

Too much Guardianship?

Reflections on
Guardianship in Victoria
1988 – 2008

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In Victoria, under the Guardianship and Administration Act, 1986, the Victorian Civil and Administrative Tribunal is able to appoint substitute decision-makers for people with a cognitive impairment who are unable to make decisions for themselves where no 'less restrictive' options are available. Since the introduction of the Act in 1986, guardianship numbers in Victoria have grown exponentially. Guardianship numbers have been driven by deinstitutionalisation, reductions in accessibility and availability of services and the development of a risk averse culture. The Office of the Public Advocate has tried to manage these increases in a variety of ways. However, it appears that a normative expectation of guardianship as a mechanism for managing complex problems and gaps in the service system has emerged. Is there 'too much guardianship'?

Background

Prior to the passing of the *Guardianship and Administration Act 1986*, the Supreme Court could appoint a guardian to manage the property of a person with a decision-making disability and one medical practitioner could certify a person with an intellectual disability or a mental illness for automatic admission as a compulsory patient. New guardianship legislation was intended to bring about a change in the extent to which legal interventions that limited freedom and access to the community were imposed on people with disabilities, reflecting civil and political rights developments in Australia and internationally.

Guardianship sought to overcome the limitations of existing legislation but was only to be used where substitute decision-making was required to protect the individual, where no other options were available and where the person was expected to derive real benefits from the order.¹ The new legislation introduced procedural protections including limited orders as well as more scrutiny, accountability and monitoring of orders relating to substitute decision-making.²

The main philosophical difference between guardianship and earlier forms of substitute decision-making for people with disabilities was that guardianship was to be used only as 'a last resort to be considered when all other protective mechanisms have been eliminated from the list of viable alternatives'.³ As it was only to be used for a 'narrow band of cases', it was proposed that three questions be asked before a guardianship order is made including whether the person is likely to gain real benefit from guardianship, whether a less restrictive alternative is available and whether the order is in the best interests of the person.⁴

Once the *Guardianship and Administration Act* was passed in 1987, there was a steady annual growth in the number of orders made by the Guardianship and Administration Board. The total number of guardianship cases managed per annum by the Office of the Public Advocate (OPA) increased from 225 in 1987/88 to 743 in 1995/96. A report by Carney and Tait in 1995 entitled 'too much access', suggested that across Australia, guardianship may be proving to be 'too successful', arguing that 'easy access to guardianship and management procedures without equivalent developments in other policies for people with disabilities may

¹ Carney, T and Tait, D 1991 *Balanced Accountability: An evaluation of the Victorian Guardianship and Administration Board*. Office of the Public Advocate, Carlton.

² Carney and Tait, 1991.

³ Cocks, E 1982 *Report of the Minister's Committee on Rights and Protective Legislation for Intellectually Handicapped Persons*, Melbourne, p 75.

⁴ Cocks, 1982.

produce negative consequences’ such as unnecessary and intrusive interventions, resulting in incursions on civil liberty.⁵

By 2007/08, OPA was carrying 1383 guardianship cases (a compound effect of new guardianship orders made to OPA and cases carried over from one year to the next). The Public Advocate has consistently argued that there has been an over reliance on guardianship to fill the gaps where other less restrictive supports like case management and coordination, mediation, advocacy and community education, more accessible health care and housing would have addressed the identified issue.

The increase in guardianship numbers has been attributed in a large part to a service system which has struggled to keep up with the support needs of people with disabilities living in the community, particularly the often complex needs of people who would once have been cared for in institutional settings. One reading of the first twenty years of guardianship is that a normative expectation of guardianship as a mechanism for managing complex problems and gaps in the service system has emerged and that there is ‘too much guardianship’.

