7	28
Column Totals	24	17	41

Chi-Square Value = 9.862 p = .002

Yates' Correction Value = 7.838 p = .005

Significant at the .01 level

Minimum Expected Frequency = 5.4

Given these difficulties, the research question is answered in two ways: (1) by giving an overall synopsis of all cases; and (2) by focusing on Category [2] as distinguished from Category [1] cases. Had this latter distinction been unproblematic (i.e. having achieved parity of meaning between the two agencies) greater attention to Category [2] client data would have been justified - i.e. more statistical analyses comparing variables on all dimensions provided by the data on this smaller number of clients.

Overall Synopsis (All Cases)

Demographic Picture

Data on age of clients showed older groups, (i.e. 61+, but particularly 81+), as predominant and as forming a larger proportion of the sample than in findings from research elsewhere which has compared all clients assessed under the Act.* The proportions of guardianship clients under 50 are much higher in Westminster, while proportions of clients over 80 are much higher in Kensington and Chelsea.

* Other research on Guardianship has been identified in Chapter V and is summarised and referenced in Appendix A.

The balance of gender differences overall were very similar, but the proportion of single clients was three times greater in this research than in comparable studies.

The ethnic make-up of guardianship clients is similar to that found in other studies. There are proportionately fewer guardianship clients from an ethnic minority background in Kensington and Chelsea.

Living Arrangements and Family Support

Most guardianship clients live alone and only a half obtain other than a 'negligible' level of family support. For only one in ten is family support judged to be substantial. A higher proportion of Kensington and Chelsea clients live alone.

Medical Background

A half of guardianship clients suffer from schizophrenia and a third suffer from dementia. The proportions of guardianship clients suffering from schizophrenia is 2:1 in Westminster compared with 1:2 in Kensington and Chelsea. Those with dementia are mainly found in Kensington and Chelsea: proportionately 16:1 compared with 50:50 in Westminster.

Six out of ten guardianship clients have experienced one or more compulsory hospital admission and three out of ten have had one or more voluntary admission. Kensington and Chelsea show lower proportions of both groups - less than four out of ten compulsory and less than two out of ten voluntary admissions - mainly because of the number of dementia sufferers with no psychiatric history. Only one in seven Westminster clients have had no compulsory admissions; a half had had no voluntary admissions.

Medical opinion was an influential factor in determining whether or not guardianship was pursued in six out of every ten cases, and in two-thirds of these the medical opinion expressed favoured guardianship. In Kensington and Chelsea medical opinion was

influential in half the cases and half of these favoured guardianship. In Westminster three out of four cases were medically influenced and the same proportion favoured Guardianship.

Social Work and Guardianship Objectives

Insufficiency of persuasion (to accept help) was the main reason prompting guardianship consideration. This was nearly three times as frequently reported in Kensington and Chelsea than in Westminster.

Regarding guardianship objectives defined in terms of client-focused needs, as between authority/control or enhanced care, these were evenly balanced in Kensington and Chelsea but the former predominated in Westminster. Overall, authority/control was a more frequent objective of guardianship than enhanced levels of care by about 5:4 and residential service provision was an objective in six out of ten cases. Day care attendance and arranging attendance for treatment was an issue for three or four clients.

In terms of service provision objectives, residential placement was the main purpose in Kensington and Chelsea, whereas regularisation of existing residential placements formed a significant proportion of objectives for Westminster clients.

There was marginally more optimism as to the achievability of guardianship objectives in Westminster.

Profile of Category [2] Clients Compared with Category [1] Clients

Demographic Picture

Comparing clients in Category [2] (n=28) with clients in Category [1] (n=13) shows that social workers choose proportionately three times more young (0-30) and old (80 plus) clients and three times fewer from the 31-40 age group. All of the nine 80+ clients come from Kensington and Chelsea and eight of these were suffering from dementia.

Social workers choose larger proportions of married and widowed/widower clients; and slightly fewer clients from ethnic minority backgrounds. There was no notable gender difference.

Living Arrangements and Family Support

Social workers tend to choose more guardianship clients from those who live alone and fewer from those who are in residential care. Social workers choose more clients where family support is reasonably close and proportionately fewer clients experiencing a limited or negligible amount of family support.

Medical Background

Social workers choose more clients suffering from dementia, though the proportionately large numbers of such clients mainly represented the view of two specialist social workers in Kensington and Chelsea.

Social workers choose a much larger proportion of clients who have not experienced compulsory hospital admissions. No difference in the balance of clients who had voluntary admissions to hospital was noted.

Medical influence one way or the other had a bearing on a proposal to adopt guardianship in half of the cases social workers had selected, a much smaller proportion than those in Category [1]. For those cases in which a medical opinion was expressed there was a 7:5 balance in favour of Guardianship for Category [2] cases, whereas for Category [1] clients, all medical opinion was in favour.

Social Work and Guardianship Objectives

The reason given for social work intervention alone not adequately meeting clients' needs is that persuasion (e.g. to accept services) was insufficient. This applied in two out of three cases chosen by social workers, compared with one out of three Category [1] clients.

Social workers choose guardianship clients who require both authority/control and enhanced care in equal measure while for clients chosen in Category [1], authority/control is the main factor.

Social workers are more inclined to seek guardianship as a means of facilitating the placement of clients into residential care where the client is unwilling or in no position to consent. There is also a slight tendency for social workers to seek guardianship as a means of enabling clients to be required to attend for medical treatment. Conversely, social workers are less likely to see guardianship as a means of regularising an existing residential care arrangement.

Social workers have a low expectation of the achievability or realisability of guardianship objectives for individual clients. It is not clear whether their pessimism stems from the poor prognosis of their clients, or whether there is a link here between assessment of social workers' clients' needs and uncertain prospects of obtaining management endorsement.

Overview of Distinctive Characteristics of Clients Chosen for Guardianship by Social Workers

The distinctive feature of social workers' choice for guardianship is that they look mainly at the needs of a comparatively large group of elderly people, living on their own at home suffering from various stages of senile dementia. They look to guardianship to facilitate a residential placement where consent to enter residential care from the client cannot be obtained. This particularly fits the profile of social workers' choice for guardianship in Kensington and Chelsea.

Of the remaining clients there are two main groups. Firstly there is a younger group, aged 18 to 43, which comprise four from each agency. Six of this group suffer from schizophrenia and two from manic depressive psychosis.

The second group are older (57 - 80), and five suffer from schizophrenia and two from dementia. The schizophrenic clients comprise three from Kensington and Chelsea, and two from Westminster. Both clients with dementia come from Kensington and Chelsea.

For the majority of clients, residential care is social workers' first concern (mainly to instigate a placement rather than to regularise an existing placement) usually in the face of persuasion to enter or remain in care proving inadequate within normal social work strategies. However, there are four clients for whom continuing treatment is the main issue, e.g. attendance at out patient clinics, three of whom are suffering from schizophrenia and one from manic depression. After 'Insufficiency of Persuasion', the second most common problem in pursuing social work strategies was the excessive amount of supervision time which the client was requiring.

The overall findings about the level of family support probably relates to the fact that although most elderly clients with dementia experience very low levels of family support, other groups were (in some instances) experiencing too much family involvement of an unhelpful kind.

The explanation around the preference for clients who have not had many compulsory hospital admissions seems to be towards a view of guardianship as preventive - particularly for the younger people with schizophrenia or with manic depression - and it could also be said that social workers see guardianship here as a way of obtaining more formalised care, i.e. the balance between authority/control and enhanced care, rather than being an alternative form of coercion. 'Insufficiency of Persuasion', seen as a 'bottom line' problem with existing social work strategies, might tend to support this view.

The above conclusions are consistent with a number of trends emerging from the review of individual cases from the preceding chapter, of which the principle are discussed below.

There was a need to renegotiate the basis of service delivery upon the failure of social work strategy. In other words, guardianship was seen as a watershed marking a change in the 'ground rules' from being a situation of prerequisite consent to one where the client can be confronted with formal requirements. For the most part this was not a confrontation arising from frustration but a recognition of the limitations both of the client's capacity to engage with the social worker and of the social worker's abilities to provide the right kind of service without such engagement.

Conceivably, the 'downward spiral' of well-being of clients noted from earlier discussion may also be related to the assessment that persuasion (i.e. encouragement or exhortation) by social workers directed towards clients who have particular needs tends to fail as clients move away from the structured authority base of institutional care. For those who have not experienced institutional care, either as compulsory or voluntary patients, the 'downward spiral' possibly relates more to the communication problems, reinforced by suspicion and uncertainty, on the part of older people living on their own, some of whom will become progressively less certain of the identities of those who try to make contact with them. This was the situation illustrated in the case of 'Gladys Holmes' discussed in Appendix C.

Not surprisingly, social workers were more likely to pursue guardianship (i.e. seek management endorsement) when under pressure to do so, and such pressures came from medical colleagues and to a much lesser extent their own management. Least likely to exercise pressure were the clients or the clients' relatives, though some individual clients' behaviour was interpreted by some social workers as tantamount to a request to be placed on guardianship.

There was a tendency for management to be more likely to adopt guardianships for clients from ethnic minority backgrounds, from those with the largest number of compulsory hospital admissions and where there was strong medical backing.

OVERVIEW OF SITUATION FACED BY SOCIAL WORKERS

Social workers have the task of caring for a group of mentally ill people in the community who pose very severe problems of behaviour, including self-neglect and unwillingness to accept services. This research has confirmed that social workers are faced with intractable care problems, and the clients they serve are often those with whom no other agency, including hospital services, have been able to achieve good results. It is therefore left to the community services to try to prevent a worse situation of deterioration and decline setting in and, if possible, to take preventive action. Reluctant as social workers are to use guardianship pre-emptively, they would seem to conclude eventually that some statutory intervention would at least convince other parties that there was determination to avoid

continued crises and possibly eventual tragedy. Guardianship is sometimes seen as a 'last resort' option to ensure that some care services reach the client.

Clearly some social workers see the need for an enhanced level of care for certain clients and realise that this degree of prioritisation of care and possibly service provision, does not occur of its own accord given the way resources are allocated in social services departments. Even though the 1960 Memorandum of Guidance explicitly disclaims a connection between guardianship and entitlement to service, social workers see that guardianship does usually contain a message of the need for such prioritisation. The onus for the recognition of need then goes back onto management.

This study has clearly indicated that social workers are not free agents, nor even necessarily the key actors, in deciding for or against guardianship for individual clients. There are a number of other parties, including social services managers and health service colleagues, who carry substantial influence and can, in effect, veto social workers' (pro or con) proposals. Social workers are therefore seen as not being fully 'empowered' to carry through the guardianship process from the initial phase (seeing the need) to the final phase (formally deciding), thereby allowing guardianship to come into force. Some social workers said that consultant psychiatrists are particularly unrealistic in their expectations that guardianship will help clients, but that they give way to these pressures in order to maintain good relationships and to avoid being seen as obstructive.

OVERALL SUMMARY OF DIFFERENCES BETWEEN THE AGENCIES

A different culture and management attitude prevailed in the two authorities: social workers in Westminster see guardianship as a pragmatic measure for dealing with particular problems of schizophrenic and other socially vulnerable clients: whereas Kensington and Chelsea social workers are more traditionally minded in linking the guardianship idea with the needs of people suffering from dementia. Kensington and Chelsea social workers seem to be more idealistic about guardianship, e.g. in its ability to ensure continuity of care.

Social workers' attitudes to guardianship in general and their views of individual cases is linked to different expectations from management in the two authorities. There is greater pressure from medical sources in Westminster to support guardianship submissions.

Management in Westminster are much more likely to support their social workers when guardianship is sought. Reluctance of management to underwrite the resource consequences of guardianship in Kensington and Chelsea may explain why this agency's social workers saw this as a key issue.

SOCIAL WORKERS' VIEWS OF MANAGEMENT

Many social workers felt that their managers were poorly briefed on the nature of guardianship, and that both procedural and practice guidance documents made available to them from social services senior management were usually conspicuous either by their absence or by their generally unhelpful tone. Social workers thought that the procedures were unduly lengthy and would inevitably result in much work on their own part which would not be rewarded by social services management endorsement. There was also the anxiety from social workers as to whether their colleagues working with this care group in residential care would be ready to accept clients on guardianship, since some evidence pointed to serious misgivings among residential social workers as to the ethics of containing a person in residential care when they were not clearly consenting to being there.

Social workers detected a management attitude which, at best, could be described as ambivalent, and which on some occasions was plainly obstructive and intended to discourage social workers from seriously considering guardianship. This in turn reflected on social workers' own concept of guardianship, tending to make them see it as an awkward anachronism which has not been properly integrated into current social services priorities and policies.

Social services management seem unclear about the nature of the responsibility they were assuming and as to whether the authority as a whole was endorsing the surrogate role for guardians. They were not clear whether a director of social services signing a

guardianship application was in effect delegating surrogate powers to individual social workers. More importantly, it was not clear to social workers whether social services management were underwriting the wider implications of guardianship, including the resource aspects.

Although it was acknowledged that all clients with long-term mental illness problems in the community demand resources, it was felt that for guardianship to have credibility, there must be some acceptance of prioritised need for guardianship clients as against others, and it was therefore an implied obligation on behalf of management to make such services available. For the most part, social services management did not see themselves in this role and this undoubtedly confused social workers about the realistic expectations from guardianship.

THE POSITION OF SOCIAL SERVICES DEPARTMENTS AND OTHER AGENCIES

Inevitably, the focus of the survey tended to see social workers' decision-making as central to guardianship usage, even allowing for some inhospitable elements in social workers' work situations. However, enough has been said about the position of social services and social workers' views of management to indicate that this is, at best, only part of the picture.

The position of social services in general and social services management in particular is seen as generally equivocal so far as guardianship is concerned. Directors of social services have few incentives, and a number of disincentives, for accepting social workers' recommendations in favour of taking on the guardianship mantle. There are few reasons why directors of social services would wish to oversee the task of developing a level of understanding, awareness and practice skills within their agencies to be able to treat applications for guardianship entirely on their merits - though no doubt some directors of social services are conscientiously endeavouring to do this.

It is doubtful on this evidence whether local authority social services departments are the best organisational milieu for taking guardianship responsibilities - unless fundamental

changes occur in the way responsibility for this care group is defined by statutory agencies. The present move towards reinforcing community care and its various component parts as the 'all-purpose' solution to the care of people with mental illness, alongside those with learning disability, and physical handicap as well as elderly people, may be insufficient to place guardianship high enough on the agenda of social services management to gain it sufficient attention, and thereby to develop the necessary resources and skills.

CIVIL RIGHTS AND CHOICE

Social workers are influenced by concern to maintain civil liberties for people with mental illness and are clearly reluctant to give them a status of limited civil rights. Where civil rights have to be curtailed, some social workers acknowledge the quid pro quo argument that in exchange for loss of liberty, clients' care needs will be better met. Clearly, however, this cannot happen unless social services underwrite the resource requirements of guardianship clients as part of an agreed policy.

Social workers do not see guardianship as a crude way of eliminating the possibility of clients making harmful or misguided choices but instead as a means to provide a basis for renegotiating the balance of choices and wishes between the client and those acting for him/her. None of the case studies outlined in the survey portray a situation of continued oppressive coercion on the part of social workers towards clients with mental illness. Social workers would seem to be much more concerned with what cannot be achieved to help their clients through guardianship than whether powers can effectively and continuously be imposed. Conversely, there is nothing inherently contradictory about clients wishing for guardianship to be imposed in much the same way as donors have to agree in advance to an Enduring Power of Attorney coming into force at such time as they become incapable of managing their own affairs. From a civil rights point of view, clients should arguably have some say at least in deciding for or against guardianship. Such implied rights are presently unavailable to clients since their wishes can only be taken into account if the eligibility criteria for guardianship apply in the first place - i.e. need for protection and welfare within the definition of mental disorder.

