

GUARDIANSHIP (March 2006)

Background

The following paper has been developed from discussions within the Group, consultation with service users and carers, the Regional Dementia Forum and Regional Approved Social Work Forum and feedback from the Legal Issues Committee and other interested parties. The purpose of the paper is to reflect the discussions and opinions shared on the subject of guardianship. The main body of the paper has been structured around the key Articles of the Mental Health (Northern Ireland) Order 1986 relating to guardianship.

Principles

The Group acknowledged the importance of reflecting the principles detailed in the *Terms of Reference for the Review*, in the work of the Group and to use these to guide future practice, policy and law.

Plan of action agreed by the Group

1. To develop supportive relationships with the service users and carers that would facilitate open discussion and maximize learning from their experience of guardianship orders.
2. To identify key points for consultation that would draw from the expert knowledge and experience in relation to guardianship across the three service user groups, mental health, learning disability and dementia.
3. To examine the specific articles within the Mental Health Order relating to guardianship, identify the strengths and weaknesses in implementing these in practice and make recommendations for further consideration.
4. Carry out a literature review to inform a critical analysis of guardianship and make informed recommendations for further examination and discussion.

Summary of the discussion in relation to specific aspects of the Mental Health Order and Recommendations (in bold)

The general ethos of guardianship is reflective of the principles outlined by Professor McClelland, as it is less restrictive than hospital admission and offers support to patients in the community to address their welfare needs. It provides the legislative framework to support working in partnership with patients with a minimum of constraint to help them to achieve as independent a life as possible and is best implemented through a multi-disciplinary care plan. There must also 'be a willingness on the part of both parties to work together' (DHSS, 1992:28).

Reception of Patients into Guardianship

18 (1) - The patient must be 16 years or more.

Recommendation: *The 16 year limit should remain for guardianship orders as it gives some protection against children and young teenagers being managed in*

isolation of the necessary 'Children Services' and resources required to meet their needs.

18(2) (a) - Are the current grounds for guardianship appropriate 'suffering from mental illness or severe mental handicap'?

Recommendation: *The definition 'severe mental handicap' was viewed as out dated and discriminating and should be replaced by a more socially accepted term. This definition has also created difficulties when IQ scores have been the sole consideration when determining this category. The needs of people with dementia are not clearly recognised within the terms mental illness or severe mental handicap, yet the powers of guardianship have proved beneficial to this user group. Cognitive impairment should be included in the grounds.*

The Group had some difficulty with the term impairment of mind or brain' much of which was to do with the lack of clarity associated with this term and concern as to how it could be interpreted in practice. If the term is to be used guidance should provide clarity.

(b) 'is necessary in the interests of the welfare of the patient'

Recommendation: *'Welfare' should be defined in associated Codes of Practice and include consideration of the patient's finances.*

18(3) The Guardianship application shall be forwarded on and accompanied by two medical recommendations and a recommendation by an approved social worker (ASW).

Feedback: Guardianship is less restrictive than the admission for assessment process but tends to require greater medical and social work involvement and has greater monitoring systems in place. The process was viewed as over complicated and cumbersome.

The benefits of other disciplines being involved in the process were also highlighted. This included the argument that appropriately skilled mental health professionals could contribute significantly by providing a more comprehensive assessment of the patient's needs and care planning. The suggestion was made that there may be some value in exploring the benefits of suitably trained mental health nurses supporting and/or contributing to the General Practitioner's medical recommendation. This may begin to address the issues in relation to GP's level of expertise in mental state assessments and reduce the demands on this pressurised resource. The benefit of psychologist involvement was also recognised, particularly in relation to people with a learning disability and assessment of the severity of the learning disability and functioning.

