

Is guardianship a successful intervention for people diagnosed with Borderline Personality Disorder?

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## **Abstract**

Understanding and treating individuals who have a combination of borderline personality disorders, self-injurious behaviours and sometimes suicidality, presents one of the most confusing and problematic challenges to mental health professionals. While the use of mental health legislation for this group is considered unusual, guardianship legislation in Australia is sometimes additionally utilised. To date, there has been no examination of the effectiveness of guardianship for people with borderline personality disorder in the Victorian context. This study aims to examine the role of guardianship for this population by assessing the contributing factors that led to the appointment of a guardian including the mental health responses prior to a guardianship application being made, subsequent service responses provided and finally to enhance current knowledge by determining whether guardianship is an effective intervention. This research has two phases. Phase one assessed guardianship as an intervention by the examination of case materials held by the Office of the Public Advocate. In phase two some participants from phase one were interviewed to elicit their experience of such an intervention. Findings indicated that the combination of high level self-injurious behaviours and refusal of treatment led to the appointment of a guardian. Service and system responses were quite diverse for this cohort, particularly regarding the ongoing provision of case management. Empathic responses were often not forthcoming from health professionals. Combined results indicated that advocacy rather than guardianship was more beneficial. Recommendations to improve the legal and healthcare framework are suggested.

**Doctor of Psychology Declaration**

"I, ....., declare that the Doctor of Psychology Clinical thesis, is guardianship a successful intervention for people with Borderline Personality Disorder, is no more than 40,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references and footnotes. The thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work".

Signature:

Date:

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## **CHAPTER 1: Literature Review**

### ***1.1. Borderline Personality Disorder***

The term Borderline Personality Disorder (BPD) arose out of the experience of psychoanalysts (Aronson, 1985). They identified a cluster of clients who responded differently in treatment to those categorised as neurotic or psychotic. The term borderline referred to the belief that these people were on the border between neurosis and psychosis, and traditionally has been conceptualized through a psychodynamic framework (e.g. Kernberg, 1975). BPD is a serious, persistent, and prevalent disorder (Clarkin, Lenzenweger, Yeomans, Levy & Kernberg, 2007), and is a major health problem (Black, Blum, Pfohl, & Hale, 2004; Lieb, Zanarini, Schmahl, Linehan & Bohus, 2004), associated with high treatment utilization (Zanarini, Frankenburg, Hennen & Silk, 2004; Clarkin, Lenzenweger, Yeomans, Levy & Kernberg, 2007). In addition, many individuals with BPD threaten and make multiple suicide attempts (Gunderson, 2001) which have sometimes been characterized as *communicative gestures* (Soloff, Fabio, Kelly, Malone and Mann, 2005, p.386). However studies have reported rates of suicide of 10% (Gunderson & Ridolfi, 2001; Paris, 2004).

### ***1.2. Diagnosis and Related Issues***

A personality disorder (American Psychiatric Association, 2000) is described as an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment (p.685). The borderline personality is described as a Cluster B personality type, which includes individuals who are dramatic, emotional or erratic.

In the Diagnostic and Statistical Manual IV–TR (DSM IV–TR) the diagnosis of BPD is described as a pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity

beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. frantic efforts to avoid real or imagined abandonment;
2. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation;
3. identity disturbance; markedly and persistently unstable self-image or sense of self;
4. impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating);
5. recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour;
6. affective instability because of marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days);
7. chronic feelings of emptiness;
8. inappropriate intense anger or difficulty controlling anger ( e.g. frequent displays of temper, constant anger, recurrent physical fights); and
9. transient, stress related paranoid ideation or severe dissociative symptoms (American Psychiatric Association, 2000, p. 710).

