should be interviewed and/or receive forensic medical examination on ward or police premises. Quiet facilities should be made available on the ward and an appropriate member of the nursing staff should be available while the patients are being seen by police officers.

7. Additional notes

Staff should be aware that not all sexual assaults are by a man on a woman, and should treat allegations of other types of assault with an equal gravity.

In the event of a sexual assault on a member of staff by a patient or visitor the Incident Room Procedure should be followed and the police informed as appropriate.

If there is an allegation that a member of staff has committed a sexual assault, this must be reported not only to the senior member of the profession concerned but also to the Unit Manager immediately, and will be fully investigated under the Disciplinary Procedure.

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Original articles

Guardianship – a case for wider use

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Few psychiatrists have had much experience of guardianship (Section 7, Mental Health Act, 1983). The two cases described have been successful and suggest wider use of this section. It seems apposite in view of the Royal College of Psychiatrists' advice on discharge of patients from hospital, and discussion on a community treatment order; the continuing drive to community care, as codified in the 'Care Programme Approach'; and the need in the future to treat increasingly disturbed individuals in the community as envisaged in the Reed report.

Case studies

Case 1

AS is a 55-year-old single man from the Sikh culture, admitted to the acute unit some three years earlier just before Christmas. His employers, a local factory, feared he would wait outside the factory over the Christmas holiday period, and consequently die of exposure. It was obvious that AS was suffering from residual schizophrenia. A solitary, self-neglected man, he was troubled with continuous auditory hallucinosis, was taciturn and concrete in thinking. He owned a house in a derelict condition in the distant town, but spent at most only a few hours a week there, the rest of the time spent in the factory where he was employed in tedious repetitive machine maintenance. He was admitted several times over the next three years until, when he refused to leave the factory at all and slept all night standing against a wall, he was retired with redundancy pay. His ample savings were a cause for concern as he had previously been robbed, and thus he was brought under the provisions of the Court of Protection. Although his house was purchased compulsorily by the local authority because it was a hazard, he steadfastly refused to consider sheltered accommodation and did not continue neuroleptic medication when discharged.

AS was made the subject of guardianship to ensure that he lived in a private residential home, found for him by the

Social Services Department. The guardian was his key-worker and approved social worker. Following implementation, AS has continued to comply with neuroleptic treatment, and it was possible to allow the guardianship order to elapse at the six-month review.

Case 2

RP is a 26-year-old separated man who was admitted on section 3 of the Mental Health Act (1983) because of increasing noisiness and strange behaviour in his mother's house. He had delusions of control, thought insertion, passivity phenomena, and firmly held paranoid delusions, indicating paranoid schizophrenia. During admission he assaulted a policeman, but was not aggressive in hospital. He required treatment with large doses of oral and depot neuroleptic medication. He maintained that he was not ill, that his symptoms were due to his work for the security services, for which he was awaiting payment, and did not require treatment. He warned that he would refuse cooperation with the psychiatric service once discharged, which had happened twice before. It was felt that he was gradually deteriorating, that he could be a danger to others if he were to act upon his delusions, and that his mother's household generated high emotional arousal.

The local housing agency were persuaded by his social worker to rent him a single person flatlet, and a Social Services Department community care worker was allocated. This was a non-professional lady employed and supported by the community care organiser of the Social Services Department. When these facilities were available, the patient was tactfully confronted by the team, who explained that a guardianship order would be made which ensured that RP would remain in that flatlet, would compel him to grant access to the CPN for medication, his social worker, the community care worker and to the psychiatrist if it proved necessary. He was also required to attend the out-patient department. The guardian was his keyworker and approved social worker. He was told that if he failed to cooperate with any part of the order, the consultant and Social Service Department would initiate re-admission to hospital under section 3. Faced with these provisions the patient complied.

In spite of absence of insight into his delusions, no problems of cooperation were encountered until about six months on the order, when his symptoms again became florid. On attending the out-patient department, he became threatening to the consultant and announced he would stop his medication. However, this was negotiated without admission by the consultant reviewing the patient in his home, regaining cooperation. The guardianship order has been renewed, treatment and care proceeding satisfactorily.

Usage

Statistics of guardianship are difficult to find and it is possible that no one statutory agency is responsible for holding them. Numbers of persons in guardianship in the Mental Health Act have remained low. Of 123 new cases in 1986–7, 93 cases were for mental illness, 19 for mental handicap, nine for severe mental handicap and two for psychopathy. Including 143 continuing cases, only 30 of these were for guardianship under Section 37 (Grant, 1992). Half of a sample of local authorities have never considered guardianship (Barnes *et al*, 1990). In Kent in 1987, 14 patients were registered as continuing in guardianship.