Not only are clients' rights to 'opt-in' to guardianship limited, but the rights of carers are even more restricted. Older parents of a mentally ill person, concerned about how care, supervision and support would be made available to their offspring when they are no longer able to provide it, find that no mechanisms exist for their wishes to be translated into an application for guardianship which could be considered on a contingency basis.

In short, this research has not supported a view of guardianship as inherently restrictive of client freedom or a denial of choice - though the possibilities of clients or clients' families opting for guardianship are clearly limited.

CONSENT TO TREATMENT IN THE COMMUNITY

Endorsement from the survey for a power to provide compulsory treatment in the community could be regarded as one indicator of the need for wider powers, although social workers were not generally looking for additional powers for the clients which were included in the survey.

The debate as to whether the Royal Prerogative Powers can be reintroduced to supplement existing legislation for the care of people with mental illness, suggests that this is a conceivable possibility where the Mental Health Act, 1983, is silent on particular powers to meet the needs of clients. It is possible that guardianship, in tandem with Royal Prerogative Powers and use of committee, could extend the range of enforceable authority exercisable by social workers in pursuing their tasks.

By these means, it is arguable, the main limitations of guardianship could be overcome - especially as regards consent to treatment and powers to convey and to detain people in certain places when their care needs would suggest that this is appropriate. These issues will assume greater importance as hospital facilities able to fulfil this role diminish.

This researcher considers that compulsory measures within guardianship carry different meanings and justifications than when the protective individual care accountability and trust that Guardianship implies is absent. From this it would follow that concerns

about net-widening and extension of social control may be unjustified where guardianship safe-guards are operating.

QUANTITY OF GUARDIANSHIP USE

Management culture in social services departments appears to be inhospitable to guardianship and suggestions of 'under use' would seem almost certainly to arise from this. Clients recommended by social workers but not accepted by managers (approximately two out of three in this research) are seen, in the absence of contrary evidence, to have been deprived of benefits. Because responsibility for determining the quantity of guardianship use is a matter for social services management, it is difficult to assess whether any given level is sufficient to meet clients' needs. Gains from guardianship, which would have been available to some clients had guardianship been pursued by social workers or supported by management, appear to be substantial. On the other hand, given that much of what social workers do with this care group could be described as informal guardianship, some of the aims of guardianship could be achieved without resort to statutory measures, and therefore (usually) without the need for senior management endorsement.

The idea of guardianship providing an enhanced level of care and prioritisation of services for guardianship clients is by no means universally accepted among social services departments, and gains for guardianship clients cannot be assumed unless other conditions apply. For instance, guardianship clients could conditionally be expected to be placed in an advantageous position on two grounds:

1. There is an expectation of continuous individual care from a social worker, in contrast to inconsistencies and changes often experienced by people with mental illness on the receiving end of care from social services departments. However, even this 'guarantee' is of uncertain value if guardian social workers change at least as often as other social workers in their agencies, giving rise to exactly the level of discontinuity which guardianship would seek to avoid.

2. Access to appropriate facilities at the right time could be an assured by-product of the implementation of a guardianship order, provided (a) the agency takes this responsibility seriously; and (b) that management accept that some of their other clients may, for the time being at least, be put under a disadvantage in gaining access to services through providing such assurances for guardianship clients.

The continuing trend of increasing numbers of guardianships for people with mental illness compared with other groups of clients (as evidenced by the statistics in Appendix B) of itself gives no indication of whether an optimum level is being achieved or how long it might take to reach that level.

RESOURCE ALLOCATION AND CARE MANAGEMENT

Perhaps the most contentious area of the wider discussion - the resource consequences of guardianship - has been shown to be something of a 'red herring'. All forms of care and treatment for people with mental illness are resource intensive, and one has therefore to ask whether guardianship is inherently excessive in this respect. If the alternative is long and frequent periods of hospital care, the answer may be 'no'. On the other hand, all community support systems which seriously claim to provide an alternative to hospital care have been shown to be far more expensive than anticipated by the policy-makers. The issue therefore becomes which of these options is the most appropriate and cost-effective in meeting clients' needs.

This dissertation has not fully explored the connection between case/care management and guardianship. However, the findings could be indicative, given certain assumptions about the models of case management under review. For example, one model of case management sees some case managers as budget holders, a view which received very little support from social workers. However, a number of versions of case management practice would not (necessarily) see the case manager him/herself as the budget holder. As against these concerns, there may be a realistic argument for aligning guardianship with care management, where the individual actual or *de facto* guardian carries a budget in order to help to prioritise the client's position and to give him/her a measure of

'independence' over the claims of other clients and other parts of the social services operation. This would also address concern as to whether guardianship requires the assembly of packages of care for clients, and the idea that statutory agencies should fund the resource consequences of guardianship.

SOCIAL WORKERS' VERDICT

Social work and guardianship have arisen from different origins and appear to share some different values which the examination of guardianship models in this dissertation has highlighted. However, the research has also found enough common ground for social workers to be able to embrace guardianship use, provided they receive sufficient backing from their peers, from social services management and from central government. The effectiveness of existing legislation and practice guidance in communicating how the guardianship operation should be carried out by statutory agencies and how its aims should be realised needs to be reconsidered.

The overall finding from this research is that social workers support guardianship as a much wider concept than intervention by statutory prescription and value the help it gives clients. Despite limitations and shortcomings, they show growing interest in guardianship's potential. They see its future prospects bound up with necessary changes to make guardianship both more enforceable and more responsive to the needs of individuals. Social workers are therefore keen to learn when Government will introduce more clear-cut and firmly-based statutory community powers within the guardianship framework, while recognising the substantial social policy and legislative changes needed to bring this about.

SUMMARY OF RESEARCH INFORMATION ON GUARDIANSHIP CLIENTS

Information from the Social Services Research Group Survey

A source of data on numbers of guardianship cases is to be found in the monitoring work of the Social Services Research Group (SSRG).⁽¹⁾

The SSRG (1990) analysis, underpinned by a more indepth study by Fisher (1989),⁽²⁾ presents the following picture:-

1. Ratio of guardianships to compulsory hospital admissions is approximately 1 : 100;
2. Variations between local authorities is within the range of nought (applicable in 18 authorities) to 10+ referrals in one authority.
3. The largest size age group being referred for guardianship is 65 + (47%);
4. Dementia is the single most common diagnosis of those referred for guardianship (38% of referrals, compared with 11% of all referrals under the Act) followed by mental handicap (27% of referrals compared with 6% of all referrals) and schizophrenia (11% of referrals compared with 40% of all referrals);
5. Guardianship is not being used as an alternative to hospital and:-
 - a. the most frequent alternative to compulsory hospital admission, i.e. a 'diversion', is voluntary admission to hospital - and guardianship rarely performs this role;

- b. it is more likely that a referral for guardianship would result in a hospital admission than visa versa.
- c. Guardianship was used only twice as a 'diversion' in response to a request for detention under Section 2, 3 or 4 of the Act and once in response a request for informal admission.
- d. A half of the requests for guardianship result in Guardianship being taken out.

Information from other studies

The following provides a synopsis of detail provided by six small scale locally based research projects, mainly produced by researchers operating within the social services departments concerned.*

Age of Guardianship Clients

The **Isle of Wight** (1990) study confirms the SSRG picture of guardianship use for older clients, indicating 58% usage for clients over 60. The relationship between Age and Diagnosis is discussed below.

Gender

With the exception of the **Cheshire** (1988) study, there is a clear indication of women being in the majority of guardianship cases, with ratios ranging from 3 : 1 to 12 : 1.

Dementia and Schizophrenia

The **Isle of Wight** study and the **Leeds** (1990) study present a picture of the differential use of guardianship as between people with schizophrenia and those with dementia, viz.:

* The studies to come from Cheshire⁽³⁾, Isle of Wight⁽⁴⁾, Leeds (based)⁽⁵⁾, Leicestershire⁽⁹⁾ and Hereford⁽¹⁰⁾. The material also draws on the Dorset-based survey upon which the Brown study⁽⁸⁾ was founded.

dementia with 28% of cases compared with schizophrenia with 40% of referrals; and dementia with 65% of cases and only 8% from those suffering from schizophrenia.

Diagnosis and Age

The **Cheshire** study looked at 14 out of 31 guardianship clients in that county between 1983 and 1989, of which seven suffered from dementia, six from schizophrenia and one from manic depression. Of the whole group (31) the age ranges were: age 20 to 59 - 13 (42%); age 60 to 90+ - 18 (58%). Age and diagnosis are not connected directly in the Cheshire study but by implication in a discussion of purpose of placements (see below).

In the **Isle of Wight** study, the pattern of diagnosis among 18 guardianship clients between 1984 and 1989 showed: schizophrenia and personality disorder - seven (40%); dementia - five (28%). Nine of a total group of 18 were aged over 65.

The **Leeds** study covered a five year period and involved a total of 26 patients. Of these, three suffered from mental impairment and 23 with mental illness of various kinds. Of this 23, 12 suffered from senile dementia, three were diagnosed as alcohol dementia, two with paraphrenic illness and one with manic depression.

Of the younger group of clients (13) in this research the average age was 42 (range 35 to 49) and divided by diagnosis as follows: two with chronic schizophrenia, one with manic depressive psychosis and one with an epileptic psychosis.

Purpose/Outcome

In terms of purpose, the majority of guardianship clients are placed on guardianship in order to obtain or sustain a residential placement, with a much smaller number (between a quarter and a third) being used to facilitate home care. There is an indirect relationship to age, as residential care placements mainly concern older people suffering from dementia.

In the **Cheshire** study, most (i.e. eight out of 14) guardianships were used to place or sustain a placement in residential accommodation, the others being to maintain care at home.

In the **Isle of Wight** study, all but three of the 18 clients were placed in residential care through guardianship, excluding 1 person placed with relatives and another one boarded out. There are no recorded incidents of placement into day-care, though the authority approve of this use of guardianship.

In the **Leeds** study, a more complex pattern of usage is discussed. In general terms the older group were being placed in homes for the elderly while for the younger group, mostly people suffering from schizophrenia, the powers were being used to maintain the patient at home. Two studies comment on outcomes, both reporting a satisfactory transition from hospital to residential care or to maintenance/care at home.

Of the elderly group:-

"In one case the stated purpose was to stop the family discharging the patient from hospital. 12 patients were put on Guardianship to facilitate transfer to residential care, 3 to facilitate home care and in 2 cases Guardianship was applied after admission to prevent the patient leaving residential care."

Of the younger group:-

"Only 1 of the orders was primarily to require the patient to live in a hostel, the remainder were to require attendance or access to treatment.

The single use of a Guardianship order to prevent relatives discharging a patient from hospital was idiosyncratic but worked...."

The **Cheshire** study divided purposes by age: for the 'over-60s' guardianship was mainly to secure placements of an individual in a particular residential setting, notwithstanding resistances from "the local 'culture' of the caring services", while for the 'under-60s', "Guardianship was motivated more by a desire to provide some form of 'structure' of care, protection and authority with which intervention into the person's life could be achieved so as to promote the person's welfare". So far as outcomes could be clearly

identified, three clients returned to hospital (presumably indicating a failure of guardianship) while guardianship was pursued in five cases (to maintain community or residential care), with another five living in the community or in residential care informally, i.e. presumably where guardianship was no longer required.

Turning to outcomes, the Leeds study says that:-

"overall 16 of the 18 [elderly] cases had good or satisfactory outcomes.... In the 14 cases where the purpose was to keep the patient in residential care, 13 settled though 1 [continued to resist].... In the 3 cases where the purpose was to facilitate home-care, 1 succeeded, 1 had only been in force briefly and 1 [returned to residential care because of illness].

Outcomes were satisfactory in all of the Isle of Wight cases, in the sense that the placements or arrangements set up were maintained; only one of the 18 cases is regarded as a failure, because the patient refused to co-operate.

Social Circumstances and Hospital Admission

Two studies refer to the circumstances of guardianship clients before hand, with typical reference to severe management problems in the community, such as risk to health, with the remainder being in hospital prior to guardianship.

The Leicester (1989) study of eight guardianship cases between 1983 and 1987 divided between 3 Section 37s and 5 Section 7s, indicates that only one general characteristic could be identified between clients: "severe management problems in the community, including self-neglect, criminal tendency and general anti-social behaviour".

In the Leeds study, of the 18 elderly people:

"8 patients were in hospital - 2 in residential care and 8 at home - when Guardianship was initiated. All but 1 of the patients lived alone and the husband of the remaining patient was seriously ill. In all cases there were problems with self-neglect and refusal of help. In 1 case fire risk and in another wandering were given as additional reasons for Guardianship."

Of the younger group:-

"2 patients lived with family, 1 alone in a flat and 1 was required to live in a hostel."

The Leeds study also indicates that all but 6 of the 23 guardianship clients had been in and out of hospitals under compulsory sections of the Mental Health Act.

Reasons for Non-Pursuance

The Hereford (1988) study refers explicitly to this question and identifies in particular that social workers found other ways of progressing care because (a) they managed to persuade the client without use of guardianship; and (b) because they approached use of guardianship as basically an infringement of civil liberties.

Looking in detail at reasons for non-pursuance of guardianship, concerning nine out of 11 cases, (with only two of these being put forward for guardianship) this study identified likely reasons as:-

- new definition of mental handicap excluded applicability;
- persuasion proved sufficient, i.e. to place a person in residential care;
- views of the social workers that guardianship would be an unwarranted infringement of civil liberties.

The implication of the latter is that other criteria for the use of guardianship were fulfilled but that social workers' decisions based on professional values chose otherwise.

The Hereford researcher concludes that a number of ASWs regard the imposition of guardianship as "quasi-parental control" and ethically unacceptable for adults. Others see the issue mainly in terms of enforcement and therefore as, in the words of one ASW, risking "creating a rod for my own back".

Pre-conditions for appropriate Guardianship use

The **Isle of Wight** study comments in some detail about: shared objectives; good practice and a need to work jointly as between health and social services; the idea of guardianship as a least restrictive alternative; and need for careful choice of guardianship clients.

These researchers regard local conditions as highly significant in answering the question: "What makes guardianship work in one authority and be virtually unused in others?"

In answering this aside from the circumstances of individuals, the team point to:-

- A strong tradition of local co-operation between health and social services (cf Mental Health Act Commission suggestion);
- Development of an appropriate range of residential alternatives for discharged hospital patients, and good relationships between the agencies providing these services;
- shared assumptions about good practice, especially seeing guardianship as the least restrictive alternative and the "lesser of two evils" for the use of compulsion in the interests of the welfare of the patient;
- arising from the three pre-conditions above, a careful and professional choice of clients for pursuance of guardianship and the exclusion of clients where it would not be reasonable to expect the client to see guardianship as in their best interests - particularly referring to young schizophrenic men.

The **Leicestershire** study indicates that such use of guardianship that has been achieved in that authority is due to "guidance to ASWs on the use of guardianship and on the proceedings involved, supported by training". By implication, the guidance appears to be cast in positive terms.

ISSUES RAISED

Resources

None of the studies have indicated that the availability of resources is a main factor in limiting or precluding pro-guardianship decisions in any particular case. The **Leicestershire** study says that precisely because numbers remain small, their resource requirements can easily be met. The researcher suggests, however, that their claim on resources could become an issue at the renewal of guardianship: "renewal of guardianship may be sought...because the order is perceived as guaranteeing continuing social services support".

The **Isle of Wight** study argues the view by inference that resources have to be in place before guardianship would adequately work, but admits that the same argument could be applied for the implementation of community care strategies in the widest sense.

Value Conflict

The **Cheshire** study refers to the elusive and ambiguous nature of guardianship and, whilst admitting that it can be an effective tool in some instances, asserts that "Guardianship does change the clients' right to self-determination" which has to be balanced against its role in providing protection against exploitation.

Reference has already been made to the **Hereford** criticism of guardianship as a "quasi-parental control" inappropriate for adults.