Zanarini and Frankenburg (2007) suggested the intense inner pain and the maladaptive manner of expressing this pain should be included in the definition of BPD for DSM-V. Nevertheless, patients with BPD generally also meet DSM IV–TR criteria for other psychiatric illnesses. In terms of axis 1 disorders, major depression, substance misuse, post-traumatic stress disorder, other anxiety disorders, and eating disorders are all common for

these individuals (Oldham, Skodol & Kellman, 1995; Zanarini, Frankenburg & Dubo, 1998; Zimmerman, & Mattia, 1999). In a study conducted by Bateman and Fonagy (1999) concurrent diagnosis of major depression (70%), dysthymia (63%), panic disorder (50%) and bulimia (38%) was reported. Furthermore, the dual diagnosis of BPD and intellectual disability (ID) presents additional problems. It has been suggested that BPD occurs in people with ID at rates perhaps well above the general population (Nugent, 1997). However, psychiatric diagnoses are difficult to make in patients with ID as the patients often cannot be relied upon to provide the usual verbal descriptions which are depended on to make such diagnoses. According to Mavromatis (2000) a diagnosis of ID and BPD is the most difficult to make. Benson (2004) believed the development of the DC-LD: Diagnostic Criteria for Psychiatric Disorder for Use with Adults with Learning Disorder (Royal College of Psychiatrists, 2001) has advanced the reliable psychiatric diagnosis in this field, but requires widespread application of the classification system before the full impact can be realised.

### **1.21 Epidemiology and Etiology**

In epidemiological studies of adults, the prevalence of BPD ranges from 0.7% in Norway (Torgersen, Kringlen, & Cramer, 2001) to almost 2% in the USA and Australia (Swartz, Blazer, George and Winfield, 1990; Krawitz & Watson, 2000). It can be estimated that around 0.5% of those individuals meeting diagnostic criteria (or one in ten thousand people) will experience the severest difficulties (Krawitz & Watson, 2000).

The cause of BPD is complex with several factors which interact in various ways with each other. Current evidence suggests that genes have both main effects (Torgersen, 2000) and interactive effects with inconsistent environmental influences (Caspi, et al., 2002). Various types of adverse events during childhood, including ongoing experiences of abuse and neglect are reported by many individuals with the most frequent of these being childhood sexual abuse (Silk, Lee, Hill & Lohr, 1995; Zanarini, Williams, Lewis

& Reich, 1997; Johnson, Cohen, Brown, Smailes & Bernstein, 1999; Bierer, Yehuda, Schmeidler, Mitropoulou, New, Silverman & Siever, 2003). Bierer et al., (2003) suggested that childhood emotional abuse and neglect are broadly represented among personality disorders.

Fonagy and Bateman (2008) believed that constitutional vulnerability and suboptimal environmental conditions at critical developmental stages combine to create a vulnerability to BPD. Moreover, early attachment trauma and neglect undermines the development of the capacity to think about mental states through the process of mentalization, that is, the capacity to make sense of each other and ourselves (Fonagy & Bateman, 2008, p. 5). Thus, trauma has a key role in shaping the pathology of BPD (Lieb et al., 2004, Fonagy & Bateman, 2008). The role of memory is also considered central, as all that enters self-memory, or the meaning-making system, gives the individual a sense of existence and meaning (Elin, 2004, p. 445). Furthermore, autobiographical memory or the aspect of memory which contains representations of one's story over time is also considered to operate differently in individuals with BPD, as borderline patients are believed to produce over-general autobiographical memories with negative memory cues (Clarkin, et al., 2007).

BPD is therefore a complex disorder with many factors which influence its formation. How the diagnosis of BPD is understood by sufferers and professionals alike, and what is considered as effective treatment will be next explored.

### ***1.3. Treatment Issues: Individuals' responses***

Many factors impinge on effective treatment for persons with BPD. As people with BPD have an impairment of interpersonal and social functioning, it makes their encounters with professionals difficult for them and those involved in their treatment. Perhaps a sufferer best illustrates this,

The best way I have heard BPD described is having been born without a skin – with no barrier to ward off real or perceived emotional assaults. What might have been a trivial slight to others was for me an emotional catastrophe... (Williams, 1998, p.173).

An American study (Miller, 1994) sought individuals' experience of the BPD disorder. A common response from all was a view of themselves as estranged from others and inadequate in the face of perceived social standards. Castillo (2000) conducted an English study on the implications of a BPD diagnosis and revealed that 44% of respondents reported being treated badly (e.g., staff didn't know what to do; told I was attention seeking; something you brought on yourself). In responding to an ideal world in terms of treatment, 34% revealed better services as essential and being listened to, treated with respect, and being understood as critical to their care (Castillo, 2000). What is necessary is an optimal holding environment that is also validating to allow for new learning to occur in an enabling relationship (Winnicott, 1965).