Recommendation: *The application should continue to be made by an ASW. In making the application, the applicant should consult with all relevant professionals and agencies involved with the user, as well as their carers.*

By simplifying the process to require one medical recommendation and one ASW application, guardianship orders could be applied for in the same working day and better protect vulnerable adult who are in need of

timely intervention to protect their rights and welfare. In situations where the application for guardianship will result in limitations being placed on the patient, these cases should be referred immediately to The Mental Health and Welfare Commission for review. The Commission should review the circumstances of the case within 14 days of the application being made. The Commission should refer to the Mental Health Review Tribunal (MHRT) and circumstances they deem appropriate for a more robust and formal review. Circumstances should permit errors in forms to be amended as is the current situation for Forms 1, 2 and 3

18(6) 'A guardianship application in which a person other than the responsible Board is named as guardian -

Feedback: Comments received indicated that there have been a few situations where the guardian had been the patient's relative and these had proved particularly useful in providing the correct balance of support and guidance to protect the patient. In one situation the patient worked well with their father and was able to remain living in their own home, prior to this they had refused to co-operate with boundaries set to protect them from potential abuse.

It is the Group's experience that the nominee guardian is normally a social worker, even though they may not always be directly involved with the patient. Consideration should be given to the inclusion of other suitably skilled mental health professionals in this function.

Patients should be actively involved, as far as possible, in deciding who is best placed to be their guardian.

Recommendation: *The Trust should normally be the patient's guardian*

18(7) 'but the application shall not be of any effect unless each of the medical recommendations describes the patient as suffering from the same form of mental disorder.

Feedback: Generally, it was accepted that if two medical recommendations were to be required, the same form of mental disorder should be recorded on both. Problems were identified in a situation where one medical recommendation stated 'dementia' and the second 'dementia and depression'. This resulted in a time delay in having the guardianship order approved and required further assessment and form completion by the professionals involved.

Recommendation: *One medical recommendation would be ample for guardianship which would address this problem.*

Persons who may make a Guardianship applications

- 19(1)** (a) the nearest relative;
(b) the approved social worker;

Feedback: The definition of ‘nearest relative’ (Article 32) does not reflect the modern relationships which exist in our communities, and should be revised. Service users presented a strong argument to remove the right of the nearest relative to make application. This was based on concerns that a nearest relative may use this power to disadvantage the patient and exercise control over them. It was the Group’s view that any applicant should have the necessary training and knowledge to make an informed, objective decision about the patient’s welfare.

Recommendation: *Applications should be made only by Approved Social Workers.*

19(2) The applicant must have personally seen the patient not more than 14 days before the date of application.

Feedback: Service users and carers stated they would prefer to have a shorter timescale as it would allow them to keep more informed of the decisions behind the process and not feel over anxious during what they viewed as an unnecessary delay in receiving confirmation that they had been received into guardianship.

Recommendation: *By simplifying the application process, the applicant should have seen and assessed the patient no more than 48 hours before making the application*

An Alternative Emergency Procedure?

Feedback: The current process required for guardianship makes it cumbersome and does not facilitate speedy application that may be required to protect vulnerable people in the community against abuse. A strong argument was made for consideration of ‘emergency applications’ that would require one recommendation by a suitably trained professional and an application by an ASW. The powers of guardianship could be exercised immediately but would only hold for 14 days to allow a fuller application process. Within this 14 day period, two professionals not involved in the emergency application, would be required to carry out independent assessments to determine the appropriateness of the guardianship application. Depending on the outcome of these assessments, the guardianship would either be discharged or accepted, to be reviewed in the normal timescales.

Recommendation: *Timescales should be reduced to reflect good practice principles. The applicant should have met with and discussed the application process with the user no more than 48 hours before the application is made.*

Reduction in timescale would allow for guardianship orders to be applied for on the same working day as the recommendation has been made. This will provide a more timely response to managing high risk situations and protecting vulnerable adults. Consideration should be given to practice timescales that involves weekend or bank holidays.

19(3) ASWs cannot make an application ‘except after consultation with the person, if any, appears to be the nearest relative unless it is not reasonably practicable or would involve unreasonable delay’.

One of the carers expressed concern that he was not fully aware of the restrictions to guardianship and had held unrealistic expectations of how it could be used to protect his daughter.