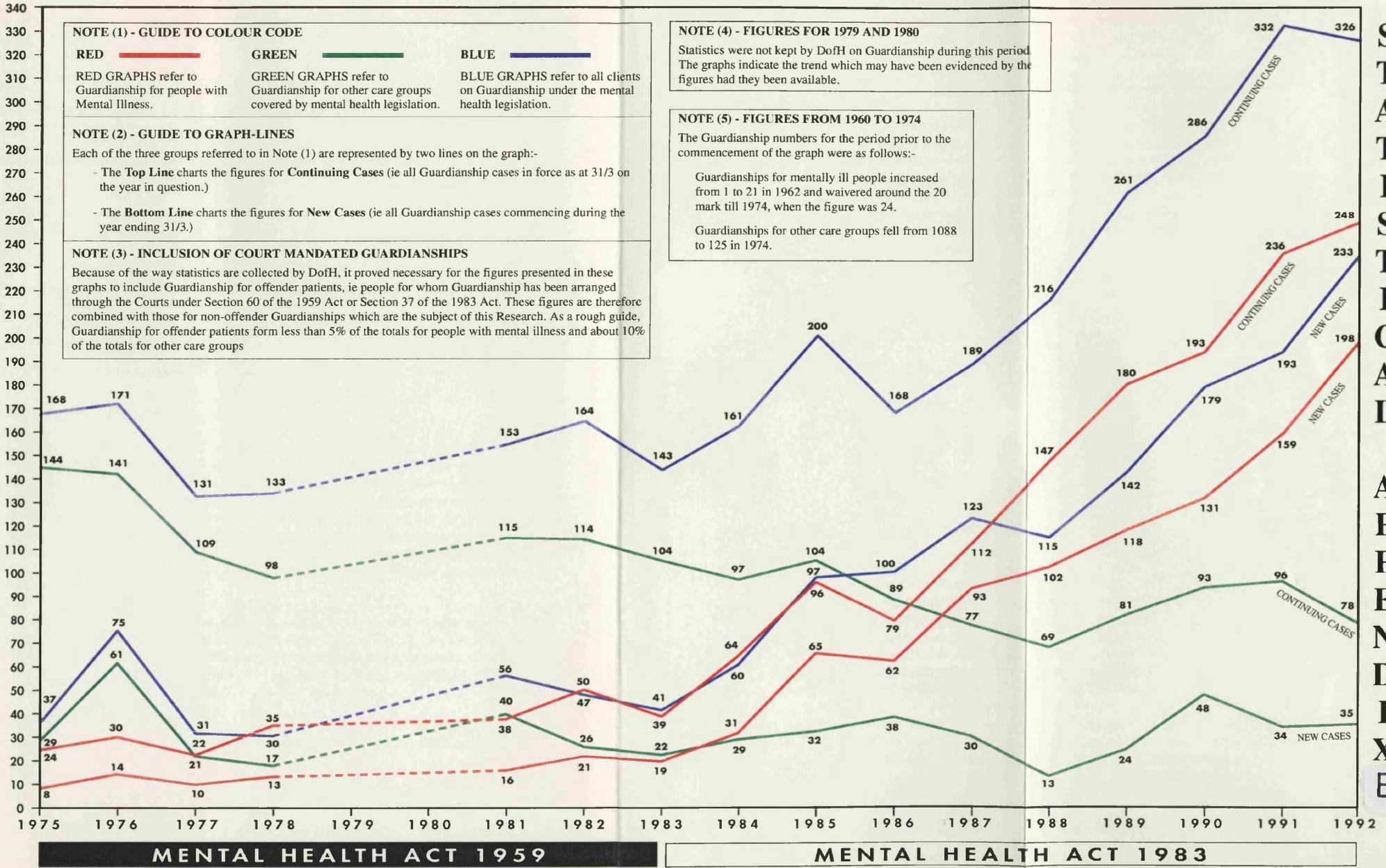
Additional Powers

The **Hereford** and **Leeds** studies recommend the inclusion of 'power to convey' within guardianship and ask for "the power of transfer to required place of residence under guardianship to be clarified". The latter study also considered "the use of guardianship to maintain mentally ill or old people in the community deserves further exploration".

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NUMBERS OF GUARDIANSHIPS



CASE STUDIES

This appendix provides five case studies. The first two are attempts by this researcher to portray actions, thinking and decision-making narratives about clients into coherent accounts, indicating how clients and the professionals involved adjust their outlook around the idea of guardianship and its ramification for the respective parties.

More ambiguous and typical of the cases discussed with the researcher during empirical work in the research agencies are the three pen-pictures which follow, drawn from experience during the pilot exercise. Two of these ('Geoff Baxter' and 'Audrey Cummings') were actual clients whereas the third ('Joan Humphries') was a composite of three clients. These were used in the form of vignettes during the survey to gain social workers' and managers' responses on the appropriateness of use of guardianship in the formal interviews and data collection.

Client with Schizophrenia - 'George Hancock'

George has had three admissions to psychiatric hospitals near London, each time with more severe psychotic episodes. At 30 he had been encouraged by his parents, who live in Lincoln, to leave his job as an insurance clerk and start a second career in architecture and had been doing well in his new studies until the break-up of a relationship with a girl friend. From then on his efforts to keep up with his studies had the effect of removing him from normal social life and eventually from the architect's office where he had been functioning reasonably well. He spent long periods in his bed-sit accommodation, musing over his situation.

Each admission to hospital came during a time when he was preparing for exams. Following the third admission it became clear that he could not return to work or to studies as his grasp of the realities governing these had apparently slipped away. At the point of discharge he faced the prospect of being apparently as well as he ever will be but with no hopes of resuming his career.

His only expressed emotion was the fear and anxiety of parental disapproval, which effectively barred him from returning to them and to his home town.

From this point, Social Services took an active interest and endeavoured to arrange for George to attend a day centre to consolidate rehabilitative activity undertaken in the hospital. Initially this programme worked well but after a few weeks George began to spend much of the day hanging around his old place of work,

trying to talk to staff about his chances of resuming his career and to begin studying again. He then found a pile of his old textbooks sent on from his previous lodgings and thought their arrival was a sign that he should resume study in his own right - i.e. without the support of his professional association. He stopped attending the Day Centre and could not be persuaded by social workers to return.

The social worker discussed the matter with the consultant psychiatrist involved. A case conference was convened which included a Community Psychiatric Nurse (CPN) who had been assigned to George but had failed to make contact with him. Day centre staff at the conference volunteered to pick him up from his lodgings and bring him to the centre on a rota basis. This worked well for four months until the day centre staff realised that his only interest during the day was in 'counting', ie checking numbers of paving stones, people walking along, buses passing by, people attending the centre, numbers of knives and forks laid for meals, etc. Inevitably, he was re-admitted to hospital, and this seemed to coincide with George finally realising that no amount of rehabilitation and day centres would return him to his previous professional career and that he was now without prospects. This led him to avoid any attempt from ward staff and the occupational therapy department to engage him in any meaningful activity. Plans to launch a realistic discharge arrangement with a more robust support system built in, which would deal with his personal sense of crisis and rejection as well as his deteriorating social behaviour, were thus thwarted. Despite efforts from social workers, nurses, Occupational therapists (OTs), and doctors to confer and make best use of ward round opportunities, an administrative error on the part of a new registrar precipitated a discharge about which none of the key parties were fully informed.

On returning to his lodgings George found that the rooms had not been reserved for him and he was homeless. He tried telephoning his social worker, and eventually went round to the Social Services office, only to find that his visit coincided with the annual leave of the only social worker he had formed any relationship with. The duty social worker misunderstood his intentions and sent him to an accommodation bureau some miles away, which George eventually reached on foot as he had spent all his money. The accommodation bureau were particularly unhelpful and accused George of wasting their time at which point George withdrew, but not before smashing a window by pushing a chair through it. He returned to hospital under Section 136.

Shortly after his re-admission, a full case conference was convened involving all those previously involved in his care. They determined, among other things, that his stay in hospital should be as short as possible commensurate with attempts to provide a fully structured after-care programme. This should aim to demonstrate to George that he was improving, ie achieving something, rather than as had been the case in the day centre, being contained there. The day centre were encouraged to discuss George's situation with a local College of Further Education with a view to setting up a course for George.

The professionals involved came away from this meeting feeling that they had at least cracked the rehabilitation problem. They had not however allowed for George's perception of his future life, and he whereupon made clear to all parties that he would refuse all attempts to engage him in anything other than his previous work in architecture. No amount of hospital care and treatment was able to alter his attitude and stalemate was reached. Medical staff reported a gradual deterioration towards 'chronicity' with less and less sign of activity or motivation on George's part. There was pressure to move George onto a back ward, where staffing levels were lower and where active interest from the Occupational centre would cease.

George's parents intervened at this point and persuaded the consultant psychiatrist to arrange a precipitate discharge. A further case conference was hurriedly convened and the upshot was that a rehabilitation programme was drawn up. Some of it might need to be imposed on George in order to break the 'log jam' - attendance at the centre was seen as a necessity by all concerned. Within a few weeks George had been reinstated in supported lodgings with a programme of regular visits from CPN and a social worker, with a clear understanding that he was to attend further 'training' at the centre. However no amount of persuasion could convince George that his future would be better served attending the day centre and he challenged their authority to enforce this. The social worker realised that the relationship with George had been based on a high level of mutual understanding and acceptance, while George had formed the view of social workers that they were anything other than authority figures. After thinking over the situation further, and discussing the matter with his senior social worker, the social worker realised that some form of authority would be needed to prompt George towards the rehabilitation programme. This view was supported by George's parents, who were now staying in London to ensure that some proper arrangement was worked out.

In considering the use of guardianship, the social worker and senior social worker saw the attendance requirement as being the major power sought in order to fulfil a rehabilitation plan and eventually put this proposition to their managers to 'test the water'. On receiving support in principle from management the social worker spelt out the intention to George, saying that if George was unable to accept the rehabilitation plan as it stood it was necessary for the authority to become George's guardian which meant, in effect, that the social worker would assert the necessary authority to get the plan underway. Initially George was angered by this news but the next day returned to say to the social worker that if this authority could be demonstrated in some tangible form he would grudgingly go along with the requirements, at which point the social worker made the necessary application.

George was given further information about the guardianship which, it was stressed, was part of his rehabilitation programme, not something separate from it. George would be required to attend the day centre five days a week and would be expected to participate fully in the programme. The social worker said that the

guardianship extended only to attendance and could not ensure that George did one or other particular activity while he was at the centre, this being a matter of trust between them, George was initially amused at this discrepancy but eventually said that if the social worker was invoking his authority to get George to the centre, he would comply with the programme.

The guardianship order was allowed to run for six months by which time George was a fully participating member. There were some failures to attend, at which point the social worker searched him out at home and encouraged him to come along. No period of absence longer than a day had gone by without an appropriate official response. Fortunately the tie-up arrangements between the centre and the college had worked reasonably well and George was encouraged to take a clerical course at the college which would equip him for another job. Without fully realising their change of stance, the professionals involved had been using the authority involved in the guardianship order to move from a position which tended to humour George's wishes to resume his earlier career to a position where a change to a more realistic working prospect was seen to be part of the package. This was conveyed in turn to George and accepted over the six months in question. It was therefore initially assumed that guardianship would lapse at the end of the six months leaving George in an improved situation but still not at the point where he had started his new employment. A further discussion between social worker, senior social worker and social services manager decided that guardianship would be continued (for a further six months) hopefully to coincide with George becoming established in a new post with appropriate support around him.

This arrangement was agreed and George, accepting that the initial guardianship had given his life more shape and substance, agreed that he could be further helped into a new career. Subsequently George and his social worker spent some time talking about the various uses of authority in socially accepted and (usually) productive ways, namely in employment where the authority of the boss can be a force for good, and in family life where the assertion of parental responsibility can be highly beneficial.

Client with Dementia - 'Gladys Holmes' - (Aged 78)

Gladys had lived all her life in the same house in an inner London suburb, and had seen her three children grow up, leave home and scatter across the world. Her husband died ten years ago and she faced the prospect of living alone with some anxiety. Eventually, however, a neighbour befriended her and encouraged her to have pets, which eventually resulted in three dogs, a budgerigar and two cats.

Two years ago, Gladys fell down stairs and broke her leg, requiring her to spend two months in hospital and a further three months in rehabilitation. The arrangements for dealing with her pets caused her great anxiety, but the neighbour took care of them without being very explicit about what she was undertaking to do. As Gladys's anxiety about her animals increased it was noticed that she began to show some confusion over which animals were her own and which were

her neighbours. It eventually became a point of some amusement that her 'menagerie' could vary from one mouse to a dozen snakes over a period of a day or two.

However no other signs of confusion appeared before she was discharged home. She then found that, in her view, her animals had been sadly neglected and this coincided with the death of one of her cats (from old age). From this point on, she seemed to associate all care from neighbours and other people as liable to lead to poor or disastrous outcomes and saw herself similarly at risk. A social worker assigned to visit her at home found that she (the social worker) was suspected of laying poison for the animals, and was even accused of taking one of the dogs away. The social worker set up a home care programme which included a home help, a welfare person from the RSPCA and a community nurse. There was concern about deteriorating hygiene in the home, related to the animals initially but also affecting how Gladys looked after herself. The care programme worked well for six months by which time it was realised that Gladys could not distinguish one person clearly from another and became quite suspicious each time one attempted to gain entry. Gladys mixed them up with a salesman from a local firm who had tried to sell her some furniture which she could not afford but had paid him a deposit consisting of all her social security money.

As conditions in the house deteriorated further and care personnel found access harder, Gladys had another fall as her eyesight, never very good, was letting her down more in her judgement of distances when negotiating the stairs and she had adamantly refused to wear appropriate glasses. At this point the care staff discussed the situation with the hospital staff who had recently treated Gladys and a further plan was made. The consultant psychiatrist who was asked to assess Gladys was not reassured by the initial statement from the care team that, provided Gladys was really well, she would again let them into the house regularly. He detected that her diet had been less satisfactory than care personnel had assumed and that she was generally under weight and under nourished. He wanted Meals on Wheels to be considered to prevent further deterioration.

The upshot of these discussions was that the medical consultant was not prepared to contemplate discharge unless care staff could gain regular access to provide appropriate care. This was not assisted by statements from Gladys indicating that she was, if anything, more confused about who she recognised as known people and who she associated with friends or allies of her neighbour. She remained convinced that this neighbour was trying to take away or kill her pets. The dilemma for care staff was that the only way for these pets to be properly fed was to rely on this same neighbour. All in all, it was regarded as essential that discharge should coincide with a formal arrangement for care staff to gain access to Gladys's house as and when required. A suggestion that guardianship arrangements would formalise this was initially viewed with some scepticism. A full and open discussion with Gladys about who should have a key to her front door produced the view from Gladys that these other people needed to convince her that they had the authority to enter her house and had her welfare at heart.

It was then agreed that guardianship arrangements should be brought into force, despite some misgivings on the ethics of 'intrusion' into a person's home without them necessarily agreeing to entry. It was decided that only the social worker and the home help should have additional front door keys and that only the social worker would normally sanction other people gaining access. In practice, this meant that the social worker agreed in advance to the home help lending her front door key to the animal welfare person, who subsequently helped Gladys cope with the deaths of a cat and dog over the next year. These events upset Gladys a great deal and seemed to mark further decline into confusion.

The effect of the home help and the social worker being able to enter the house with a key, as would a family member, seemed eventually to spell out that the relationship was based on both authority (to legitimate entry) and demonstrated care. The need to gain entry increased greatly after the second hospital admission, as Gladys was often so involved with her animals as not to notice the door bell ringing. She was occasionally seen at an upstairs bedroom window looking on as people came to her front door and rang, thinking they were the next door neighbour or the neighbour's friends. The guardianship was renewed at six monthly intervals for two years and is still in force.

'Geoff Baxter' - First Vignette

Geoff Baxter is in his late sixties, a wealthy retired businessman who had been 'eased out' of his firm during a takeover bid. He lives with his wife in comfortable accommodation by the sea.