### **1.31 Staff Responses to People with BPD**

The individual's own feelings regarding his/her diagnosis is further heightened by the mobilization of intense feelings in those who treat them. Negative responses engendered by staff working with people with BPD (Bowers, 2002; Gallop, 1992; Gutheil, 1985; Hinshelwood, 1999; Linehan, 1993; Nehls, 1999; O'Brien & Flote, 1997; Potter, 2006) serve to aggravate an aggressive or passive aggressive response from patients (Bowers, 2002; Nehls, 1999; Norton & Hinshelwood, 1996), and it has been shown that the label of BPD was sufficient to damage the behaviour of treatment providers (Gallop, Lancee & Garfinkel, 1989; Aviram, Brodsky & Stanley, 2006). This in turn makes the interface between the individual with BPD and the mental health professional strained, and maladaptive interpersonal relationships are adopted. In addition, individuals with BPD can also create hostile divisions or

splits among the staff involved in their care (Bowers, 2002; Krawitz & Watson, 2000; Norton & Hinshelwood, 1996). Divided environments undermine any collaborative approach to treatment which can support the achievement of mutually agreed clinical goals (Bowers, 2002).

Thus, a clear structure, fairly applied by staff in a spirit of integrity and equality, with the courage to confront difficult behaviour is needed to create and maintain a stable therapeutic environment. Best practice is next discussed.

### **1.32 Best Practice**

Best practice incorporates co-ordinated systems approaches, which include: a variety of therapeutic techniques, such as Dialectal Behaviour Therapy, (DBT), (Linehan, 1993), or psychoanalytic for example, crisis interventions, and hospital issues. It is essential that the system for people with BPD is based on comprehensive assessment followed by treatment planning (Milton & McMahon, 1999). A challenge for those working with BPD persons is to find the appropriate level of involvement. In addition, many troubling behaviours are believed not to occur because of the BPD but as a consequence of treatment environments and interventions. These behaviours are referred to as iatrogenic (Krawitz & Watson, 2000; Milton & McMahon, 1999).

An adequate assessment of an individual's problems and needs is required for the clinician and individual to engage in a mutually agreed plan. Thorough risk assessment analysis incorporating previous and aborted suicide attempts, distinguishing acute from chronic suicide patterns and short versus long term risk are examined and documented. In addition, contracts are frequently used and have an important role to play in the management of clients with BPD (Northern Area Mental Health Service, 2001; Milton & McMahon, 1999).

Hospitalisation is a common occurrence for people with BPD and the management of such stays must be sensitive to the treatment needs of the individual. An in-patient ward that is marked with empathy, firm limits and consistency to contain the distressed individual with BPD is reliant upon nursing staff and presents significant clinical and therapeutic challenges to psychiatric nurses (Bowers, 2002; O'Brien & Flote, 1997). As previously stated effective treatment requires a skilled balance between encouraging individual responsibility and autonomy, and offering clear reporting structures when needed. To ensure best practice, Victoria established a program specifically designated to the needs of people with BPD.

#### ***1.4. Historical Context to BPD Treatment in Victoria***

In 1994, a seminal document on Victoria's mental health system recognized that the psychiatric service system would include people with BPD (Morton & Buckingham, 1994). At this time, changes in the Mental Health Act occurred simultaneously with the establishment of Victoria's Statewide Specialist Personality Disorder Service, Spectrum. It was acknowledged that most individuals with BPD would receive care from the area mental health agencies. Spectrum would provide support to existing services and would target the most severely disabled amongst this group for more intensive treatment (Milton & McMahon, 1999).

Spectrum offers secondary consultations to area mental health agencies, and for BPD sufferers the community mental health setting allows for a variety of therapeutic interventions. Spectrum together with mental health agencies have provided manuals to assist with service provision for clients with BPD (refer Northern Area Mental Health Service, 2001). Yet irrespective of documentation, legal issues still arise.