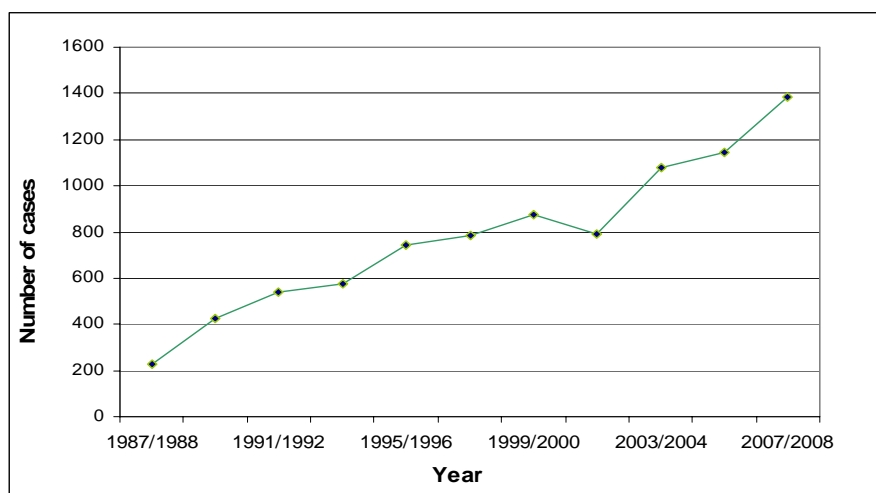


Figure 1. Guardianship cases managed by OPA 1987/88 - 2007/08
(Source: OPA Annual Reports 1987/88 to 2007/08)

Using OPA annual reports as a data source, this paper identifies the drivers contributing to the increase in statutory (OPA) guardianship numbers between 1987/88 and 2007/08. It documents some of the actions OPA has taken to try and manage guardianship numbers including operational strategies and systemic advocacy. It asks the reader to consider the question ‘is there too much guardianship?’

What is driving increasing guardianship numbers?

Deinstitutionalisation, changes to the operation of the service system resulting in the reduction in accessibility and availability of services and the development of a risk averse culture resulting in a transfer of responsibility to guardianship have all been reported by OPA as having an impact on guardianship numbers.

⁵ Tait, D and Carney, T 1995 *Too much access: the case for intermediate options to Guardianship*. Australian Journal of Social Issues, Vol 30, No 4, November, p 445.

Deinstitutionalisation

The incidence of an estimated 30,000 people with disabilities/mental illness living in the community who would have lived in institutional settings and nursing homes 30 years ago has been reported by OPA as a significant factor in the increased use of guardianship.⁶ The process of 'deinstitutionalisation' had only just commenced at the time the guardianship legislation was introduced.

In 1985, around 3,000 people lived in training centres for people with intellectual disabilities and 200 in newly developed community residential units. By 1995, only 1,350 people lived in training centres and another 2,175 lived in community residential units. A similar 'deinstitutionalisation' process occurred in the psychiatric sector. In 1956, there were 5,400 psychiatric hospital beds. In 1986 there were 3,673 psychiatric hospital beds and by 1993, there were 2,420 beds.⁷

There is evidence that deinstitutionalisation has not been accompanied by adequate resources to support people successfully in the community, particularly in the area of mental health where there have been large shortfalls in community-based accommodation and support.⁸ While the primary purpose of guardianship legislation is for a substitute decision-maker to be appointed where it is needed, OPA has argued that guardians have often been appointed to fill gaps created by the failure of the service system to address needs created during this period of rapid 'deinstitutionalisation'.⁹

Changes to the service system

Demands for guardianship were compounded in the mid-nineties by political changes that had an impact on the operation of the service system ultimately resulting in cultural shifts and a reduction in the accessibility and availability of services.¹⁰ The contracting out of services previously provided by government and the introduction of compulsory competitive tendering for community-based services, changes in regulatory requirements and shifts to output-based funding led to changes in the structure and delivery of disability services.¹¹

Overall the changes had an impact on issues of access, quality, consumer protection and coordination leading to a more diversified and specialised service system with services more tightly targeted but more fragmented.¹² OPA reported that alongside increasing fragmentation of services there appeared to be deteriorating service cooperation in the context of tighter budgets with cost implications for services responding to people with multiple disabilities and complex needs. 'The levels of cooperation between different services in some regions – particularly intellectual disability, psychiatric and drug and alcohol services appear to be diminishing rather than improving'.¹³

In the absence of an accessible service system, what appeared to be developing was a reliance on guardianship for managing complex problems that the service system was unable to manage. There is an 'emerging and distorted perception of guardianship arising' which

⁶ OPA Annual Report 1995/96.