Always a heavy drinking man, he began to use alcohol as a means of combating the isolation of his social life compared with his previous active business interests. The couple have no close relatives and few friends. Geoff is prepared to admit to heavy drinking but when his alcohol level reaches beyond a certain point (1+ bottles of Scotch a day) he then totally denies his drink problem.

On two occasions his heavy drinking has brought him to a stuporous condition which has been followed by aggressive responses towards anyone who tries to intervene. His wife is increasingly scared of these episodes.

Both episodes have resulted in admission to hospital under Section 2 of the Mental Health Act, 1983, as the level of aggression or threatened aggression has reached beyond the limits containable at home. In each case the consultant psychiatrist viewed the behaviour as closely linked with depression and withdrawal. In each case also, Geoff Baxter eventually entered hospital without trauma, recognising the authority of those concerned and being particularly impressed by the documentation which accompanied the admission arrangements.

During his periods in hospital he made a good relationship with Peter Durant, CPN, who has recently left the hospital to set up a private residential care home. Jean Thompson, Approved Social Worker, has been involved in both admissions, is aware of this and liaised with Peter Durant, as well as the Consultant Psychiatrist, at the time of Geoff Baxter's second discharge.

Jean Thompson was assigned the aftercare work with Geoff Baxter and his wife during which she noticed evidence of depressive and angry behaviour from the client. She received some support from Mrs Baxter for some more structured form of aftercare to hopefully prevent further deterioration in her husband's condition.

This suggestion was discussed at a case conference convened between the General Practitioner, Peter Durant, the Social Services Area Manager and Jean Thompson, and the following proposals were tabled:-

1. Peter Durant to visit Geoff Baxter at home in liaison with Jean Thompson to try to offer a tough but supportive relationship (the assumption here is that for this to happen, problems of entry and access will need to be dealt with in advance);
2. As and when appropriate, Peter Durant to arrange day care admission to his establishment, initially on a 'collect-and-return' basis;
3. If and when necessary and appropriate, Geoff Baxter to be admitted into residential care.

'Mrs Audrey Cummings' - Second Vignette

Mrs Cummings is 75 and has lived alone in a cul-de-sac of bungalows where she has been since she was widowed 10 years ago. She enjoys friendly relationships with neighbours who have helped her as she has become a little infirm.

However last year she showed increasing signs of disorientation, and there have been episodes of wandering and odd behaviour in public - eg she walked along the road naked one night and was brought back by neighbours who, according to her general practitioner (Dr Williams), felt that such episodes were tolerable as Mrs Cummings was generally able to look after herself.

As Winter approached she made it known that she was not heating her house properly, having been scared by a gas leak, seemingly, to lack of proper servicing of her gas central heating which, in turn, had apparently arisen because Mrs Cummings was unsure of the identity of the Gas Board service engineers who had called on her and had sent them away. Soon after this, a cold snap occurred and Mrs Cummings was again found wandering naked along the street; she had fallen down a few times in the snow.

As a result of this, neighbours made representations to Dr Williams who in turn contacted Social Services. The latter had been aware of the previous incident of wandering but had not continued to be involved. The up shot was a discussion between Dr Williams and the Approved Social Worker, Peter Crisp, regarding a proposal for Mrs Cummings to enter an old people's home.

Peter Crisp argued that the uppermost care need was for Mrs Cummings to enter residential care immediately, i.e. on a short term basis until the hazards of the winter were left behind. Dr Williams felt that admission to a residential unit should not take place unless and until Mrs Cummings could be persuaded to go voluntarily. Peter Crisp persuaded Dr Williams Peter Crisp persuaded Dr Williams that admission into residential care was the first priority as he had, meanwhile, established that Mrs Cummings' family were not accepting responsibility for her welfare as they were not in a position to provide her with accommodation, even on a short term respite basis, to see her through the winter. Mrs Cummings continued to express unwillingness to enter residential care, saying that she did not need to be looked after. She was not reassured when Peter Crisp told her that there would be no question of her losing her bungalow.

Eventually Mrs Cummings was admitted to the home under a guardianship order on the understanding that the case would be reviewed as soon as the spring weather came, or sooner if there was evidence of change of heart from relatives. As a result, Mrs Cummings expressed some anger and despair about her situation but agreed to accompany the ASW to the Home.

Scenario 1

Mrs Cummings settles in well at the home with an occasional protest at the threat to her independence but otherwise appears to benefit physically and emotionally from the comfort provided by the Home. Likewise, residential care staff feel more able to cope with Mrs Cummings' complaints and protests that she would rather be in her own home.

Scenario 2

After a short period of initial resignation to being in residential care, Mrs Cummings fairly suddenly becomes anxious and aggressive, demands her personal belongings and appears to be looking for a chance to slip out of the building. Staff become concerned about the extent of their powers and the Head of home calls the ASW.

By the time Peter Crisp arrives at the home, staff are clearly distressed by the conflicting views and reactions they experience in response to Mrs Cummings' apparent intention to leave. Some feel that as she is there under statutory care, staff have a right and a responsibility to ensure that that care is maintained whether or not Mrs Cummings can accept it at that point in time; they argue that there is a major difference between one incident of demanding to leave, as against a continuous unwillingness on Mrs Cummings' part to stay in the home.

So far, the indications are that this is an incident rather than a continuing phenomenon. Other care staff at the home feel equally strongly that no one should be forced to stay in the home against their will and that residents should be treated equally in this respect and not seen as different just because one is on a guardianship order.

'Joan Humphries' - Third Vignette

Joan Humphries is in her late thirties, divorced, and her three children are living away from her and see her only occasionally. She lives in a suburban semi which has seen better days and shows obvious signs of neglect.

She is diagnosed as schizophrenic (though other diagnoses such as depression and psychopathy have occasionally been offered) and her behaviour is bizarre and unpredictable insofar as neighbours and others are aware of it. Much of the time, however, she is alone and withdrawn, neglecting herself, not acknowledging the need for regular nutritious meals and often not opening the door, whoever the caller may be.

She has a history of five admissions to psychiatric hospital, three of which were compulsory, and each of which followed incidents of disturbed behaviour with neighbours. Neighbours feel threatened by her behaviour, though, as yet, she has done no physical harm to them.

Following each hospital discharge, unsuccessful attempts made by the hospital consultant, Dr Preston, and the General Practitioner, Dr Felix, to encourage her to take her medication. Attempts to provide social work support to Joan Humphries and to get her to attend a day centre also failed. She has recently been tried on a regime of long-term depot injections through the CPN, Helen Johnson and early signs were that this had a stabilising effect. Over the last few weeks, however, Helen Johnson has been in touch with Jenny Felgate, ASW, as she has been unable to gain access to her client. She made the unfortunate 'mistake' of asking neighbours whether they knew of Joan's whereabouts and Joan saw one of these exchanges going on whilst peeping from behind the curtain in her front room.

Subsequently a case conference took place between Drs Preston and Felix, Helen Johnson and Jenny Felgate, the result of which was that all were agreed that the new treatment, having been apparently successfully commenced, should if at all possible be persisted with. Insofar as the problem turned on access, the view of medical colleagues was that Social Services should use a guardianship order to facilitate this. This would mean that the ASW, as *de facto* guardian, would have to provide access for the CPN for her fortnightly visits while the beneficial possibility of joint visiting had not been ruled out.

Use of guardianship to gain access to Joan Humphries at home was ruled out as impracticable, and it was therefore proposed that she attends a combined day treatment/day care centre. The centre has close contacts with the CPN service and the hospital medical team.

Arrangements were made with the day centre to receive Joan Humphries and the ASW visited her to explain the proposal. Joan Humphries flatly declined to attend the Centre, as she perceived the unit as similarly restrictive to the regime in the hospital, and she did not accept the need for either form of care in any case. Joan Humphries' view is that Helen Johnson has joined forces with the neighbours and that if it had not been for this, she would still have let Helen Johnson into the house. All rational discussion of the issue and the attitude of neighbours failed to shift Joan Humphries' views.

HISTORICAL TYPOLOGIES

GUARDIANSHIP ARRANGEMENTS REVIEWED BY THE ROYAL COMMISSION ON THE CARE OF THE FEEBLE MINDED, 1904/8

The Commission were considering revisions in the law for people with mental handicap but accepted that the care group was widely defined and not exclusive. They were keen that Britain should learn from practice elsewhere and looked for alternative models of Guardianship as follows:

1. **COLLECTIVE GUARDIANSHIP OR 'FAMILY COLONIES'**

So-called family colonies, of which the most famous was (and is) at Gheel in Belgium, were intended to provide a mutually supportive environment for people with mental health difficulties who no longer needed hospital care. They might be referred to as a form of collective guardianship where the protective element is provided by 'hosts', i.e. lay-persons deployed by a professional team to provide oversight. Such placements were described as suitable for "aged people certified as insane, but in whom the condition of dementia, incurable but tranquil, and senile enfeeblement of their faculties, hardly justify their detention in an asylum." Also to be found in such colonies are "many cases of delusional insanity, chronic mania and melancholia, and adolescent (sic) dementia".

Apart from commenting on developments on the continent, the Commission also referred to similar arrangements in parts of Scotland.

2. **'FAMILY GUARDIANSHIP' OR BOARDING OUT**

The Commission reviewed traditional Scottish guardianship practice, usually associated with what would now be referred to as family placement schemes, ie arrangements by which:

"people [are] placed in private dwellings, either with relatives or unrelated persons, and either singly or in numbers not exceeding four [whether or not they

have previously lived in an asylum, provided] the circumstances in which the patient will be placed are suitable or as efficient for his proper care and treatment."

Describing a development of one of these schemes, a Mr Motion, Inspector of Poor to the parish of Glasgow, referred to his efforts from 1885 onwards in St Andrews, Fyffe, to generate local enthusiasm for the scheme. In the chosen area, he comments:-

"...There are a number of little Hamlets or Villages where weaving have been practiced for ages past, and I went there personally and sent my assistant to elicit sympathy and good offices of the local medical gentleman. I was able to board out, roughly speaking, what has now risen to a very large proportion of our insane, at sums varying from 6s to 7s per week [a very considerable saving on the cost of them staying in an asylum]...After the first few we could then pick and choose the best type of Guardian...medical men in the district advocated and assist in the movement greatly, and care was taken in the selection of cases [chosen from people in asylums who] were working about the farm, and on the land, and were otherwise suitable for boarding out".

"Most of the selection of homes we take the houses as they are, and preferably with some aged couples whose family have gone off and left them with plenty of bed accommodation, and preferably in fruit-growing districts....The house is first inspected by the Inspector of Poor; if it passes him, application is made to the General Lunacy Board, and...the Deputy Commissioner in Lunacy and his colleague then visit, before we can put a patient in their it must receive their approval".

The Commission's Report did not refer to the family care or boarding-out system already well established in America by 1890.*

3. WARDSHIP

The Commission considered the relevance of wardship, at that time mainly used to afford protection to children, seeing the connection as follows:-

"Infancy, in cases in which the infant is the prospective possessor of property, is ground for Wardship; and the analogy between infancy and unsoundness of mind, or idiocy, and states of insufficient or defective discernment, is obvious, and has long been recognised...[Child Care legislation, eg the Prevention of Cruelty to Children Act, 1904, has tended] to extend the field of Guardianship, and to use it as the instrument of a control, not merely educational, but social and personal".

* H R Stedman, 'The Family or Boarding-Out System - Its Uses and Limits as a Provision for the Insane' *American Journal of Insanity*, Vol.46, (January 1890, pp.327-338).

The Commission then go on to draw their inspiration from the form of 'guardianship of neglected children' practiced in Germany, administered by the Court of Ward (Vormundschaftsgericht), providing for the ward:

"...to be placed in a suitable family [or institution, possibly including one for the 'insane', having considered] the peculiarities of each individual case...the nature of the degeneracy and the causes of it; and [the availability of] a curator to supervise the young person in the family."

Thus, though on the face of it more applicable to children and more geared to those with learning difficulties and behaviour problems, such a scheme could conceivably be regarded as a form as guardianship for adolescents with serious mental health problems up to age of twenty-one, a limit somewhat arbitrarily decided by the Commission in advance. Bateson*, whose comments on Royal Wardship are referred to below in the context of borough guardianship, was a contemporary observer of the Commission's deliberations, She drew attention to similarities and differences between English and German guardianship, explaining the connection as follows:-

"The earliest Germanic Law had known a Guardianship exercised by the whole kin; later, a 'tutela legitima' in the person of the next of kin of the father's side; and later still, a dative (court appointed) Guardianship. It is doubtful how and when the early Germanic folk-law first came to admit anything equivalent to the Roman 'Jusdandi tutores', an appointment by Public Authority of a 'mundwaldus' for those who were without kindred to claim the 'mund'....As the protection of the orphan contain less of the 'mund' and more of 'Cura', a doctrine of responsibility was forced upon the Guardian."

4. CURATELLE

The Commission reviewed guardianship practices on the Channel Islands, referring particularly to the Civil, Municipal, and Ecclesiastical Laws of the Island of Jersey, 1861, from which it was quoted:-

"It is to be observed by the Law of Retirement that recourse may be had to a Curatelle not only in cases of lunacy and mental incapacity, but whenever through drunkenness, prodigality, misconduct, or incapacity of any other kind may become necessary expedient to subject a person to control in the management of his property".

* M Bateson, **Borough Customs** (Selden Society, London: Bernard Quaritch, 1904 p.CXXVII).

In effect, however, the order provided both for the management of the person's estate and person. Apparently this "compulsory process of appointing a curator was looked upon as a disgrace" and an alternative method of providing guardianship was for the person concerned to place themselves voluntarily under the control of a procurer, whose powers are very similar to those of a curator's, including that of placing the person under restraint.

Evidence to the Commission then went on:

"If the Curator...could not keep the man under proper and sufficient constraint in his own home they might place him as a boarder in general hospital of the Island or some other Institution of that sort, or in a Private Asylum, or in Public Lunatic Asylum".

It was particularly stressed that curatorship "applies to rich and poor alike".

5. CONSELL DE FAMILLE

This is a French system of guardianship "in many respects similar to Curatelle" but the categories of persons for whom it is intended are more nearly those broadly described as mentally disordered, i.e. those suffering from "imbecility, dementia, or fureur".

Neither the Channel Islands or French system appealed to the Commission, who said that of 'Norman Law', that it "recognises the Unity and Obligations of a family as a whole in relation to property" whereas English law is more concerned with "the liberty of the individual so that 'the restraint of the unfit' would be affected, not with the family acting of itself as a controlling agency under the co-operative guardianship of a curator, but by the guardianship of a court whose protection is obtained by a procedure like that in force under Section 116 of the Lunacy Act".

6. CURATOR BONIS

The curator bonis is the Scottish system of guardianship of the estate. The curator is appointed by the court in circumstances in which a mentally ill person is found to be

unable to manage his/her affairs. Petitions have to be supported by recommendations of two doctors.

The Commission seemed to have been under the impression that "while the Curator...is not given specific control over the person of the Ward, he has in effect such control...." They did not refer to the official position by which guardianship of the person was provided by tutors dative or tutors-at-law.

7. 'LEGAL GUARDIANSHIP'

It is interesting to examine the perception of so-called legal guardianship by the Commission who seem to have assumed the absence of any pre-existing form of legal guardianship.

This proposal was brought to the Commission's attention by one Sir James Crichton-Browne who suggested:

"....That the County Court Judge should, on the application of the Board of Guardians or Parish Council, having satisfied himself of the existence of idiocy or mental defect, appoint a Guardian who should have all the powers of the Committee of the person [i.e. who would have custody of the person, could decide his place of residence, would visit the person and to be generally] responsible of the safety and conduct of their wards...and stand in loco parentis".

The reference to committee of the person in this quotation suggests that the witness was proposing a form of legal guardianship for people with mental handicap comparable to the form of guardianship known as committee of the person applicable to mentally ill people and the lunacy legislation. Whether committee of the person under the 1890 Lunacy Act was, strictly speaking, a form of statutory guardianship remains uncertain, though it conceivable that the matter is one of semantics.