#### ***1.5. Legal Issues***

People meeting diagnostic criteria for BPD represent a significant legal risk for clinicians and organisations providing service. Moreover, a lack of

understanding about optimal treatment choices and risks involved may result in clinicians being blamed for ineffective treatment even when the treatment is of a satisfactory or better standard (Gutheil, 1985; Krawitz & Watson, 2000). Gutheil (1985) explained areas of medico-legal vulnerability peculiar to work with BPD individuals and suggested preventative intervention. Expert opinion agrees that the use of mental health legislation should be considered an unusual part of treatment (Goin, 2001; Krawitz & Watson, 2000; Smith, Ruiz-Sancho & Gunderson, 2001; Stone 1993). This includes the use of involuntary admissions which are seen as particularly problematic with clients with BPD.

In Australia in some instances mental health legislation as well as guardianship legislation is utilised. Before examining the legislation it is useful to understand what guardianship means, how it fits in the legal context, and how guardianship is applied.

### ***1.6. Role of guardianship***

Apart from Flanders, Australia stands alone in the use of tribunals to handle guardianship and substitute consent (Carney & Tait, 1997). A variety of court systems are utilised by New Zealand, England and Wales, most states in the United States, and most Canadian provinces. The system in Ontario, Canada, is considered the most similar to that utilised by most Australian states. Although the Victorian legislation served as the basis for most other states and territories, differences exist within the Australian system (Carney & Tait, 1997).

Guardianship legislation is perhaps best understood in the context of modern life. Modern society requires its citizens to make legally effective choices. Irrespective of choice, individuals who make choices should be able to provide consent and be accountable. Thus they should be legally competent. In the Australian context individuals who lack competency, due to a cognitive impairment, may have a substitute decision-maker or a guardian appointed to make decisions on their behalf. In Victoria, the judicial body to appoint a guardian is the Victorian Civil and Administrative Tribunal (VCAT).

A guardian can be appointed for certain domains of an individual's life, for example health matters, and so a guardian can be appointed limited to decisions of healthcare. A guardian can also be appointed for all domains of an individual's life and have unlimited powers, and these are referred to as plenary guardians. The decision-making responsibilities describe the guardian in terms of the role of a parent to a child. "All the powers and duties" exercised by a parent in relation to a child are given to plenary guardians in Victoria (Guardianship and Administration Act, Vic, 1986, [GAA] s.24,1.). In addition, the common law best interests test can be applied to adults unable to care for themselves. The Victorian Supreme Court has a power known as the *parens patriae* jurisdiction, to appoint a decision-maker for a person unable to adequately safeguard his or her own interests. In Victoria, with regard the VCAT process, all less restrictive options should have been exhausted before application is made to the Supreme Court for determination.

To restate, in Victoria VCAT can appoint a guardian, and this process is next discussed.

#### **1.6.1. Victorian Civil and Administrative Tribunal (VCAT).**

Initially an application is made to VCAT, seeking the appointment of a guardian for an individual. The individual is described as the Proposed Represented Person (PRP). The matter is then referred to VCAT, Guardianship List, for hearing. The appointment of a guardian can occur if:

1. a) the Tribunal is satisfied that the person in respect of whom an application for an order appointing a guardian is made- is a person with a disability; and
- b) is unable by reason of the disability to make reasonable judgment in respect of all or any matters relating to his or her person or circumstances; and
- c) is in need of a guardian. (GAA, s.22, 1.).

The Tribunal may make an order appointing a plenary or a limited guardian in respect of that person.

Further,

2. In determining whether or not a person is in need of a guardian, the Tribunal must consider-
  - a) 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 decisions and action (GAA, s.22, 2.).

If the Tribunal is satisfied of the aforementioned, the PRP can then be appointed a guardian. The Tribunal may appoint anyone over 18 years of age, who consents to act as the guardian providing they satisfy the relevant criteria (refer GAA, s.23, 1, 2, & 3). The Tribunal may appoint the Public Advocate or his/her delegate as the plenary or limited guardian of that person (GAA, s.23, 4.).

Furthermore as identified in sections 22 and 23 of the GAA a general principle to be applied in the interpretation of the legislation is that the means are least restrictive of the individual's freedom of decision and action. Thus all options must be canvassed and then dismissed before a guardian can be appointed. The role of an advocate and advocacy in general is next considered, as advocates should consider options with the individual, facilitate communication and assist in the understanding of the situation, to ensure that guardianship is only used as the last resort.

