

Correspondence

Limitations of guardianship

DEAR SIRs

Weatherhead (*Psychiatric Bulletin*, June 1991, 15, 341–343) makes pertinent points about the limitations of guardianship which are not confined to practice in Scotland. We describe a case in point where there is unanimous agreement between doctors, social services and family to invoke guardianship to secure a residential placement but inability to convey makes the order impotent.

A 76-year-old woman admitted to hospital under Section 2 in October 1990 had a 15 year history of recurrent depression requiring several admissions and treatment with ECT and antidepressants with diminishing response. Her husband died in 1989, leaving her alone, and she gradually deteriorated until she was living in an appallingly neglected state, having lost stones of weight and refusing access to her home. The house was in extreme disrepair and unsafe. Over years she had purchased a vast array of consumer items which had been hoarded but never used and filled the home. A bedroom was inaccessible because it was floor to ceiling with new goods, two bedrooms contained only brand new unwrapped fur coats, every drawer, cupboard and space was crammed with unopened food, sweets, china sets, boxed glassware, kitchen utensils, clothes and dozens of unworn shoes with multiples of the same object. The refrigerator contained mouldy food with sell-by dates in 1979 and psychotropic drugs prescribed over 30 years filled a dustbin bag. Her brother suffered from depression and hung himself two years ago.

High doses of antidepressants (clomipramine 300 mg nocte with lithium carbonate and 1-tryptophan) produced limited improvement but she remains apathetic, solitary and unmotivated while sustaining her physiological needs but offering no subjective complaints. ECT has been refused.

She insists on returning home, refusing even to view a residential home but never attempting to leave hospital yet knowing she has been able to do so for six months.

Her current condition and poor prognosis, previous non-compliance and refusal to accept services make it inappropriate for her to return home. The house remains unsafe as repairs have been impossible because workmen cannot gain access to rooms and she refuses to sanction this work or give relatives power to act on her behalf.

Surely it is a nonsense that were this lady in residential care guardianship could detain her there, but as she is not we have no power to convey and detain

her there. When the Act states that it gives “the power to require the patient to reside at a place specified” this is clearly a hollow statement and we are unable to act “in the interests of the welfare of the patient”. It is anomalous that we could convey her to hospital “in the interests of her own health or safety” but not then to another establishment for the same reasons.

It is common practice for elderly people to be moved into residential care without any assessment by deceit and deception yet this is ignored and indirectly encouraged by the Act as a means of circumventing its inadequacies. The powers of guardianship must be reconsidered as it is failing to protect patients’ rights and we would suggest that it should at least become possible to convey from hospital to other residences thereby ensuring patients are fully assessed and treated before such a decision is made.

If any reader has a solution to our particular dilemma we would be interested to hear from them.

D. N. ANDERSON
D. BACH-NORZ

*Fazakerly Hospital
Liverpool L9 7AL*

Psychological treatments

DEAR SIRs

The letter by Dr Stern (*Psychiatric Bulletin*, May 1991, 15, 296) draws attention to the failure of psychiatrists to carry out psychological treatments. He is right to do so, but let us consider some of the reasons for this. Medical training with its emphasis on the soma leads to an orientation toward physical treatments and it is in fact from this direction that the major advances in treatment of psychiatric disorders has come. Psychological treatments are generally rather time-consuming and firm evidence for their effectiveness, certainly in the long term, is lacking. Then the trainee in psychiatry is not obliged to provide any evidence to the examiners for Membership of the Royal College of Psychiatrists, that he or she has acquired any competence in, or even attempted, psychological treatments; mere nodding acquaintance with textbook knowledge suffices.

Dr Stern also draws attention to the need for ‘retooling’ of behavioural and cognitive techniques. Again, he is correct if skill in application is to be acquired by trainees in psychiatry; trainees have a heavy work load and few will find several hours a week together with skilled supervision in the