⁷ Various reports, cited in OPA Annual Report 1995/96, p 4 -5.

⁸ OPA Annual Report 1995/96.

⁹ OPA Annual Report 1995/96.

¹⁰ OPA Annual Report 1996/97.

¹¹ OPA Annual Report 1996/97.

¹² OPA Annual Report 1996/97.

¹³ OPA Annual Report 1996/97, p 4.

fosters the use of guardianship to address deficiencies in the service system.¹⁴ OPA has argued that the largest number of guardianship cases come from areas of the service system where there is an inadequate service system response.¹⁵

Management of risk

Associated with deinstitutionalisation and political changes, a culture of risk aversion emerged in the service system and a rising expectation that guardianship could be used to manage potential risk or dangerousness to self or the community.¹⁶ This was referred to in OPA annual reports as a 'transfer of duty of care' to substitute decision-makers which was reported to occur where service providers were for example, unwilling to make decisions to continue to care for people at home where they may be at risk, without the authorisation of a guardian or where appointment of a guardian means the risk can be transferred from the person or agency to OPA.¹⁷

Successive OPA annual reports have noted the trend towards the transfer of responsibility from the service system to guardianship and the extent to which this has contributed to the exponential growth in the total number of guardianship cases.¹⁸ It was reported that guardianship was 'under considerable pressure to shift its emphasis from a rights-based humanitarian approach to the role of predicting and managing risk'.¹⁹ This was seen as a concern particularly given the 'apparent increase in disturbing and/or destructive behaviour as reported by police and front line agencies working with people with disabilities. 'It appears that some applications may be driven by a concern to spread the responsibility and potential liability associated with a client, rather than by the individual needs and rights of the client'.²⁰

OPA has argued that the intention of applications for guardianship is not always the 'best interests' of the potential represented person as is the intention of the legislation. Applications are sometimes made to deal with 'difficult' behaviour or in the interests of 'protecting the community'. Guardians have expressed concerns about applications being made for a person for whom there is questionable disability but where services are frustrated by the non-compliance of a 'client' with a service expectation or due to what is perceived as a 'socially unacceptable' lifestyle. Further investigation by a guardian may find little evidence of disability other than that the person lacks insight into the impact of their behaviour or lifestyle.²¹

What actions has OPA taken to manage increasing guardianship numbers?

OPA has taken a number of actions over the twenty year period to respond to increasing guardianship numbers. Actions taken have been informed by the 'least restrictive' principle, which stems from the Public Advocate's function of 'minimising the restrictions on the rights of persons with disabilities'.²² The application of this principle has led OPA to ensure there is adequate scrutiny of guardianship and administration applications and to advocate for

¹⁴ OPA Annual Report 1995/96, p 31.

¹⁵ OPA Annual Report 2003/04.

¹⁶ OPA Annual Report 1995/96.

¹⁷ OPA Annual Report 2003/04.

¹⁸ OPA Annual Reports 1995/96; 1996/97; 2002/03; 2003/04.

¹⁹ OPA Annual Report 2002/03, p 15.

²⁰ OPA Annual Report 2003/04, p 15.

²¹ OPA Annual Report 1995/96.

²² Guardianship and Administration Act, 1986, s15(a)(ii).

mechanisms which limit or divert the use of guardianship where appropriate. Within this agenda, OPA has worked on a broad range of operational strategies and systemic advocacy strategies.

Operational strategies

In 1999/00, a legal officer position was introduced into VCAT by OPA to play a screening role to ensure that guardianship and administration applications were least restrictive of the options available to meet the proposed represented person's needs. This included 'OPA seeking to enhance the Tribunal's understanding of the options available to it in making its determinations'²³, including the options of support and advocacy.

OPA's Telephone Advice Service acts as the first point of contact for many queries about guardianship and administration, providing referrals and information for people that in many cases may prevent an unnecessary application for guardianship and administration being made. The service manages Section 42K applications for medical or dental treatment where there is no person responsible and provides information on consent for medical treatment, Enduring Powers of Attorney and other less restrictive alternatives to guardianship.