### **1.6.2. Advocacy**

In Australia, the only discussion on guardianship for people with BPD was from the New South Wales perspective. Earlam and Kennard (2007) examined the possible benefits and the difficulties of guardianship with individuals with a personality disorder. Their study was largely anecdotal from both their own and colleagues' experiences, and they provided case study material to illustrate the challenges of working with these individuals. They

concluded that for this population, coercion only works if there is coercive authority in the guardianship order, confrontation is notoriously unsuccessful, and that collusion can do some good but does not necessarily require the appointment of a guardian. They concluded from their experiences that working together with a client as one does in an advocacy role was more beneficial, and that guardianship was less effective for the BPD cohort. There has been no evaluation on this issue from a Victorian perspective. The Office of the Public Advocate (OPA) is empowered by the GAA (refer s.15) to be an advocate for a person with a disability separate to the role of guardian. An advocate can utilise a variety of ways to ensure that the larger community gives greater prominence to the rights and needs of people with disabilities. Different approaches to advocacy will use different ways of accomplishing increased justice and empowerment. This may result in individual or systemic advocacy, but irrespective of approach, both types are inextricably linked to each other (Parsons 1994; Healy, 1996; and Stone, 1999). When advocacy is considered to have failed or to have been insufficient to exact appropriate change, then guardianship legislation can be utilised.

### **1.6.3. Paradoxes of Guardianship**

There are several paradoxes in appointing guardians for adults. As discussed by Carney and Tait (1997), in guardianship there is an ideology that freedom is linked to a set of tools which restrict freedom. A main task of guardianship is to remove from individuals some of their rights and entrust guardians with the exercise of legal decision-making. The question arises whether perhaps unwittingly, VCAT in exercising its guardianship and administration jurisdiction, has allowed the balance to swing too far in favour of paternalism or protection against individual autonomy. Examining the use of guardianship, how it is enacted and how problems are addressed, may provide some valuable answers for the community.

### ***1.7. Rationale for the Present Study***

People with BPD present the community with the challenge of what is acceptable from and for the individual and for the community at large. In Victoria, guardianship legislation has been used as a “tool of last resort” for people with BPD, yet there has been no evaluation on its effectiveness. Moreover there is paucity of information published in the area of guardianship in general and for those with BPD specifically. As a guardian myself, it appeared that the appointment of an independent guardian was problematic in these cases. Why was there a need to utilise guardianship legislation when mental health legislation should suffice? Do these individuals need a substitute decision maker, a guardian, or do they need someone to stop them making bad decisions? How can a guardian navigate this difficult terrain when others have presumably failed? At monthly OPA Issues Forums attended by all staff including advocates and guardians, similar questions were raised by my colleagues and the former Public Advocate who questioned whether guardianship assisted or inadvertently further complicated the situation. As not all people with BPD have a guardian, what was unique about these individuals and each one’s predicament to warrant the intervention of a guardian? An expected outcome of the study is to enable a greater understanding of BPD which will inform and hopefully improve practice in this area, and thus this research received strong endorsement by the former Public Advocate. The examination of the OPA case files should provide an evaluation of the research objectives. It is hoped that this study will advance the current understanding of BPD, the suitability or otherwise of guardianship for these individuals and its subsequent impact on both the sufferers and the community.

### ***1.8. Research Objectives***

The research has four objectives. To:

- (1) enhance existing knowledge of the contributing factors which led to the appointment of an OPA guardian;

- (2) enhance the understanding of the mental health service response/s prior to the application of a guardian to VCAT;
- (3) extend existing knowledge of service responses for people with BPD; and
- (4) enhance our knowledge as to whether guardianship was an effective intervention for people with BPD. This objective will be further addressed to determine if guardianship has achieved:
  - a. a change in behaviour of the person with BPD, and as a consequence the guardianship order was no longer necessary,
  - b. a limited change in the person's behaviour necessitating a further guardianship order sometime following the revocation of the original order, and
  - c. long term outcomes for the client after the guardianship order.

## **CHAPTER 2: Methods**

### ***2.1 Research Design***

This research utilised two phases, phase one was based on case files from OPA guardians and phase two utilised interviews from individuals who have been the subject of a guardianship order to determine whether guardianship has been an effective intervention for people with BPD.

### ***2.2 Positioning of the Researcher***

I am approaching this research from many years' experience working at the OPA as a guardian. My initial experience as a guardian for a person with BPD and being confronted first hand with what appeared to be a seemingly endless variety of complex issues motivated this study.