It is also unclear whether these discussions took into account the fact that precisely this form of guardianship was already available for people with mental illness within the terms of The Lunacy Act, 1845.

HISTORICALLY SIGNIFICANT CATEGORIES OF GUARDIANSHIP

FEUDAL GUARDIANSHIP

This form of guardianship, which dominated up to 1660, was essentially an expression of obligations between the Crown and Royal Tenants, ie those whose lands belong to the Crown but were given over to individuals and families in return for services to the Crown. From the time of the Norman conquest, these services were essentially military, but as the need for military service diminished, other services were sought instead. If the land holders were not able to give military service or offer alternative services, obligations of socage arose, whereby services to the Crown were substituted by 'fines'.

When a person was not in a position to honour his or her obligations to the Crown, the King assumed guardianship of the person as well as the property. This situation most commonly affected infants but to a lesser degree also people with mental illness who could not support themselves or honour their allegiance to the Crown. In the circumstances, as with infants, the Crown assumed the guardianship over the person with mental illness as 'pater postierias', thereby protecting lands and properties as well as offering some protective care for an individual.

In practice, the degree of effective protective care varied. Kings frequently used guardianship as a useful form of gaining extra remuneration and sold the guardianship entitlements to others. Thus, whereas the Crown had basic responsibilities for the care of mentally ill people, guardians 'once removed' did not necessarily see their obligations in this light. Feudal guardianship was not sensitive or well adjusted to wards whose needs were particular and special, and the most common feature of this situation was of wards being prone to abuse by guardians who viewed the arrangement as an opportunity for financial gain.

How effective the Court of Wards and Liveries was in keeping guardians mindful of the particular needs of mentally ill wards is difficult to say. Nevertheless, the demise of the Court coincides with the effective demise of feudal guardianship following the passing of the Land Tenures Act, 1660, which finally dissolved the obligation to provide services to the Crown in lieu of obligations for holding land.

CHANCERY (OR CIVIL LAW) GUARDIANSHIP

In Chancery or Civil Law, guardianship from 1660 onwards became linked to the delegated authority of the Lord Chancellor to administer those concerned with the protection of the property of people who are incapable of so doing themselves. Although the authority of the Lord Chancellor to appoint guardians for the care and protection of mentally ill people was not officially recorded until 1845, [8 and 9 Vict c 100] most authorities recognise a growing influence of the Chancellor and a corresponding willingness to accept responsibility for people incapable of managing their own affairs.

Chancery guardianship has survived as 'guardianship of the estate', within the jurisdiction of the Court of Protection whose current responsibilities are confined to the protection of the property of people with mental illness and mental impairment.

CANON LAW GUARDIANSHIP

Two authorities in particular (Neaman* and Helmholz**) trace a continuing influence of Roman law into ecclesiastical affairs and suggest that the church in England offered protective care for people - who could not seek this protection from any other institution. Canon law carried with it the two forms of Roman guardianship most commonly applied to people in this situation, namely tutela and curatura, but it was the latter, curatura, that was most commonly advanced as the way to provide guardianship for people with mental illness who required representation and protection. It is not clear whether this law only gained help for such people within the legal systems for which the church were responsible, or whether this in effect offered a parallel form of redress to courts administering common law principles. As most of the Canon law concerned with guardianship was eventually merged with Chancery law, this suggests that a parallel set of laws and legal systems operated.

* J S Neaman, *Suggestion of the Devil: The Origins of Madness* (New York: Anchor Press/Doubleday, 1975).

** R H Helmholz, in 'The Roman Law of Guardianship in England, 1300-1600' (*Tulane Law Review*, 52/2, 1978), (p. 225, refers to: "a general jurisdiction in favour of 'miserabiles personae'").

Aside from the legal maxims of Canon law, was a humanitarian view that mentally ill people had sufficiently suffered by being mentally ill without the need for any further correction or punishment. Thus the basis for the Church offering protection was to remove such people from the possibility of recrimination and impoverishment. This applied whether or not the mentally ill person had behaved in a way which would otherwise have been regarded as criminal.

The position of mentally ill people subject to canon law and their need for guardians is the particular focus of a study by Sesto*, who summarises the position thus:-

"Historically, there appears very little canonical legislation concerning the subject of guardians, as the institute of guardianship was considered of particular concern to civil authorities. Moreover, the prescriptions of the Roman Law of Guardianship were considered adequate and were referred to consistently in canonical writing up to the publication of the [Canon Law Code in 1917]."

BOROUGH GUARDIANSHIP

Bateson** and Taylor*** see forms of guardianship applicable to the care of mentally ill people having been delegated through Royal recognition to mayors and officials of particular towns. The rationale may have arisen from patronage but whatever the basis of the delegation, local authorities, following local customs, were empowered to assist in the care of mentally ill people. Thus, by Bristol II, CAP 14, (14th Century):-

"and concerning the insane, the mayor shall take their goods and chattels and deliver them to the next of kin to be kept until they are restored to sanity. And the next of kin must provide a Guardian for the bodies of such insane persons, that no harm or mischief may happen to them and that they do no harm to others".

* Rev E J Sesto, **Guardians of the Mentally Ill in Ecclesiastical Trials** (Washington: The Catholic University of America Press, 1956).

** M Bateson, **Borough Customs** (Selden Society, London: Bernard Quaritch, 1904), p.CXXVIII.

*** H B Taylor, **Law of Guardian and Ward** (Ph D Dissertation, University of Chicago, 1935), pp. 13-14.

Bateson notes from the above that Bristol was one of only two boroughs whose customs deal with the subject of insanity, i.e. where it was notable that "the King's Wardship is excluded". She adds:-

"The subject of account is not treated, but there can be little doubt that account was required and that Wardship was not a profitable right of the next friends, for by this time, the boroughs had developed a Guardian's account....[Therefore there was clearly] a Wardship analogous to that provided for children who received bequests of land - namely a Wardship by Guardians appointed by the borough council [by which] the lands...of a lunatic who did not recover seemed therefore to have been taken up in trust by the borough..."

COMMITTEE

Bell* points out that the procedure whereby mentally ill people were committed to the care of their relatives by the Court of Wards became associated with arranging custody, and it would appear that the origin of the term 'committee' (meaning an individual rather than a group) is the person made legally responsible for custody and care of mentally ill persons. It is not clear from the literature whether committee was in itself regarded as another name for guardianship or as an alternative form of guardianship in either a derivative or delegated sense.

Citing Fitzherbert, Bell refers to guardians being involved in the sale of wardships through the Court of Wards and says that:-

"Such transference of the guardian's rights have been recognised from medieval times-for instance, the grantee, or as he has often termed committee, was entitled to the writ of Ravishment of the Ward in the same way as the original guardian."

No other reference to the term 'grantee' as an alternative to 'committee' has been traced.

* H E Bell, *An Introduction to the History and Records of the Court of Wards and Liveries* (Cambridge: Cambridge University Press, 1953), pp. 128-131.

Pope* says that the duties of the committee of the person:-

"relate to the personal care of the lunatic, and...imply the duties of fixing his residence, selecting his attendants, regulating his establishment, and making all other provisions for his maintenance, support, and comfort [and in pursuance of these tasks] to visit the lunatic at certain intervals,...and to have consideration for the health and comfort of the lunatic and, of course, where the possibility exists, his recovery. [Furthermore] the Committee is required, with the concurrence of the medical attendant, to make half-yearly an accurate report of the state of mind and bodily health of the lunatic, and, in particular, to report specially from time to time any important change occurring in either". (40)

The committee of the person was entitled to apply for reception of the mentally ill person "into an institution for lunatics or as a single patient". Pope also mentions particularly that "the Committee of the Person is not entitled to any remuneration for his care and trouble in protecting the lunatic" but could occasionally obtain recompense for particular expenditures. (41)

Theobold** summarises the above as follows:-

"The Committee of the Person has complete control over the person of the lunatic and it is his duty to make all necessary arrangements for his care and treatment. The lunatic may be received into an institution, or as a single patient, upon an Order signed by the Committee of the Person...[and] the choice of the lunatic's residence is within the discretion of the Committee of the Person."

Wood Renton*** identifies the duties of the committee of the person as follows:-

1. Duties as to residence:

"The Committee may settle and change at pleasure the lunatic's residence, which may be either with himself or with some other suitable person to whom he is responsible. He may also, if he thinks fit, place the lunatic in an institution for lunatics or under care as a single patient; and for this purpose an Order signed by the Committee will be sufficient authority for the lunatic's reception."

* H M R Pope, **Law and Practice of Lunacy** (London: Sweet and Maxwell, 1890), p. 372.

** Sir H S Theobold, **The Law Relating to Lunacy** (London: Stevens & Sons, 1924), p. 48.

*** Sir A Wood Renton, **The Law of and Practice in Lunacy** (Edinburgh: W Queen & Son, 1896).

2. Duties as to treatment:

"...the Committee of the Person has a wide discretion on all matters of treatment. He is entitled and bound to secure for the lunatic all the comfort and enjoyment that his fortune will admit of, to provide him with medical attendants as necessary, to protect him from designing persons, and even from the access of relatives and friends if it is likely to increase his disorder...."

3. Duties as to visitation and reports:

"...[included making] half-yearly a report to the Board of Visitors [of Lunatics, Royal Courts of Justice, London] on the mental and bodily state of the lunatic."

Of committees generally, Wood Renton says:-

"Committees in England and Ireland correspond to the tutors and curators [ie Guardians] of the civil law. There is Committee both of the Person and of the Estate of the lunatic. Both offices may be united in the same individual or in two or more individuals jointly. But as a rule the Committeeship of the Person is now kept distinct from the Committeeship of the Estate."

Rules governing the appointment of committee of the person are summarised by Wood Renton as follows:-

1. Committee of the Person should be resident within the jurisdiction of the Court.
2. Committee of the Person should reside within easy access of the lunatic.
3. The relations of a lunatic are to be preferred to strangers in regard to Committeeship of the Estate" but in the case of Committee of the Person there is the view referred to by Blackstone (see above) that the heir of the lunatic should not generally exercise the function of Committee of the Person. This concern diminished over time and relatives gained preference for the task-though with some reservations to preclude 'heirs-at-law'.
4. Consanguinity, although entitled to great regard, does not constitute any right to the Committeeship of the Person.
5. In the appointment of a Committee of the Person the wishes and inclinations of a lunatic will as far as possible be regarded, even if unreasonable.
6. A Committee of the same sex as the lunatic will be preferred".

Pope adds to point (6) the exception that "Where a lunatic is married the personal custody will be granted to the husband or wife, as the case may be."

The role of committee of the person in practice can be inferred by the agreements committees were expected to consent to when undertaking the task; in an example provided by Heywood the following was stated:-

"I, Jane Smith, of Black Acre in the County of Essex, Spinster, do hereby consent to be appointed and to act as Committee of the Person of the above named Mary Smith, and I hereby undertake to visit her once at least every three months, and at such other times that may be required, and see that she is duly attended to and has all necessary enjoyments and comforts."*

The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1954-1957) considered the relationship between guardianship and committee in the following terms:-

"...the procedure of legal inquisition for determining the control of the property or of the person of the patient, or both, remains in existence and is still occasionally used....The question at issue in an inquisition is whether the person is 'of unsound mind and incapable of managing himself or his affairs'. The exercise of the royal prerogative in relation to the care and commitment of the custody of persons found to be of unsound mind by inquisition and of their estates is now entrusted to the Lord Chancellor and the Judges of the Chancery Division of the High Court; the Court of Protection (the Judge and Master in Lunacy), which is responsible for the administration of the receivership procedures and for the general control of the management of patients' estates for which receivers have been appointed, also deal with the now rare cases on inquisition. The person appointed as 'Committee of the Person' following an inquisition can determine the patient's place of residence and can order his admission to and detention in hospital without using the certification or other admission procedures which are now used for other patients...."

* N A Heywood and R C Romer, *Lunacy Practice*, 5th Edn., (London: Stevens & Sons, 1920)

**SYNOPSIS OF 'COMPULSORY TREATMENT IN THE COMMUNITY':
DISCUSSION PAPER PRODUCED BY THE MENTAL HEALTH ACT
COMMISSION (1986)**

Introduction

The paper was introduced by reference to the 1985 Biennial Report of the Commission as having reopened the debate "about the balance of good and ill" in enforcing community treatment on mentally ill people, and this is linked with a report on "The Long Leash" promised in the Draft Code of Practice.

Recent case law*, is discussed together with attempts to make provision for compulsory treatment in the community within the terms of the Disabled Persons Act, 1986. The Commission's conclusion is that "Section 17 of the Mental Health Act, in its present form, cannot lawfully be pressed into service as a long term community treatment order".

The Commission admitted that they were not of one mind on the issue of compulsory community treatment and the paper is presented as a basis for wider discussion.

Past Community Treatment Order Proposals

Because the BASW 1977 Community Care Order proposals proved unacceptable, any new proposals along similar lines would need to take note of the reasons for these objections and produce "objective evidence...that such a power would reduce the incidence of relapses and decrease the need for in-patient care". Possibly a "different climate" of professional and inter-agency co-operation was evident compared with 1977.

Arguments Against Compulsory Treatment in the Community

- Such powers threaten the principle of personal autonomy.

* *Regina v Hallstrom and Another, ex parte W* and *Regina v Gardner and Another, ex parte L*, 20 December 1985

- The phenomenon of 'net-widening': ie more people being brought within the ambit of legal powers and control than would otherwise be the case (or the same people for longer periods).
- Philosophical/moral objections to the use of compulsion - i.e. should be used only as last resort.
- Enforced medication "may have unpleasant and disabling side effects" as well as not being necessarily beneficial.
- If to be well means to be symptom-free, those subjected to compulsory community treatment could have to contend with side effects which are more uncomfortable than residual effect of the illness.
- Lack of sanction.

Arguments in favour of compulsory treatment in the community

- As the extension of the use of 'maintenance' treatments reduces further the incidence of relapse and re-admissions to hospital, this process will begin to impact on those who not only lack insight and are unwilling to take medication but are "less amenable to professional authority than patients discharged in previous years". Compulsory community treatment will enable these people to live outside hospital provided their behaviour is socially acceptable.
- Why should those outside hospital be seen to have less of a right to treatment and/or care than their counterparts in hospital? Or, are such rights only given to those (outside hospital) who are able to rationally appreciate the value of the treatment?
- Those prone to relapse and to a downward spiral of deterioration, should be protected.

- The task of key workers in the management of mentally ill people in the community would be assisted with additional legal authority.
- There should be alternatives to hospital facilities for containing and detaining people under mental health legislation.
- An alternative to Section 17 arrangements needs to be found.

The Available Options

This section was introduced with comment to the effect that the Commission wanted to disturb the 1983 Act as little as possible and that they wished treatment to be seen in its widest sense: i.e. "care, support and supervision in the community" as well as medication.

Options A: No New Power

- No change.
- Transfer the patient onto guardianship.

Options B: Legislative Amendments

- An addition to existing guardianship of a statutory authority to physically convey the patient (as with admission to hospital) to out-patient treatment.
- Extensions of Section 17 and 20 (to allow renewal).
- A new Community Treatment Order (similar to BASW's Community Care Order).
- An expanded form of guardianship to be used in special cases. Implication: RMO has power to enforce treatment.

Which Option?

Options A1 and A2 could be tested forthwith.

B1 would remove doubt about guardian's powers to physically transport someone to a treatment situation but would not bring with it further powers to compel acceptance of medication.

B3 is too closely linked with the failure of the CCO, and associated with an increased authoritarian role for the social worker.

B4 - the favoured option.

Implementing this expanded form of guardianship would require various changes to the legislation, i.e. modifications to Section 8(1)(a), Section 25, Section 56, Section 61(b) and Sections 120/121.