In 1995/96, OPA developed a proposal which was taken up by VCAT, to investigate all applications for the temporary appointment of guardians and administrators.²⁴ The Public Advocate wanted to ensure that all avenues for less restrictive options were explored for applications coming to VCAT before the hearing. In 1997/98 it was reported that, 'the proportion of investigations and reports prepared for the Board by OPA increased from 9% to 25% of all originating applications'.²⁵

In 1996/97, OPA introduced the concept of 'short-term' or 'fast track' advocacy. The advocacy functions of the Telephone Advice Service, Independent Third Person Program and After Hours Investigations for Temporary Orders were defined as such and incorporated within the Advocacy Program. The acknowledgement across the organisation of the important role of advocacy gave further credibility to OPA's preferred course of action, that 'through advocacy all options are explored before considering the more restrictive course of guardianship'.²⁶

Community Education is another strategy by which OPA aims to 'encourage diversion from statutory guardianship'.²⁷ Although OPA's Community Education activities are spread across a range of other non-guardianship related disability issues, one consistent focus of education has been on the Guardianship and Administration Act and the role of substitute decision-making, the role of the 'person responsible' in relation to medical and dental consent and the role of Enduring Powers of Attorney. Through education, OPA aims to provide information that will ensure the correct application of the relevant legislation.

OPA has monitored the use of guardianship since the establishment of the office and has worked with service providers to address systemic problems of lack of service options which, 'if not resolved satisfactorily in policy or practice would overburden the Office'.²⁸ OPA has

²³ OPA Annual Report 1999/00, p 25

²⁴ OPA Annual Report 1997/98.

²⁵ OPA Annual Report 1997/98, p 1.

²⁶ OPA Annual Report 1996/1997, p 15.

²⁷ OPA Annual Report 1996/1997, p 32.

²⁸ OPA Annual Report 1991/92, p 1.

also been involved in public presentations on the ‘questionable use of guardianship’ at National Conferences.²⁹

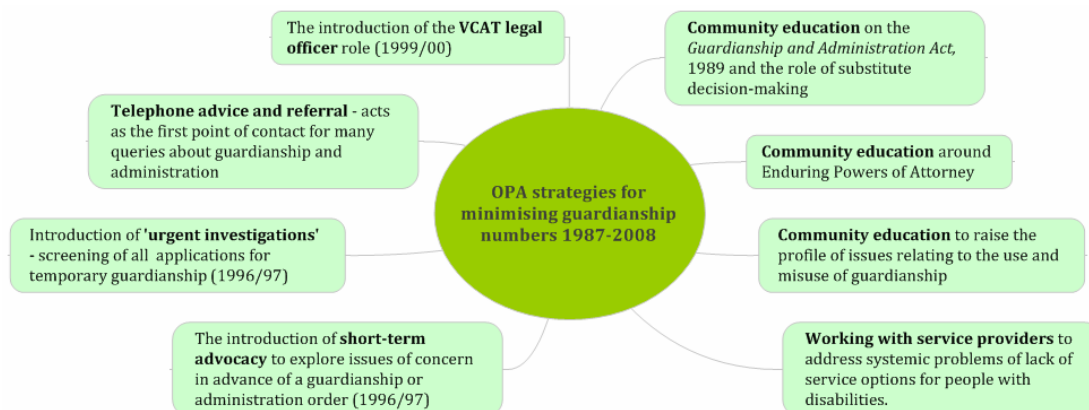


Figure 2. OPA strategies for minimising guardianship numbers 1987/88 - 2007/08

In the 1989/90 Annual Report, the Public Advocate made the point that while OPA continues to accept responsibility for the provision of guardianship where there is no other appropriate person who can be appointed, it was never intended that OPA guardians would carry the bulk of the guardianship work.³⁰ The Cocks Committee was clear that the expectation was for the community to take responsibility for guardianship and this intention is reflected in the Act.³¹ In an effort to ensure that the community takes responsibility for guardianship, OPA provides support to the Community Guardianship Program and the Private Guardianship Program.