### ***2.3 Ethics***

Research approval was sought from the Victoria University Department of Psychology Human Research Ethics Committee. Approval was granted after some amendments (see Appendix 1). The Department of Justice Research Ethics Committee granted full approval following amendments (see Appendix 11).

### ***2.4 Phase 1: Case Files***

The Office of the Public Advocate case files examined in this study are complex and have specific features that make them unique. As such, each case file is considered to be a bounded system, as it is purposive and is part of an integrated system (Stake, 1995). This method of research is nonexperimental, and is often referred to as descriptive. The aim of descriptive research is to examine events or phenomena (Merriam, 1998; Stake, 1995). Furthermore, Herriot and Firestone (1983) concluded that this

method of research is applicable to policy study and social science as well as the description of complex programs.

The multicase study method is utilized to examine in detail something with a variety of parts. In this study documentation for a small collection of people was examined in detail, with each case having its own problems and relationships. Each case had its own stories, but the main aim was in the collection of these cases, or in the commonality of the phenomena exhibited in them.

#### **2.41 Data Selection**

To be included in this study, an individual had to satisfy two criteria: (a) to have a diagnosis of BPD, and (b) to have been the subject of a guardianship order.

To obtain participants, I initially contacted by e-mail all current OPA staff employed as guardians, and those still employed at OPA but not working in this capacity, to seek their assistance. Once cases were identified, I spoke to the staff member to ensure that the nominated case fulfilled the study criteria. In addition, OPA staff were also asked to consider any cases with which they may have been familiar which also satisfied the study requirements. These two processes yielded 12 cases.

Another possible source of participants emerged from a list identified by former staff as being *difficult* individuals. This list was compiled in the late 1990s when staff identified a number of individuals who had significant ongoing complex issues. The *difficult* label was in regard to a number of matters which included, but were not exclusive to: poor compliance to recommended strategies, ineffectual service responses, and an apparent system inability to deal with the needs of the individual. The number of cases in this category totalled 53.

The combined case files totalled 65, and were either current (active) or closed (archived). I then examined each file and found that in the majority of

cases the assigned disability, provided by the applicant to VCAT (normally either the assigned case manager or mental health services provider), was either insufficient or inaccurate. I referred to many recordings of disability as insufficient or inaccurate as often the assigned disability was merely recorded as cognitive impairment, which although appropriate in justifying an application before VCAT, is nevertheless inaccurate with regard to a DSM IV-TR diagnosis for example. Thus from a total pool of 65 cases, seven cases fully met the study requirements. The seven case files spanned the years between 1990-2004.

## 2.42 Case File Participants

The demographic information for each participant whose case file was included in the study is set out in Table 1.

Table 1

Demographic information for participants.

Gender	Age in years at first appointment of guardian	Assigned Disability	Guardianship status
Male	20	Psychiatric Illness	No longer current (whereabouts unknown)
Female	24	BPD and depression	No (completed suicide)
Male	29	Intellectual Disability and BPD	No longer current (whereabouts unknown)
Male	26	BPD	No longer current (potential for interview)
Male	55	BPD	Yes (potential for interview)
Male	29	Intellectual Disability and BPD	No longer current (potential for interview)
Male	24	Schizophrenia and BPD	No (death due to self-neglect)

### **2.43 Data Sources and Method of Analysis**

Each of the seven OPA case files included: the materials and supporting evidence by the person/s making application to the VCAT; the writings by the guardian as to the Tribunal member's reasons to appoint the guardian; and formal records kept by the guardian throughout the life of the guardianship order. If case files were ambiguous or verification of information was needed, I was granted permission by the Deputy President of VCAT to examine their files.

### **2.44 Procedure and Method of Data Analysis**

#### *2.441 Objective 1*

To enhance existing knowledge of contributing factors which led to the appointment of a guardian for people with BPD, the seven files were first examined to determine the demographic information. I then assessed the level of risk to self and its corresponding effects on others to gain an understanding of what was occurring for the participant at the time of application to VCAT.