Regulations would need to be introduced to define the conditions being provided for: i.e. that the mental illness is "of a long standing or severe psychotic type"; person refuses medication because of his acute illness apparently linked to failure to take medication.

Special guardianship is supported because the particular use envisaged for it can be closely defined and be seen to be in the "interests of the welfare of the patient" etc.

However in supporting the move the Commission say that they expect it to be "linked to a duty to provide other forms of care and supervision" in a more extensive attempt to combat relapses.

Would Special Guardianship work?

The existing reluctance of social services to use guardianship is seen as related to the resource question so the use of special guardianship would turn on growing awareness, presumably through assessment, of individual patients "who would have to remain detained in hospital if guardianship was not accepted".

ASWs are expected to support the move because they see the results of re-admissions following relapse and the social problems that ensue.

The move should also be linked to the wider question of the "transfer of resources and responsibilities from hospital to community services", not as an extra imposition but as "an integral element of such a transfer".

Conclusion

"... Special Guardianship ... would provide the most compassionate and effective control: for particular individuals with the least infringement of personal liberty. Wide professional endorsement was anticipated.

The need for "additional resources" and a substantial contribution from both health and local authority personnel is seen as "obviously" necessary to bring about a meaningful shift from hospital to community care.

STATISTICAL DATA ON SOCIAL WORKERS' VIEWS

GUARDIANSHIP PROVIDES:

Protective Care

Table No.93

	Kensington and Chelsea	Westminster	Row Total
Pro	9 (81.8%)	12 (75%)	21 (77.8%)
Neutral	1 (9.1%)	1 (6.3%)	2 (7.4%)
Con	1 (9.1%)	3 (18.8%)	4 (14.8%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Structured Care

Table No.94

	Kensington and Chelsea	Westminster	Row Total
Pro	10 (90.9%)	16 (100%)	26 (96.3%)
Neutral	1 (9.1%)	0	1 (3.7%)
Con	0	0	0
Col Totals	11 (100%)	16 (100%)	27 (100%)

Continuity of Care

Table No.95

	Kensington and Chelsea	Westminster	Row Total
Pro	10 (90.9%)	11 (68.8%)	21 (77.8%)
Neutral	1 (9.1%)	1 (6.3%)	2 (7.4%)
Con	0	4 (25%)	4 (14.8%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Reinforcement of Authority

Table No.96

	Kensington and Chelsea	Westminster	Row Total
Pro	7 (63.6%)	9 (56.3%)	16 (59.3%)
Neutral	4 (36.4%)	5 (31.3%)	9 (33.3%)
Con	0	2 (12.5%)	2 (7.4%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Priority Access to Services

Table No.97

	Kensington and Chelsea	Westminster	Row Total
Pro	4 (36.4%)	5 (31.3%)	9 (33.3%)
Neutral	3 (27.3%)	5 (31.3%)	8 (29.6%)
Con	4 (36.4%)	6 (37.5%)	10 (37.0%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Recognition of Need

Table No.98

	Kensington and Chelsea	Westminster	Row Total
Pro	5 (45.5%)	8 (50%)	13 (48.1%)
Neutral	3 (27.3%)	4 (25%)	7 (25.9%)
Con	3 (27.3%)	4 (25%)	7 (25.9%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Stabilising Influence

Table No.99

	Kensington and Chelsea	Westminster	Row Total
Pro	9 (81.8%)	13 (81.3%)	22 (81.5%)
Neutral	2 (18.2%)	3 (18.8%)	5 (18.5%)
Con	0	0	0
Col Totals	11 (100%)	16 (100%)	27 (100%)

GUARDIANSHIP AS SURROGACY AND IMPLICATIONS

Substituted Judgement

Table No.100

	Kensington and Chelsea	Westminster	Row Total
Pro	11 (100%)	13 (81.3%)	24 (88.9%)
Neutral	0	2 (12.5%)	2 (7.4%)
Con	0	1 (6.3%)	1 (3.7%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Pre-emption: Anticipating Need

Table No.101

	Kensington and Chelsea	Westminster	Row Total
Pro	3 (27.3%)	7 (43.8%)	10 (37.0%)
Neutral	6 (54.5%)	2 (12.5%)	8 (29.6%)
Con	2 (18.2%)	7 (43.8%)	9 (33.3%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Pre-emption: Onset of Dementia

Table No.102

	Kensington and Chelsea	Westminster	Row Total
Pro	3 (27.3%)	5 (31.3%)	8 (29.6%)
Neutral	2 (18.2%)	4 (25.0%)	6 (22.2%)
Con	6 (54.5%)	7 (43.8%)	13 (48.1%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

GUARDIANSHIP OBJECTIVE

Facilitating Change: General Sense

Table No.103

	Kensington and Chelsea	Westminster	Row Total
Pro	8 (72.7%)	8 (50.0%)	16 (59.3%)
Neutral	2 (18.2%)	3 (18.8%)	5 (18.5%)
Con	1 (9.1%)	5 (31.3%)	6 (22.2%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Facilitating Change: Emotional and Psychological

Table No.104

	Kensington and Chelsea	Westminster	Row Total
Pro	3 (27.3%)	6 (37.5%)	9 (33.3%)
Neutral	6 (54.5%)	4 (25.0%)	10 (37.0%)
Con	2 (18.2%)	6 (37.5%)	8 (29.6%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Facilitating Change: Behaviour

Table No.105

	Kensington and Chelsea	Westminster	Row Total
Pro	8 (72.7%)	10 (62.5%)	18 (66.7%)
Neutral	2 (18.2%)	2 (12.5%)	4 (14.8%)
Con	1 (9.1%)	4 (25.0%)	5 (18.5%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

DIFFERENTIAL USE

For Depressed Clients

Table No.106

	Kensington and Chelsea	Westminster	Row Total
Pro	4 (36.4%)	5 (31.3%)	9 (33.3%)
Neutral	3 (27.3%)	5 (31.3%)	8 (29.6%)
Con	4 (36.4%)	6 (37.5%)	10 (37.0%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Clients with 'Compliant' Personalities

Table No.107

	Kensington and Chelsea	Westminster	Row Total
Pro	4 (36.4%)	5 (31.3%)	9 (33.3%)
Neutral	3 (27.3%)	4 (25.0%)	7 (25.9%)
Con	4 (36.4%)	7 (43.8%)	11 (40.7%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

CIRCUMSTANTIAL/CONTINGENT USE

Socially Vulnerable Clients

Table No.108

	Kensington and Chelsea	Westminster	Row Total
Pro	10 (90.9%)	10 (62.5%)	20 (74.1%)
Neutral	0	3 (18.8%)	3 (11.1%)
Con	1 (9.1%)	3 (18.8%)	4 (14.8%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Enforce Specific Authority

Table No.109

	Kensington and Chelsea	Westminster	Row Total
Pro	11 (100%)	13 (81.3%)	24 (88.9%)
Neutral	0	3 (18.8%)	3 (11.1%)
Con	0	0	0
Col Totals	11 (100%)	16 (100%)	27 (100%)

Firming Up After Care

Table No.110

	Kensington and Chelsea	Westminster	Row Total
Pro	9 (81.8%)	12 (75.0%)	21 (77.8%)
Neutral	0	2 (12.5%)	2 (7.4%)
Con	2 (18.2%)	2 (12.5%)	4 (14.8%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

ESSENTIAL POWERS

Access

Table No.111

	Kensington and Chelsea	Westminster	Row Total
Pro	11 (100%)	9 (56.3%)	20 (74.1%)
Neutral	0	1 (6.3%)	1 (3.7%)
Con	0	6 (37.5%)	6 (22.2%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Attendance

Table No.112

	Kensington and Chelsea	Westminster	Row Total
Pro	10 (90.9%)	10 (62.5%)	20 (74.1%)
Neutral	0	5 (31.3%)	5 (18.5%)
Con	1 (9.1%)	1 (6.3%)	2 (7.4%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Residence

Table No 113

	Kensington and Chelsea	Westminster	Row Total
Pro	10 (90.9%)	13 (81.3%)	23 (85.2%)
Neutral	1 (9.1%)	2 (12.5%)	3 (11.1%)
Con	0	1 (6.3%)	1 (3.7%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

CONTAINMENT AND RESTRAINT

Physical Restraint

Table No.114

	Kensington and Chelsea	Westminster	Row Total
Pro	5 (45.5%)	11 (68.8%)	16 (59.3%)
Neutral	2 (18.2%)	0	2 (7.4%)
Con	4 (36.4%)	5 (31.3%)	9 (33.3%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Containment

Table No.115

	Kensington and Chelsea	Westminster	Row Total
Pro	7 (63.3%)	10 (62.5%)	17 (63.0%)
Neutral	1 (19.1%)	1 (6.3%)	2 (7.4%)
Con	3 (27.3%)	5 (31.3%)	8 (29.6%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

RESIDENTIAL PLACEMENTS

Means of Facilitation

Table No.116

	Kensington and Chelsea	Westminster	Row Total
Pro	9 (81.8%)	10 (62.5%)	19 (70.4%)
Neutral	1 (9.1%)	2 (12.5%)	3 (11.1%)
Con	1 (9.1%)	4 (25.5%)	5 (18.5%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Detention Justified

Table No.117

	Kensington and Chelsea	Westminster	Row Total
Pro	5 (45.5%)	8 (50.0%)	13 (48.1%)
Neutral	4 (36.4%)	4 (25.0%)	8 (29.6%)
Con	2 (18.2%)	4 (25.0%)	6 (22.2%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Adaptation of Regimes

Table No.118

	Kensington and Chelsea	Westminster	Row Total
Pro	9 (81.8%)	12 (75.0%)	21 (77.8%)
Neutral	2 (18.2%)	2 (12.5%)	4 (14.8%)
Con	0	2 (12.5%)	2 (7.4%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

ROLES OF SOCIAL WORKERS AND GUARDIANS COMPARED

Social Work As Basic Care Taking

Table No.119

	Kensington and Chelsea	Westminster	Row Total
Pro	10 (90.9%)	13 (81.3%)	23 (85.2%)
Neutral	0	1 (6.3%)	1 (3.7%)
Con	1 (9.1%)	2 (12.5%)	3 (11.1%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Guardianship As Basic Care Taking

Table No.120

	Kensington and Chelsea	Westminster	Row Total
Pro	11 (100%)	15 (93.8%)	26 (96.3%)
Neutral	0	1 (6.3%)	1 (3.7%)
Con	0	0	0
Col Totals	11 (100%)	16 (100%)	27 (100%)

Social Work As Enabling

Table No.121

	Kensington and Chelsea	Westminster	Row Total
Pro	11 (100%)	16 (100%)	27 (100%)
Neutral	0	0	0
Con	0	0	0
Col Totals	11 (100%)	16 (100%)	27 (100%)

Guardianship As Enabling

Table No.122

	Kensington and Chelsea	Westminster	Row Total
Pro	5 (45.5%)	13 (81.3%)	18 (66.7%)
Neutral	3 (27.3%)	2 (12.5%)	5 (18.5%)
Con	3 (27.3%)	1 (6.3%)	4 (14.8%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Social Work As Advocacy

Table No.123

	Kensington and Chelsea	Westminster	Row Total
Pro	11 (100%)	16 (100%)	27 (100%)
Neutral	0	0	0
Con	0	0	0
Col Totals	11 (100%)	16 (100%)	27 (100%)

Guardianship As Advocacy

Table No 124

	Kensington and Chelsea	Westminster	Row Total
Pro	9 (81.8%)	14 (87.5%)	23 (85.2%)
Neutral	2 (18.2%)	1 (6.3%)	3 (11.1%)
Con	0	1 (6.3%)	1 (3.7%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Social Work As Surrogacy

Table No.125

	Kensington and Chelsea	Westminster	Row Total
Pro	4 (36.4%)	6 (37.5%)	10 (37.0%)
Neutral	5 (45.5%)	2 (12.5%)	7 (25.9%)
Con	2 (18.2%)	8 (50.0%)	10 (37.0%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Guardianship As Surrogacy

Table No.126

	Kensington and Chelsea	Westminster	Row Total
Pro	11 (100%)	16 (100%)	27 (100%)
Neutral	0	0	0
Con	0	0	0
Col Totals	11 (100%)	16 (100%)	27 (100%)

**Are There Guardianship Functions
Incompatible With Social Work?**

Table No.127

	Kensington and Chelsea	Westminster	Row Total
Yes	4 (36.4%)	10 (62.5%)	14 (51.9%)
Neutral	4 (36.4%)	3 (18.8%)	7 (26.9%)
No	3 (27.3%)	3 (18.8%)	6 (22.2%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Social Work As Informal Guardianship

Table No.128

	Kensington and Chelsea	Westminster	Row Total
Pro	8 (72.7%)	14 (87.5%)	22 (81.5%)
Neutral	2 (18.2%)	2 (12.5%)	4 (14.8%)
Con	1 (9.1%)	0	1 (3.7%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Other SSD Employees As Guardians

Table No.129

	Kensington and Chelsea	Westminster	Row Total
Pro	7 (63.6%)	13 (81.3%)	20 (74.1%)
Neutral	1 (9.1%)	2 (12.5%)	3 (11.1%)
Con	3 (27.3%)	1 (6.3%)	4 (14.8%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Guardians Outside Social Services

Table No.130

	Kensington and Chelsea	Westminster	Row Total
Pro	8 (72.7%)	10 (62.5%)	18 (66.7%)
Neutral	2 (18.2%)	3 (18.8%)	5 (18.5%)
Con	1 (9.1%)	3 (18.8%)	4 (14.8%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Guardian As Family Member

Table No.131

	Kensington and Chelsea	Westminster	Row Total
Pro	6 (54.5%)	9 (56.3%)	15 (55.6%)
Neutral	4 (36.4%)	2 (12.5%)	6 (22.2%)
Con	1 (9.1%)	5 (31.3%)	6 (22.2%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

FUTURE PROSPECTS AND PROBLEM AREAS

Extended Use

Table No.132

	Kensington and Chelsea	Westminster	Row Total
Use more	9 (81.8%)	6 (37.5%)	15 (55.6%)
Same as now	0	2 (12.5%)	2 (7.4%)
Less	2 (18.2%)	8 (50.0%)	10 (37.0%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Demand On Agencies' Resources

Table No.133

	Kensington and Chelsea	Westminster	Row Total
Pro	7 (63.6%)	6 (37.5%)	13 (48.1%)
Neutral	0	2 (12.5%)	2 (7.4%)
Con	4 (36.4%)	8 (50.0%)	12 (44.4%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Concern Over Use Of Coercion

Table No.134

	Kensington and Chelsea	Westminster	Row Total
Pro	9 (81.8%)	12 (75.0%)	21 (77.8%)
Neutral	0	1 (6.3%)	1 (3.7%)
Con	2 (18.2%)	3 (18.8%)	5 (18.5%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

'Toothless Wonder' (Insufficient Powers)

Table No.135

	Kensington and Chelsea	Westminster	Row Total
Pro	8 (72.1%)	11 (68.8%)	19 (70.4%)
Neutral	2 (18.2%)	1 (6.3%)	3 (11.1%)
Con	1 (9.1%)	4 (25.0%)	5 (18.5%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Civil Rights Infringed

Table No.136

	Kensington and Chelsea	Westminster	Row Total
Pro	2 (18.2%)	8 (50.0%)	10 (37.0%)
Neutral	4 (36.4%)	3 (18.8%)	7 (25.9%)
Con	5 (45.5%)	5 (31.3%)	10 (37.0%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Misuse/Abuse of Authority

Table No.137

	Kensington and Chelsea	Westminster	Row Total
Pro	7 (63.6%)	9 (56.3%)	16 (59.3%)
Neutral	0	2 (12.5%)	2 (7.4%)
Con	4 (36.4%)	5 (31.3%)	9 (33.3%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Inappropriate Responsibility for Adults