OPA’s statutory guardianship role is complemented by two other key roles, investigation and advocacy, one purpose of which is to explore the applicability of less restrictive interventions than guardianship. In 2001/02, it was noted that the demands of guardianship were having a disproportionate impact on advocacy resources.³² Ongoing concerns were raised through the 2000s about the impact of increasing guardianship numbers on the organisation’s capacity to provide a viable advocacy service.³³

Systemic advocacy strategies

As early as 1989/90, concerns were expressed in OPA annual reports about increases in demand for guardianship, with predictions that the demand would continue to grow. OPA was concerned about the reliance on guardianship and reported on groups of cases where guardianship did not represent the ‘least restrictive’ option. OPA undertook systemic advocacy, calling for policy and legislative solutions where alternative mechanisms to guardianship were identified by the organisation.

²⁹ OPA Annual Report 1996/97, p 32.

³⁰ OPA Annual Report 1989/90.

³¹ The Cocks Committee said that the proposed guardianship scheme reflected the development ‘away from state control and towards community participation’ and had as one of its aims ‘the promotion of family and community responsibility for involvement in decision-making’. Cocks 1982, p 48; See Guardianship and Administration Act, s 15(b)(iii).

³² OPA Annual Report 2001/02.

³³ OPA Annual Report 2004/05, p 22.

Three examples are discussed here:

- proposed new legislation to address the issues of protective legislation resulting in ‘civil detention’ of a person with an intellectual disability - a key issue reported until the introduction of the *Disability Act* 2006;
- the need for a ‘person responsible’ in the case of decisions that need to be made regarding simple medical procedures – a key issue reported until changes to the Guardianship and Administration Act in 2000;
- questioning the use of Guardianship instead of a CTO where someone with a mental illness already subject to the Mental Health Act is being discharged from hospital.

Civil detention

In 1996/97, OPA reported that there were ten orders made where OPA was appointed guardian to authorise detention within the Statewide Forensic Program or other secure residential programs. In 1999/2000, 13 cases were reported where a guardian was appointed to authorise the use of chemical restraints. The appropriateness of the appointment of a guardian to authorise restrictive interventions for a person where the primary reason for the appointment is the interest of the community rather than the interest of the represented person was questioned by OPA.

OPA argued that the lack of a supportive framework to support actions amounting to civil detention of a person considered a risk to others was a gross violation of human rights, and when compared to protections for the rest of the community, was discriminatory.³⁴ In 2001/02, OPA participated in advocacy that led to an inquiry by the Victorian Law Reform Commission into the care and treatment of persons with an intellectual disability or other cognitive impairment who are at risk to themselves or the community. This was followed by a partnership between DHS, the Intellectual Disability Review Panel and OPA to review admissions to the Statewide Forensic Service.³⁵

The new *Disability Act* 2006 includes provisions for the compulsory treatment of persons with an intellectual disability and has meant that ‘some matters of civil detention, which would previously have come to guardianship, are now dealt with more appropriately by VCAT making a Supervised Treatment Order’³⁶ or other processes outlined in the Disability Act. One of OPA’s roles under the new legislation is monitoring supervised treatment orders and other restrictive interventions. OPA welcomed being excluded from guardianship in these matters, noting that guardianship is not a suitable mechanism for civil detention.³⁷

Decision-making in relation to medical treatment

Amendments to the Guardianship and Administration Act in 1999 represented ‘the successful combination of a long advocacy campaign by OPA’.³⁸ Before changes were made, the Public Advocate was ‘frequently appointed guardian to fulfil the legal requirement of providing informed consent to a medical procedure for a person with a disability’.³⁹ A change in Department of Health and Community Services policy in 1993/94 requiring a guardian’s consent for simple medical decisions previously made by the Department meant that

³⁴ OPA Annual Report 2001/02; 2005/06.

³⁵ OPA Annual Report 2001/02, p 6.

³⁶ OPA Annual Report 2007/08, p 14.

³⁷ OPA Annual Report 2007/08.

³⁸ OPA Annual Report 1999/00.