#### *2.442 Objective 2*

To enhance the understanding of the mental health service response/s prior to the application being made to VCAT, I examined the seven OPA files. I then (a) identified and (b) evaluated the responses made by the mental health group/s, and, (c) identified the reasons given by the tribunal member/s for the appointment of a guardian and their relationship to mental health service responses.

#### *2.443 Objective 3*

To extend existing knowledge of service responses for people with BPD, I identified and evaluated the various service responses from the seven case files. The responses were further categorised as being either beneficial or ineffective in dealing with the individual.

#### *2.444 Objective 4*

To enhance our knowledge as to whether guardianship was an effective intervention for people with BPD, I reviewed the decisions made by the guardian. These decisions were then evaluated to determine whether they achieved an improved quality of life. This was assessed by whether the guardian sought a continuation, an extension, or a revocation of the original order. The determination of quality of life for each participant was further addressed by determining if guardianship had achieved: (a) a change in the individual's behaviour, thus revoking the order; (b) a limited change in behaviour thus necessitating a further order sometime following revocation of the original order, and (c) long term outcomes for the person, with little if any ongoing involvement of a guardian or OPA in the individual's life.

Although numbers initially identified each participant during the research, pseudonyms were later chosen for writing the cases to preserve both the humanness of the story and the privacy of each participant.

### **2.5 Phase 2: Interviews**

The next phase of the research sought the opinions of case study participants from phase one who were available to be interviewed. The interviews aimed to explore further objectives three and four. The literature review found no record of individuals being interviewed who have been the subject of a guardianship order, let alone those who had been diagnosed with BPD and also the subject of a guardianship order.

#### **2.51 Rationale for interviews**

In many qualitative studies, the interview is a major source of qualitative data utilized for understanding the phenomenon under study (Merriam, 1998). As discussed by Patton (1980), an interview is perhaps the only way to find out "what is in and on someone else's mind" (p.196). As recommended by Merriam (1998) I utilized a semi structured interview guided by a set of issues to be explored, where neither the wording nor the order of questions was

predetermine. The general questions involved the participant's opinions on the diagnosis of BPD and what this meant, the reasons behind the appointment of a guardian, was a guardian beneficial or otherwise, and what was important from the guardianship process.

## **2.52 Participant Recruitment**

After reviewing data from each file in phase one, I also recorded whether the client was still alive, and noted whether the client was possibly a candidate to interview with regard to their experience of guardianship. This process revealed three potential candidates, all of whom were male (see Table 1).

Being mindful of the psychological state of each participant, I initially engaged a key person currently working with the participant, to act as a conduit. In two cases, an OPA guardian was no longer involved in the matter, but provided me with the contact details of a key person involved in the individual's day to day care. I contacted this person. Following a brief introduction, I outlined my study, and the rationale for wishing to interview the potential participant. I also sought the current psychological assessment provided by the key person, and of their opinion as to whether they believed the potential participant would be suitable to interview. Once these assurances were given, I requested the key worker convey my interest. The key worker then advised me of the discussion and whether the participant was willing to be contacted by phone.

In the initial telephone contact to the participant, I explained my study and why I wanted to interview him, and the voluntary nature of the decision to participate, and with the participant's verbal consent, I also arranged a time to visit. In addition, I arranged my visit while another person with whom the participant was both comfortable and familiar, was also present. Two interviews were conducted in the home of the participants. This procedure will be detailed.

The day prior to the scheduled interview, I again telephoned the participant to allay any concerns and to confirm details for the following day. Upon arrival at the participant's home, I formally introduced myself and engaged in general discussion to establish rapport building. I also briefly spoke with the friend of the participant, to ensure that they were satisfied with the current mental status of the participant, and of their opinion on the ability of the participant to manage the interview that day. Both participants wanted the interviews conducted in the lounge room.

When the participant and I were alone, the research process was explained both verbally and in writing using the plain language statement on invitation to participate in a research study (see Appendix 111). The participant was then asked to sign the consent to participate in the study form (see Appendix IV). I then emphasized the voluntary nature of participation in my study, and of the right to withdraw at any time. Specific emphasis was also placed on the storage of the data, of who could access this information, and why. I advised that I was interested in their story regarding guardianship, and that I would be taping our conversation. These interviews lasted between 50 and 70 minutes.