Table No.138

	Kensington and Chelsea	Westminster	Row Total
Pro	8 (72.7%)	5 (33.3%)	13 (50.0%)
Neutral	0	2 (13.3%)	2 (7.7%)
Con	3 (27.3%)	8 (53.3%)	11 (42.3%)
Col Totals	11 (100%)	15 (100%)	26 (100%)

Guardianship Needs to Change

Table No.139

	Kensington and Chelsea	Westminster	Row Total
Pro	6 (54.5%)	10 (62.5%)	16 (59.3%)
Neutral	4 (36.4%)	4 (25.0%)	8 (29.6%)
Con	1 (9.1%)	2 (12.5%)	3 (11.1%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Adjustment to Individual

Table No.140

	Kensington and Chelsea	Westminster	Row Total
Pro	9 (90.0%)	10 (76.9%)	19 (82.6%)
Neutral	0	2 (15.4%)	2 (8.7%)
Con	1 (10.0%)	1 (7.7%)	2 (8.7%)
Col Totals	10 (100%)	13 (100%)	23 (100%)

Guardianship Powers: Should stay the same

Table No.141

	Kensington and Chelsea	Westminster	Row Total
Pro	0	3 (18.8%)	3 (11.1%)
Neutral	0	1 (6.3%)	1 (3.7%)
Con	11 (100%)	12 (75.0%)	23 (85.2%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Detention Powers: 'Outlaw Them'

Table No.142

	Kensington and Chelsea	Westminster	Row Total
Pro	2 (18.2%)	0	2 (7.4%)
Neutral	0	1 (6.3%)	1 (3.7%)
Con	9 (81.8%)	15 (93.8%)	24 (88.9%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Package of Care

Table No.143

	Kensington and Chelsea	Westminster	Row Total
Pro	11 (100%)	13 (81.3%)	24 (88.9%)
Neutral	0	1 (6.3%)	1 (3.7%)
Con	0	2 (12.5%)	2 (7.4%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

Resource Consequences

Table No.144

	Kensington and Chelsea	Westminster	Row Total
Pro	10 (90.9%)	12 (75.0%)	22 (81.5%)
Neutral	1 (9.1%)	4 (25.0%)	5 (18.5%)
Con	0	0	0
Col Totals	11 (100%)	16 (100%)	27 (100%)

Budgets for Guardians

Table No.145

	Kensington and Chelsea	Westminster	Row Total
Pro	0	1 (6.7%)	1 (3.8%)
Neutral	4 (36.4%)	8 (53.3%)	12 (46.2%)
Con	7 (63.6%)	6 (40.0%)	13 (50.0%)
Col Totals	11 (100%)	15 (100%)	26 (100%)

COMPULSORY TREATMENT IN THE COMMUNITY

Is This Power Required?

Table No.146

	Kensington and Chelsea	Westminster	Row Total
Pro	8 (72.7%)	12 (75.0%)	20 (74.1%)
Neutral	3 (27.3%)	1 (6.3%)	4 (14.8%)
Con	0	3 (18.8%)	3 (11.1%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

- Within 'Special Guardianship'?

Table No.147

	Kensington and Chelsea	Westminster	Row Total
Pro	6 (54.5%)	8 (50.0%)	14 (51.9%)
Neutral	3 (27.3%)	4 (25.0%)	7 (25.9%)
Con	2 (18.2%)	4 (25.0%)	6 (22.2%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

- Outside Guardianship Framework?

Table No.148

	Kensington and Chelsea	Westminster	Row Total
Pro	2 (18.2%)	2 (12.5%)	4 (14.8%)
Neutral	6 (54.5%)	3 (18.8%)	9 (33.3%)
Con	3 (27.3%)	11 (68.8%)	14 (51.9%)
Col Totals	11 (100%)	16 (100%)	27 (100%)

STATISTICAL DATA ON GUARDIANSHIP CLIENTS**DIAGNOSIS AND AGE****TABLE NO. 62**

	Schizophrenia	Dementia	Depression	Other	Row Totals
-21	1 (5.3%)	0	1 (14.3%)	0	2 (5%)
21-30	1 (5.3%)	0	1 (14.3%)	2 (66.7%)	4 (10%)
31-40	5 (26.3%)	0	0	1 (33.3%)	6 (15%)
41-50*	4 (21.2%)	0	0	0	4 (10%)
51-60*	2 (10.6%)	0	1 (14.3%)	0	3 (7.5%)
61-70	3 (15.8%)	0	2 (28.6%)	0	5 (12.5%)
71-80	2 (10.6%)	2 (18.2%)	1 (14.3%)	0	5 (12.5%)
80+	1 (5.3%)	9 (81.8%)	1 (14.3%)	0	11 (27.5%)
Col Totals	19 (100%)	11** (100%)	7 (100%)	3 (100%)	40 (100%)

* Only one of the seven clients in these age ranges was aged between 44 and 54

** Age of one client not known - total number of clients with dementia = 12

DIAGNOSIS AND LIVING ARRANGEMENTS**TABLE NO. 63**

	Schizophrenia	Dementia	Depression	Other	Row Totals
Alone	14 (73.7%)	9 (75%)	5 (71.4%)	1 (33.3%)	29 (70.8%)
Nuclear Family	3 (15.8%)	2 (16.7%)	2 (28.6%)	0	7 (17.1%)
Residential	2 (10.6%)	1 (8.3%)	0	2 (66.7%)	5 (12.2%)
Col Totals	19 (100%)	12 (100%)	7 (100%)	3 (100%)	41 (100%)

DIAGNOSIS AND FAMILY SUPPORT

TABLE NO. 64

	Schizophrenia	Dementia	Depression*	Other	Row Totals
Close	4 (21.1%)	0	1 (14.3%)	0	5 (12.2%)
Variable Limited or Negligible	15 (78.9%)	12 (100%)	6 (85.7%)	3 (100%)	36* (87.8%)
Col Totals	19 (100%)	12 (100%)	7 (100%)	3 (100%)	41 (100%)

* 20 of these clients were said to experience a negligible amount of support

DIAGNOSIS AND GUARDIANSHIP OBJECTIVES: ESSENTIAL POWERS AS SERVICES

TABLE NO. 65

	Schizophrenia	Dementia	Depression*	Mental Handicap	Other	Row Totals
Residence	10 (52.6%)	9 (75%)	6 (85.7%)	2 (100%)	1 (100%)	28 (68.3%)
Access	6 (31.6%)	3 (25%)	0	0	0	9 (21.9%)
Attendance	3 (15.8%)	0	1 (14.3%)	0	0	4 (9.8%)
Col Totals	19 (100%)	12 (100%)	7 (100%)	2 (100%)	1 (100%)	41 (100%)

* Depression refers also to Manic Depressive Psychosis

STATUS CATEGORY GROUP AND GENDER

TABLE NO. 66

	Category [1]	Category [2]	Row Totals
Male	4 (30.8%)	10 (35.8%)	14 (34.1%)
Female	9 (69.2%)	18 (64.3%)	27 (65.9%)
Col Totals	13 (100%)	28 (100%)	41 (100%)

STATUS CATEGORY GROUP AND MARITAL STATUS

TABLE NO. 67

	Category Group [1]	Category Group [2]	Row Totals
Married	0	2 (7.1%)	2 (4.9%)
Single	9 (69.2%)	18 (64.3%)	27 (65.9%)
Widow/Widower	2 (15.4%)	6 (21.4%)	8 (19.5%)
Cohabiting	1 (7.7%)	1 (3.6%)	2 (4.9%)
Separated	0	1 (3.6%)	1 (2.4%)
Not Known	1 (7.7%)	0	1 (2.4%)
Col Totals	13 (100%)	28 (100%)	41 (100%)

STATUS CATEGORY GROUP OF GUARDIANSHIP CLIENTS AND ETHNICITY

TABLE NO. 68

	Category Group [1]		Category Group [2]		Row Totals	
British	8	(61.5%)	23	(82.1%)	31	(75.7%)
Polish	1	(7.7%)	2	(7.1%)	3	(7.3%)
Jewish	0		2	(7.1%)	2	(4.9%)
West Indian	1	(7.7%)	1	(3.6%)	2	(4.9%)
Other	3	(23.1%)	0		3	(7.3%)
Col Totals	13	(100%)	28	(100%)	41	(100%)

STATUS CATEGORY GROUP AND LIVING ARRANGEMENTS

TABLE NO. 69

	Category Group [1]		Category Group [2]		Row Totals	
Alone	9	(69.2%)	20	(71.4%)	29	(70.7%)
Nuclear Family	2	(15.4%)	5	(17.9%)	7	(17.1%)
Residential Care	2	(15.4%)	3	(10.7%)	5	(12.2%)
Col Totals	13	(100%)	28	(100%)	41	(100%)

STATUS GROUP AND LIVING ARRANGEMENTS

TABLE NO. 70

	Category Group [1]		Category Group [2]		Row Totals	
Alone	9	(69.2%)	20	(71.4%)	29	(70.7%)
Family or Residential	4	(30.8%)	8	(28.6%)	12	(29.3%)
Col Totals	13	(100%)	28	(100%)	41	(100%)

Chi-Square Value 0.021 p = .886

Yates' Correction Value 0.000 p = 1.000

Fisher's Exact Text p = 1.000 *df = 1*

Minimum Expected Frequency = 3.8

STATUS GROUP AND LIVING ARRANGEMENTS

TABLE NO. 71

	Category Group [1]		Category Group [2]		Row Totals	
Residential Care	2	(15.4%)	3	(10.7%)	5	(12.2%)
Alone or Family	11	(84.6%)	25	(89.3%)	36	(87.8%)
Col Totals	13	(100%)	28	(100%)	41	(100%)

Fisher's Exact Text p = .645 *df = 1*

Minimum Expected Frequency = 1.6

STATUS CATEGORY GROUP AND FAMILY SUPPORT

TABLE NO. 72

	Category Group [1]		Category Group [2]		Row Totals	
Close	1	(7.7%)	4	(14.3%)	5	(12.2%)
Variable	2	(15.4%)	4	(14.3%)	6	(14.6%)
Limited	4	(30.8%)	6	(21.4%)	10	(24.4%)
Negligible	6	(46.2%)	14	(50.0%)	20	(48.8%)
Col Totals	13	(100%)	28	(100%)	41	(100%)

STATUS CATEGORY GROUPS AND DIAGNOSIS

TABLE NO. 73

	Category Group [1]		Category Group [2]		Row Totals	
Schizophrenia	7	(53.8%)	12	(42.9%)	19	(46.3%)
Dementia	2	(15.4%)	10	(35.7%)	12	(29.3%)
Depression	3	(23.1%)	4	(14.3%)	7	(17.1%)
Mental Handicap	1	(7.7%)	1	(3.6%)	2	(4.9%)
Other	0		1	(3.6%)	1	(2.4%)
Col Totals	13	(100%)	28	(100%)	41	(100%)

STATUS CATEGORY GROUP AND SCHIZOPHRENIA

TABLE NO. 74

	Category Group [1]		Category Group [2]		Row Totals	
Schizophrenia	7	(53.8%)	12	(42.9%)	19	(46.3%)
Others	6	(46.2%)	16	(57.1%)	22	(53.7%)
Col Totals	13	(100%)	28	(100%)	41	(100%)

Chi-Square Value .43115 p = .5114

Yates' Correction Value .10246 p = .7489 df = 1

Minimum Expected Frequency = 6.0

STATUS CATEGORY GROUP AND DEMENTIA

TABLE NO. 75

	Category Group [1]		Category Group [2]		Row Totals	
Dementia	2	(15.4%)	10	(35.7%)	12	(29.3%)
Others	11	(84.6%)	18	(64.3%)	29	(70.7%)
Col Totals	13	(100%)	28	(100%)	41	(100%)

Chi-Square Value 1.77242 p = .1841

Yates' Correction Value .92643 p = .3358

Fisher's Exact Text p = .276 df = 1

Minimum Expected Frequency = 3.8

**STATUS CATEGORY GROUP AND HOSPITALIZATION -
COMPULSORY ADMISSIONS**

TABLE NO. 76

	Category Group [1]		Category Group [2]		Row Totals	
None	2	(20%)	11	(57.9%)	13	(44.9%)
One	2	(20%)	3	(15.8%)	5	(17.2%)
Two	1	(10%)	2	(10.5%)	3	(10.3%)
Three or more	5	(50%)	3	(15.8%)	8	(27.5%)
Col Totals	10	(100%)	19	(100%)	29	(100%)

**STATUS CATEGORY GROUP AND HOSPITALIZATION -
VOLUNTARY ADMISSIONS**

TABLE NO. 77

	Category Group [1]		Category Group [2]		Row Totals	
None	7	(77.8%)	14	(70%)	21	(72.2%)
One	0		3	(15%)	3	(10.3%)
Two	2	(22.2%)	1	(5%)	3	(10.3%)
Three or more	0		2	(10%)	2	(6.9%)
Col Totals	9	(100%)	20	(100%)	29	(100%)

**STATUS CATEGORY GROUP AND GUARDIANSHIP OBJECTIVES -
ESSENTIAL POWERS (AS SERVICE PROVISION)**

TABLE NO. 78

	Category Group [1]		Category Group [2]		Row Totals	
Residential Care*	10	(76.9%)	18	(64.3%)	28	(68.3%)
Providing Access**	3	(23.1%)	6	(21.4%)	9	(21.2%)
Ensuring Attendance***	0		4	(14.3%)	4	(9.8%)
Col Totals	13	(100%)	28	(100%)	41	(100%)

*Divided as follows:-

	Category Group [1]		Category Group [2]		Row Totals	
Residential Placements	6		17		23	
Regularising Residential Placements	4		1		5	
Col Totals	10		18		28	

**Divided as follows:-

	Category Group [1]		Category Group [2]		Row Totals	
Access to Social Worker	1		1		2	
Access - Other Services	1		2		3	
Access - Regularising Existing Arrangements	1		3		4	
Col Totals	3		6		9	

***Divided as follows:-

	Category Group [1]		Category Group [2]		Row Totals	
Attendance - Day Care	0		1		1	
Attendance - Out Patient Treatment	0		3		3	
Col Totals	0		4		4	

STATUS CATEGORY GROUP AND MEDICAL INFLUENCE: 'WAS THERE?'

TABLE NO. 79

	Category Group [1]		Category Group [2]		Row Totals	
Yes	9	(75%)	13	(50%)	22	(57.9%)
Uncertain	1	(8.3%)	1	(3.8%)	2	(5.3%)
No	2	(16.7%)	12	(46.2%)	14	(36.8%)
Col Totals	12	(100%)	26	(100%)	38	(100%)

STATUS CATEGORY GROUP AND MEDICAL INFLUENCE: 'WHICH WAY?'