³⁹ OPA Annual Report 2001/02, p 14.

guardians were being appointed for minor medical or dental treatment decisions that could easily have been made by the service provider.⁴⁰

The introduction of the provision for a 'person responsible', when a person with a cognitive impairment is unable to provide consent and the requirement for OPA to be notified through use of a section 42K notice where there is no person responsible, has the net effect of reducing the number of cases where a guardian is appointed to make medical decisions.⁴¹ It was reported that the majority of guardianship orders for health care following the legislative change involved 'complex, conflictual situations where there may also be significant ethical challenges'.⁴²

OPA supported the introduction of the Enduring Power of Guardianship which enables a competent person to proactively appoint an 'enduring guardian' to make medical and other lifestyle decisions when they themselves are no longer able to. This was expected to result in less need for guardians to be appointed, something which would only be measurable over the long-term.⁴³ Another significant change which OPA had input into was in relation to consent to 'special' medical procedures (treatment which could render the person infertile, termination of pregnancy and removal of tissue and medical research) which previously required consent from a guardian and the tribunal, and became the sole province of VCAT with OPA playing an investigative role.⁴⁴

Mental Health Act

An ongoing issue raised in OPA annual reports has been the intersection between the *Mental Health Act 1986* Community Treatment Order (CTO) provisions and the Guardianship and Administration Act, in particular who should have responsibility for decision making regarding accommodation. 'Whilst a guardian cannot make decisions for a person in relation to psychiatric treatment, applications for guardianship are frequently made when a person is about to leave a psychiatric hospital and there are decisions to be made about where they will live, and what supports should be provided'.⁴⁵

In the view of OPA, 'where there is a nexus between the treatment to be provided in the community and a need for a person to have particular supports or structure in order to receive that treatment, the person should be discharged on a CTO which has an accommodation clause'.⁴⁶ Applications for guardianship in many of these cases are regarded by OPA as reflective of a lack of understanding of the Mental Health Act or a reluctance to use the residential component of a CTO, by some authorised psychiatrists.

OPA advocated for the use of CTOs in preference to Guardianship orders for people already being treated under the Mental Health Act in its submission to the review of the CTO provisions of the Mental Health Act in 2003 and again in 2009, with a view to reducing the number of state interventions people are subject to. There has been no change to date in this area.

⁴⁰ OPA Annual Report 1993/94.

⁴¹ OPA Annual Report 2000/01.

⁴² OPA Annual Report 2001/02, p 14.

⁴³ OPA Annual Report 1998/99.

⁴⁴ OPA Annual Report 1999/00.

⁴⁵ OPA Annual Report 2003/04.

⁴⁶ OPA Annual Report 2003/04, p 14.

Conclusion

In summary, a consistent theme in OPA annual reports has been the ‘net widening demand’ of guardianship appointments, many which do not represent the ‘least restrictive course of action’ and are seen as the culmination of the effect of deinstitutionalisation combined with the diminishing accessibility of the service system and the development of a normative expectation of guardianship as a mechanism for managing complex problems. OPA has maintained a commitment to the ‘least restrictive’ principle embedded in the Act where it states that the Tribunal must be satisfied in respect of an order appointing a guardian of ‘whether the needs of the person in respect of whom the application is made could be met by other means less restrictive of the person’s freedom of decision and action’.⁴⁷

OPA has been under constant pressure since its establishment to maintain a balance between advocacy, investigation and guardianship due to the driving pressure on the organisation created by the statutory demands of guardianship. The organisation has responded to the demand for guardianship by seeking to limit potential applications where appropriate through operational means by using the tools of investigation and advocacy and through systemic means by contributing to policy and legislative reforms. OPA’s contribution to policy and legislative reforms has resulted in some less restrictive solutions to guardianship. However, the unremitting rise in guardianship cases continues and OPA still strains under extremely high case loads.

The review of the Guardianship and Administration Act is an appropriate time to pose a similar question to that asked by Carney and Tait in 1995, when they reflected on whether guardianship as an intervention has been ‘too successful’. Is there too much guardianship?

⁴⁷ Guardianship and Administration Act, s22(2)(a).