There has been considerable social services discussion on the use of guardianship, reviewed by Grant (1992). Guardianship has been criticised for its weakness, and financial stringencies have prevented full implementation. A detailed study of a sample of guardianship orders made in the Northern and Yorkshire Regions (Wattis *et al*, 1990) showed that the majority were for mental illness, usually dementia, most were elderly and female, mainly to enable transfer to residential care.

The present guardianship order does not compel treatment, but only requires access to treatment; power is given to require residence at an address but not to convey the patient to the address; yet, surprisingly power is given to return the patient to the address. Although access to carers is required, force cannot be used to achieve it. Guardianship should form part of a comprehensive treatment plan, particularly if the main reason for its use is to require residence at a particular location. If, however, the patient is persistently resisting, the order should be discharged.

The future of guardianship

The Code of Practice leaves no doubt as to the desirability of guardianship in the future. It enjoins doctors and approved social workers to consider guardianship as a "positive alternative" to hospital treatment.

Psychiatrists in the UK have been dissatisfied with provisions for compulsory treatment in the community under the present Mental Health Act. The practice of using 'extended leave' for hospital patients detained on treatment orders (Mental Health Act 1959, 1983) was quashed by the Hallstrom judgement. Resulting from this the Royal College of Psychiatrists explored the concept of a community treatment order, of mental illness only, for patients who had responded before. It would have been equivalent to section 3 (Mental Health Act 1983), received by the health authority rather than the local authority. The Mental Health Act Commission suggested that the application should remain with the local authority, proposing a form of 'Special Guardianship', which would empower the taking and conveyance of a patient to a place of treatment in the community, and to require medical treatment. This would occur only after discharge from hospital, only for the long-term psychiatrically severely disabled patient, and only if the patient was refusing treatment (Fennel, 1992).

The power to treat is the most significant omission of the guardianship order. Even outside the bodies

immediately concerned with mental health, there is a move to change to greater compulsion. The coroner in the Beverley Lewis case heard in 1989, in which a mentally handicapped adult died from her schizophrenic mother's neglect, criticised those who had not applied for guardianship, and said that the mother should have been required to take medication. The Law Commission presently sitting is considering *inter alia* "consent to certain kinds of medication provided the patient does not actively object" but continues to advise against the imposition of treatment forcibly in the community. Thus a stage is being placed between the present guardianship order and the forcible administration of treatment to a resisting patient in the community. Where a patient objects to treatment in a community setting, but does not actively resist it, and when treatment can be given safely, it is being urged that this should no longer be unlawful.

Conclusions

Guardianship may now be applied to patients formerly thought to require prolonged stay in hospital, particularly the schizophrenic patient with poor prognosis. As the numbers under guardianship remain low, few psychiatrists can have had experience of more than one or two such orders. Objections to the use of guardianship are thus largely theoretical and usually rest on the reluctance of the local social services department and the belief that the powers involved are weak, and exclude compulsory treatment. The secret of success lies in good cooperation between the psychiatrist and the social services department, and in using the order as a means to a comprehensive plan of community management. To do this requires the local authority to have sufficient resources to monitor, support and educate the patient. In this situation guardianship can then be used to command local authority resources. Our patient, RP, was an example of a recalcitrant and very deluded patient, previously failing to respond to mental health care, but faced with a united and determined team approach, the relatively weak powers of guardianship could be used to their limit, to ensure successful community treatment. It is possible that legislation will extend these powers in the future.

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A full list of references is available on request to Dr Symonds.

Psychiatrists able to assist patients who cannot speak English

The College receives regular enquiries from members of the College and general practitioners regarding patients who are unable to speak English. We are asked if we can give the name of a psychiatrist able to communicate with patients in their own language.

We maintain a list of members who are fluent in languages other than English. This list is also forwarded to the central offices of the Mental Health Act Commission.

At present, we are having particular difficulty in identifying members who speak Chinese, Gujarati, Bengali, Sudanese, Arabic, Farsi, Somalian and Swahili. I should be grateful if any member who is able and willing to help in this way could write to me giving the relevant particulars, (language spoken, contact address and telephone number) so that this list can be expanded.

VANESSA CAMERON
The Secretary

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