Recommendation: *It is appropriate that the patients caring relatives should be consulted. Guidance should be given to support staff in situations where the patient has requested their relative is not to be consulted. Relatives should be informed of their rights to object to an application being made. The requirement to consult should include 'if reasonable, practicable or involve unreasonable delay'.*

19(4) If the nearest relative objects, involvement of a second ASW is required.

Recommendation: *Patient's rights should continue to be protected by having a second independent ASW assessment of their situation and needs, should there be an objection to the application for guardianship being made.*

General Provisions as to Medical Recommendations

20(a) Is it sufficient to have 'medically examined' the patient within two days?

Feedback: Service users associated 'medically examined' with a physical examination. The term 'medically assess' may be more appropriate to reflect the process undertaken. A psychological assessment would be preferable for people with a learning disability.

Recommendation: *An assessment of the patient's medical needs should be undertaken by the person making the recommendation, no more than 48 hours prior to making the recommendation.*

22(1) (a) + (b) + (c) Effect of guardianship application.

The current powers are:

- (a) The power to require the patient to reside at a place specified by the Board or person named as guardianship.
- (b) The power to require the patient to attend at places and times so specified for the purpose of medical treatment, occupational, 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 medical practitioner, ASW or person so specified.

Feedback: The power to 'reside' is not always sufficient to meet the needs of some service users, and has presented some difficulties when the need arises to encourage a patient to leave hospital and they do not want to reside in an environment best suited to meet their needs eg a person with advanced dementia being transferred into an Elderly Mentally Infirm (EMI) facility?

Guidance provided in the Code of Practice (DHSS,1992:33)which stipulates that guardianship 'does not provide the legal authority to detain a patient physically in such a place', was viewed by the Group as potentially encouraging dangerous

practice in so far as the patient must be permitted to leave the place if residence before they can be brought. This created difficulties for the patient, their family and the professionals which may be overcome by strengthening the power to prevent the patient from leaving in the first place. Decisions to retain the patient in the residence against their wishes would obviously need ongoing assessment and review of the level of risk and degree of capacity to make informed decisions.

Recommendation: *This ‘residency power’ should be extended to permit transfer to a specified place of residence and to prevent the patient leaving and being placed at risk. The Mental Health and Welfare Commission would have a role in reviewing these patient’s circumstances.*

Discussion and feedback highlighted concerns practitioners had in determining the patient’s capacity to give informed consent. Difficulties were also experienced in making decisions on whether or not the patient was ‘working along with the recommendations’. In some circumstances, absence of the patient’s physical resistance or verbal objection to a move was accepted as compliance.

Recommendation: *The Group also agreed that consent issues must also be determined in an inclusive, informed and structured manner. DHSS guidance on Consent should be expanded to support assessment of consent issues with people with mental disorders.*

In order to uphold service user’s rights, stronger guidance is required to support staff make informed decisions in relation to capacity, consent and informed decision making. The Group found the guidance provided in the Mental Incapacity Bill Part 1 beneficial. The assumption of capacity unless otherwise established provides a sound ethical base to work from and build upon (Section 3). Direction on how to determine the person’s inability to make decisions was also accepted as a constructive process in the absence of other guidance, in that the decision would be based on the person’s ability to understand, retain, use information to make decisions or communicate these decisions (Section 2).

The Group agreed that in situations where the patient had the capacity to make decisions, even if others viewed these as ‘unwise decisions’, the patient’s decision should not be over ruled. However, in situations where the patient had been systematically assessed as being incapable of making decisions as to his preferred place of residence, the professionals involved should in consultation with the patient as far as possible and their nearest relative and family, make this decision on the patient’s behalf, based on the patient’s best interests. Guidance under Section 4 was also viewed as supportive in determining the patient’s best interest. The power to ‘move the patient to a specified place of residence’ in situations such as these, was deemed appropriate. Transfers on these grounds must be managed sensitively, taking into consideration the patient’s level of distress.

There was a very strong opinion expressed in feedback on drafts, that protection of guardianship should be explored in relation to patients who are admitted to locked door EMI facilities. The Group acknowledged that there are currently many patients ‘detained’ in locked door facilities who do not wish to be there.