TABLE NO. 80

	Category Group [1]		Category Group [2]		Row Totals	
Favourable	9	(100%)	5	(41.7%)	14	(66.7%)
Variable/Uncertain	0		2	(16.7%)	2	(9.5%)
Against	0		5	(41.7%)	5	(23.9%)
Col Totals	9	(100%)	12	(100%)	21	(100%)

AGES OF GUARDIANSHIP CLIENTS IN THE TWO AGENCIES

TABLE NO. 81

	Kensington & Chelsea		Westminster		Row Totals	
40 or below	4	(17.4%)	8	(47.1%)	12	(30%)
41-50	1	(4.3%)	3	(17.6%)	4	(10%)
51-60	3	(13.0%)	0		3	(7.5%)
61-70	2	(8.6%)	3	(17.6%)	5	(12.5%)
71-80	3	(17.0%)	2	(11.8%)	5	(12.5%)
81+	10	(43.5%)	1	(5.9%)	11	(28.4%)
Col Totals	23	(100%)	17	(100%)	40	(10%)

MARITAL STATUS IN THE TWO AGENCIES

TABLE NO. 82

	Kensington & Chelsea		Westminster		Row Totals	
Married	1	(4.2%)	1	(6.3%)	2	(5.0%)
Single	16	(66.7%)	11	(68.8%)	27	(67.5%)
Widow/Widower	6	(25.0%)	2	(12.6%)	8	(20.0%)
Cohabiting	1	(4.2%)	1	(6.3%)	2	(5.0%)
Separated	0		1	(6.3%)	1	(2.5%)
Col Totals	24	(100%)	16	(100%)	40	(100%)

GUARDIANSHIP CLIENTS AND ETHNICITY IN THE TWO AGENCIES

TABLE NO. 83

	Kensington & Chelsea		Westminster		Row Totals	
British	21	(87.5%)	10	(58.8%)	31	(75.6%)
Polish	2	(8.3%)	1	(5.9%)	3	(7.3%)
Jewish	1	(4.2%)	1	(5.9%)	2	(4.9%)
West Indian	0		2	(11.8%)	2	(4.9%)
Other	0		3	(17.6%)	3	(7.3%)
Col Totals	24	(100%)	17	(100%)	41	(100%)

DIAGNOSIS OF GUARDIANSHIP CLIENTS IN THE TWO AGENCIES

TABLE NO. 84

	Kensington & Chelsea		Westminster		Row Totals	
Schizophrenia	8	(33.3%)	11	(64.7%)	19	(46.3%)
Dementia	11	(45.9%)	1	(5.9%)	12	(29.3%)
Depression (& Manic Depression)	4	(16.7%)	3	(17.7%)	7	(17.1%)
Mental Handicap	0		2	(11.8%)	2	(4.8%)
Other	1	(4.2%)	0		1	(2.4%)
Col Totals	24	(100%)	17	(100%)	41	(100%)

LIVING ARRANGEMENTS IN THE TWO AGENCIES

TABLE NO. 85

	Kensington & Chelsea		Westminster		Row Totals	
Alone	19	(79.2%)	10	(58.8%)	29	(70.7%)
Nuclear Family	3	(12.5%)	4	(23.5%)	7	(17.1%)
Residential Care	2	(8.3%)	3	(17.6%)	5	(12.2%)
Col Totals	24	(100%)	17	(100%)	41	(100%)

FAMILY SUPPORT IN THE TWO AGENCIES

TABLE NO. 86

	Kensington & Chelsea		Westminster		Row Totals	
Close	3	(12.5%)	2	(11.8%)	5	(12.2%)
Variable	3	(12.5%)	3	(17.6%)	6	(14.6%)
Limited	6	(25%)	4	(23.5%)	10	(24.4%)
Negligible	12	(50%)	8	(47.1%)	20	(48.8%)
Col Totals	24	(100%)	17	(100%)	41	(100%)

HOSPITALIZATION - COMPULSORY ADMISSIONS IN THE TWO AGENCIES

TABLE NO. 87

	Kensington & Chelsea		Westminster		Row Totals	
0	11	(64.7%)	2	(14.3%)	13	(41.9%)
1	2	(11.8%)	3	(21.4%)	5	(16.1%)
2	2	(11.8%)	2	(14.3%)	4	(12.9%)
3	1	(5.9%)	2	(14.3%)	3	(9.7%)
4	0		2	(14.3%)	2	(6.5%)
5 or more	1	(5.9%)	3	(21.4%)	4	(12.9%)
Col Totals	17	(100%)	14	(100%)	31	(100%)

HOSPITALIZATION - VOLUNTARY ADMISSIONS IN THE TWO AGENCIES

TABLE NO. 88

	Kensington & Chelsea		Westminster		Row Totals	
0	16	(84.2%)	5	(50%)	21	(72.4%)
1	2	(10.5%)	1	(10%)	3	(10.3%)
2	0		3	(30%)	3	(10.3%)
3 or more	1	(5.3%)	1	(10%)	2	(6.9%)
Col Totals	19	(100%)	10	(100%)	29	(100%)

**GUARDIANSHIP OBJECTIVES IN THE TWO AGENCIES - ESSENTIAL
POWERS AS SERVICES**

TABLE NO. 89

	Kensington & Chelsea	Westminster	Row Totals
Residential Care*	16 (66.7%)	12 (70.6%)	28 (68.3%)
Providing Access**	5 (20.8%)	4 (23.5%)	9 (21.9%)
Ensuring Attendance***	3 (12.5%)	1 (5.9%)	4 (9.8%)
Col Totals	24 (100%)	17 (100%)	41 (100%)

* Divided as follows:-

	Kensington & Chelsea	Westminster	Row Totals
Residential Placement	16	7	23
Regularising Residential Placement	0	5	5
Col Totals	16	12	28

** Divided as follows:-

	Kensington & Chelsea	Westminster	Row Totals
Access to Social Worker	1	1	2
Access - Other Services	2	1	3
Access - Regularising Existing Arrangements	2	2	4
Col Totals	5	4	9

***Divided as follows:-

	Kensington & Chelsea	Westminster	Row Totals
Attendance - Day Care	1	0	1
Attendance - Out Patient Treatment	2	1	3
Col Totals	3	1	4

GUARDIANSHIP PURPOSE REALIZABILITY IN THE TWO AGENCIES

TABLE NO. 90

	Kensington & Chelsea		Westminster		Row Totals	
Achieved/Achievable	10	(43.5%)	9	(52.9%)	19	(47.5%)
Not Clear	11	(47.9%)	5	(29.4%)	16	(40.0%)
Unlikely	2	(8.7%)	3	(17.6%)	5	(12.5%)
Col Totals	23	(100%)	17	(100%)	40	(100%)

MEDICAL INFLUENCE IN THE TWO AGENCIES: 'WAS THERE?'

TABLE NO. 91

	Kensington & Chelsea		Westminster		Row Totals	
Yes	11	(45.9%)	12	(70.6%)	23	(56.1%)
Uncertain/Variable	2	(8.3%)	2	(11.8%)	4	(9.8%)
No	11	(45.9%)	3	(17.6%)	14	(34.1%)
Col Totals	24	(100%)	17	(100%)	41	(100%)

MEDICAL INFLUENCE IN THE TWO AGENCIES: 'WHICH WAY?'

TABLE NO. 92

	Kensington & Chelsea		Westminster		Row Totals	
Favoured	6	(54.5%)	9	(75.0%)	15	(65.2%)
Variable/Uncertain	1	(9.1%)	2	(16.7%)	3	(13.0%)
Against	4	(36.4%)	1	(8.3%)	5	(21.7%)
Col Totals	11	(100%)	12	(100%)	23	(100%)

GUARDIANSHIP RESEARCH

LWBC254

SECTION A QUESTIONNAIRE

I. SOCIAL WORKER IDENTIFICATION

This form is for completion by the Social Worker identified as follows:-

Social Worker
Reference Code

II GUARDIANSHIP CASE CASE IDENTIFICATION AND BASIC DATA

This form is for completion in respect of a Guardianship client identified as follows:-

Number of cases (per SW)	Reference Code	Status (Encircle appropriate No.)	Date for Renewal/ Lapse
		In force - 1	
		Lapsed - 2	
		Considered	
		-Prop'd/Acc'd- 3	
		-Proposed/ Not accepted- 4	
		-Considered/ not proposed- 5	

III. CASE DATA: THE INFORMATION REQUIRED

1. What is the Age of your client? | |
 (Please enter age in figures in the adjoining box)

2. Please put a tick against the appropriate box to indicate the Sex and Marital status of your client.

Male Female

Married Single Widow/Widower

Cohabiting

3. What is the nationality/ethnic origin of your client?

please provide brief details of client under headings (4)-(8):-

4. Family situation and relationship within family.
5. Diagnostic label and/or description of mental health problem
6. Brief history of hospital care and treatment
7. Brief history of community care and treatment
8. Brief history of Social Work involvement: how long, why etc.
9. How did the question of the suitability for Guardianship first arise?
10. When was this?
11. Who first made the suggestion?
12. How did these considerations relate to the main social work goals and social work care needs in this case.
13. What other means have been tried to achieve these ends?
14. Which have these have been tried and found wanting?

Why do you consider that these other means did not succeed?

In summary, what is (or would have been) the objective of Guardianship in this case?

How would you expect (or how would you have expected) Guardianship to achieve this objective?

This question concerns your understanding of the views of SSD Management on this case, depending on its category, viz:-

If your case is in Category 1 (In force) - please indicate on what grounds Management agreed to Guardianship.

If your case is in Category 2 (Lapsed) - On what grounds did Management agree to this case lapsing?

If your case is in Category 3 (Proposed/Accepted) - On what grounds did Management accept the Guardianship proposal in this case?

If your case is in Category 4 (Proposed/Not Accepted) - On what grounds did Management decline to accept this proposal for Guardianship?

If your case is in Category 5 (Considered/not Proposed) - Why did you not put forward this as a Guardianship proposal to Management?

9. Is there an aspect of Departmental Policy on Guardianship which bears particularly on this case? (Please tick as appropriate).

Yes	Uncertain	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. If your answer is 'yes', please indicate which aspect of Policy applies.

11. Have the views* of medical colleagues influenced your decision to pursue a Guardianship submission to SSD Management?

Please tick as appropriate.

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Please explain.

12. Have the views* of medical colleagues influenced your decision not to pursue a Guardianship submission to SSD Management?

Please tick as appropriate

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Please explain.

* Please note this refers to the professional views of medical colleagues rather than their formal willingness or otherwise to sign medical

recommendations).

Introduction

Sections B,C and D of the Guardianship Questionnaire are for completion BY THE RESEARCHER. You are, however, welcome to rehearse your answers by writing in your reactions to the various items, as the Questionnaire document sent to you are for your retention.

Before the interview with the Researcher, it is hoped that you will have completed your Section A form(s) and considered the implications of your answers; looked at and tried to answer the questions raised by their vignettes; looked through Sections B, C and D of this Questionnaire to see how the subject is being covered in the Research.

Social Worker Reference	No of Section A cases Considered	Refs of Sec A cases considered

SECTION B

OBJECTIVES AND USES OF GUARDIANSHIP

Consider whether you agree or disagree with the following statements describing the objectives or usage to which Guardianship can be made.

	Strongly Agree	Agree	Uncer- tain	Dis- agree	Strongly Disagre
1. "Guardianship provides 'protective care' 1.e. reducing possibilities of harm or neglect to clients, or to protect them from exploitation from third parties."					
2. "Guardianship provides a framework of structured care."					
3. "Guardianship provides a basis for ensuring continuity of care."					
4. "Guardianship can be used to reinforce the authority of other people (besides that of the Guardian) - e.g. parent etc."					
5. "Guardianship can be used to provide clients with preferential priority access to services, e.g. to residential care of a particular kind and at a particular time."					
6. "Guardianship is a way of ensuring that client's particular needs (over and above those revealed in normal social work assessment) are properly recognised and taken note of."					

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
12. Would you consider the use of Guardianship as a means of enforcing one or more of the three essential powers, i.e.					
a) To obtain access to client in his place of residence					
b) To determine client's 'attendance' (e.g at a day centre)					
c) To determine client's place of residence					
13. Would you regard Guardianship as a means of actually containing or detaining a person in the places listed above					
14. How would you view your own involvement in the physical holding or detaining of a person under Guardianship?					
15. With regard to Residential Care:-					
a) Do you see Guardianship as a means of enabling people to be placed in non hospital facilities without their express agreement.					
b) Is de facto detention of people under Guardianship in residential care justified.					
c) Should residential care managers and staff adapt the regimes of residential units to meet the particular needs of those on Guardianship?					

SECTION C

THE ROLE OF SOCIAL WORKER COMPARED WITH THE ROLE OF GUARDIAN

1. Consider the similarities and differences between the role of Social Worker and Guardian in the following areas.

SOCIAL WORK FUNCTIONS	DESCRIPTIVE CATEGORIES OF FUNCTIONS	GUARDIAN'S FUNCTIONS
Strongly Agree Un- Dis- Strongly agree Certain agree Disagree	BASIC CARETAKING (Supervision, Surveillance and protective care)	Strongly Agree Un- Dis- Strongly agree Certain agree Disagree
Strongly Agree Un- Dis- Strongly agree Certain agree Disagree	ENABLING (Casework, Counselling and Development Work)	Strongly Agree Un- Dis- Strongly agree Certain agree Disagree
Strongly Agree Un- Dis- Strongly agree Certain agree Disagree	ADVOCACY (Making representations to have the particular needs of the client met)	Strongly Agree Un- Dis- Strongly agree Certain agree Disagree
Strongly Agree Un- Dis- Strongly agree Certain agree Disagree	SURROGACY (Deciding or acting for the client in their best interests)	Strongly Agree Un- Dis- Strongly agree Certain agree Disagree

Are there Guardian's functions which you see as definitely compatible with that of social work functions?

If 'yes', say which these are

Yes	No

Are there Guardian's functions which you see as definitely incompatible with those of social work functions?

If 'yes', say which these are.

Yes	Un- certain	No

Does the authority invested in the Guardian make the Guardian's role with mentally ill people different from that that of the Social Worker?

If your answer is 'yes', say how

5. Could some kinds of social work with mentally ill people be described as a form of voluntary or informal Guardianship?

If yes, specify

6. Should other social services department employees besides ASWs be Guardians?

If your answer is 'yes', list these in order of priority.

Yes	Un- certain	No
/		

7. Should people other than SSD employees be Guardians?

If 'yes', list these in order of priority.

8. Would non SSD employees as Guardians find it easier or harder to act as advocate for the client e.g. in pressing for services.?

Easier	Harder

9. Should the Guardian be one of the client's family?

10. Should the Guardian normally be a person with whom the client lives (as in Scotland)?

Yes	Un- certain	No
/		

SECTION D

POSSIBILITIES FOR FUTURE DEVELOPMENT

1. Should Guardianship be used

	about the same	
More often	as currently	less often

2. How do you arrive at this view?

3. Have you any suggestions as to how to arrive at an objective measure for determining the appropriate amount of Guardianship usage?

4. The following reasons or concerns are sometimes advanced to support an argument that Guardianship is presently under-used.

Consider whether you agree with them or not.

i. "Guardianship makes demands on Social Services resources, i.e. for provision of suitable settings and appropriate personnel."

ii. "There is concern about the use of Guardianship to sanction the use of coercion and compulsion outside the boundaries of psychiatric hospitals."

iii. "Guardianship is a 'toothless wonder' -i.e. it includes insufficient powers and sanctions to be considered as a serious alternatives to hospital."

iv. "Guardianship entails an undue infringement of civil liberties."

v. "Guardianship raises the possibilities of abuse and/or misuse of authority."

vi. "Guardianship under the Mental Health legislation involves taking over responsibility for the lives of adults."

Strongly agree	Agree	Un-Certain	Disagree	Strongly Disagree

5. Does Guardianship need to be changed to make it more effective in meeting the needs of clients?

Yes	Uncertain	No

6. Should the number of essential powers be

Reduced	Stay the same	Un-certain	In-creased

Please say which powers should be added or taken away.

7. Guardianship powers should be tailored to meet the assessed needs of clients, i.e. individually contracted.

Strongly agree	Agree	Un-Certain	Dis-agree	Strongly Disagree
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/				

8. The powers to detain people against their express^d wishes under Guardianship need to be (a) made explicit

(b) left as they are

(c) outlawed

9. Guardianship should include a requirement on statutory services to develop community based 'packages of care' designed particularly to meet the assessed needs of clients on Guardianship - whether or not the SSD has these resources immediately to hand.

10. The resource consequences of Guardianship need to be specifically funded by statutory agencies.

11. Each Guardian should be accountable for an allocated budget sufficient to meet the particular needs of his or her client.

2. There needs to be a power to provide compulsory treatment in the community?

- This should be provided for within a "special" form of Guardianship (as proposed by the Mental Health Act Commission).

- This should be provided for outside the framework of Guardianship, (e.g. in the form of a Community Treatment Order, as suggested by the Royal College of Psychiatrists).

Strongly agree	Agree	Un- Certain	Dis- agree	Strongly Disagree

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BRITISH STATUTES

De Prerogativa Regis, 1324
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