Recommendation: *The Mental Health and Welfare Commission should have a more active role in reviewing patient’s who are being cared for in a locked door*

facility without application of the Mental Health Order. The Commission should have referred to them all patients who are to be cared for in a locked door facility. The Commission would review the needs of these patients within 14 days of placement. The Commission would have automatic referral to the Mental Health Review Tribunal for all cases they wished to have reviewed through a more formal and robust process. The Commission should review the needs and circumstances of patients in locked door facilities on a yearly basis, thereafter.

The power to attend was highlighted as insufficient to meet the needs of patient's who on attendance, refused to accept medication. Guardianship was not however viewed as the correct piece of legislation to address this problem as it should reflect as far as possible the principles outlined and no recommendation was made to strengthen its power in this area of practice.

Recommendation: *The power to 'require access' should be strengthened to include the powers to interview and/or engage with the patient in a private manner.*

The benefits of expanding the power of the guardian to support the management of patient finances were also highlighted through our discussion. This may support patients to have control over aspects they have capacity to manage and prevent potential abuse/ misuse in other areas.

Recommendation: *Guardianship powers should include management of patient's finances, possibly up to an agreed limit, before they are required to be referred to the Office of Care and Protection.*

22(2) Is the period of 7 days from last medical sufficient?

Feedback: Viewed as too long a period. Impact of any reduction requires further discussion.

Recommendation: *Will not be relevant under refined application process.*

22(3) Is the period of 6 months for first application appropriate? If not, what should it be?

Recommendation: *6 months is deemed to be an appropriate time period.*

22(4) A Guardianship Order should not provide sufficient powers to have a patient admitted to hospital against their wishes

Recommendation: *This should remain as current to protect patient's rights.*

Recommendation: *A copy of the application and other papers should be forwarded to the Commission.*

22(5) The Commission should continue to receive a copy of the medical and ASW forms and reports, or any alternative reports resulting from changes in the legislation as this acts as a necessary monitoring mechanism.

Renewal of authority of Guardianship

23(1)

Recommendation: The renewal periods of 6 months, 6 months and yearly thereafter were viewed as appropriate.

23(2)

Recommendation: The renewal process was assessed as sufficiently simple and should remain

Discharge of a patient from Guardianship.

24(4) (a) + (b)

The grounds for discharge were assessed as appropriate, however the benefits of having an additional clause to address the patients lack of co-operation was identified.

Transfer of Guardianship on death, incapacity etc of Guardian

25

No changes required

Duty on Boards to refer cases to the Tribunal

73

Trust's responsibility to refer patients for review by the Tribunal when they have been on a Guardianship Order for two years and have not been reviewed in that period.

Recommendation: *This protective monitoring arrangement should be implemented one year from the application being made as two years was viewed as too long a period. Referral should also be made by the Commission.*

Additional Comments

The Group had lengthy discussions stimulated by Herr 'Self Determination, Autonomy and Alternatives for Guardianship' and in principle agreed with the benefits of the mentorship model. However, the introduction of this type of system would require a much more radical change in our culture, structure and the percentage of finance contributed to health and social care. Without these systems being in place the introduction of this model would be ineffective and fail to meet the needs of patients.

The Group were also of the opinion that guardianship is under utilised and there is a need to promote its application among patients, their carers and professionals. The strengthening of its powers may contribute to this development.

Summary of Issues re Capacity

When a patient lacks capacity, professionals and family will make a best interest decision. If this decision involves restrictions on the patient's freedom or activities, the patient should be referred to the Mental Health and Welfare Commission for review within 14 days of enactment of the careplan restricting liberties. The Commission can refer to the MHRT for formal legal review when necessary. Where patients actively resist or are unhappy with their careplan recommendations, there is a need for guardianship and formal review by the MHRT. If however they are willing to co-operate with the recommended careplan, there is no need for guardianship but they will have the benefit of an independent review by the Mental Health and Welfare Commission, which could refer the case, if appropriate, to the MHRT.