For the third interview, the participant was still under a current guardianship order, and so the guardian acted as the intermediary. In this instance, the participant was in a major city hospital. He had been in hospital for six weeks and had surgery as a consequence of neglecting his health. He was recuperating and still awaiting further surgery for complications. The guardian initially spoke with this participant who then requested that I explain my study to him in detail. After this occurred he agreed to participate in an interview. An agreed time and private location was arranged. As in the other cases, I telephoned the participant the day before the interview, to ensure that he was still comfortable to proceed and to ensure that he was medically and psychologically capable.

On the day of the interview, I spoke with the Nurse Unit Manager to ensure that the participant had medical clearance. When the participant and I were alone in the private room, I again outlined all the ethical components of my study prior to the interview commencing, and the participant signed both the Plain Language Statement and the informed consent form. This interview lasted approximately 65 minutes.

### **2.53 Method of Data Analysis**

I tape recorded each interview to ensure what was said was preserved for later analysis. I later transcribed each interview verbatim, to enable optimum data analysis. A thematic analysis (Miles & Huberman, 1994) was undertaken. Initially the themes emerging from each interview were summarized to provide a picture of each individual's experience with guardianship. Subsequently the themes across the three interviews were considered in relation to the research objectives.

## **CHAPTER 3: Phase 1: Findings**

### ***3.1 Objective 1: To enhance our knowledge of the contributing factors which led to the appointment of a guardian for people with Borderline Personality Disorder (BPD).***

A small minority of individuals with BPD are the subject of a guardianship order. What has set the individuals in this study apart from those individuals that have a BPD diagnosis but do not have a corresponding guardianship order? Anecdotal evidence from both OPA guardians and findings from this study suggested that three factors contributed to a guardianship order. The first is the level of self-harm in which the person engaged; the second is the corresponding effects these behaviours had on others such as carers, and hospital staff for example; and the third factor is the apparent inability of the person to accept care and/or medical interventions afforded them. These factors possibly supported the applicant's belief that an independent guardian was required.

Suspecting that the level of self-harm and its corresponding effects on others might prove a significant contributing factor to an application being brought to VCAT, I rated each participant on a 10-point rating (where 1 signified "no self-harm" and 10 "extreme self-harm"). Because of the need to safe guard confidentiality I relied on my supervisor also to examine all information with regard to each participant. Her ratings and mine never differed by more than 1 point.

Table 2.

## Summary of Effect of Self-Harm and Guardianship Orders

Case No.	Pseudonym	Score out of Ten		No. Guardianship Orders
		Level of Self Harm	Effect on Others	
1	Joe	7	8	1
2	Jane	10	10	3
3	Bill	9	10	2
4	Dave	9	9	4
5	Chris	9	9	2
6	Nigel	10	10	4
7	Andre	10	10	3

As indicated in Table 2 all participants expressed a desire to kill themselves and engaged in extreme self-injurious behaviours. The extent to which each participant engaged in self-harm and its effects on others is briefly described.

### 3.11 Case 1 (Joe):

Joe rated a high level, seven, on the level of self-harm and slightly higher, eight, on the corresponding effect on others.

Joe engaged in illicit drug use, and frequently severely slashed himself. Upon self-presentation or after transportation by others (often the police intervened as Joe's public acts of self-harm engendered feelings of helplessness in others) to the hospital department, Joe would discharge

himself without receiving the recommended medical treatment. Conversely, Joe accepted medical treatment but continued to slash himself in the emergency department or hospital car park with whatever implement he could find. With regard to his effect on carers or others, on one quite infamous occasion at a Magistrates' Court hearing (and without any apparent warning), Joe became violent, upturned and destroyed court furniture. Jagged pieces of furniture were then used as tools to engage in acts of self-harm within the courtroom. The courtroom was subsequently cleared and police were again used to transport Joe to hospital. As was so often the case, all present were reportedly quite traumatized at what they had witnessed.

### **3.12 Case 2 (Jane):**

Jane demonstrated extreme levels of both self-injurious behaviours, and its effects on others with a score of ten on each rating.

Jane displayed extreme levels of self-harm including: self cannibalization of forearms leading to exposure of tissues and muscle, insertion of foreign objects into self that is, wire and biro's into urethra, fish hooks into vagina, super gluing of eyes, and slashing of face and arms. The majority of these acts required surgical removals and or medical interventions. Not only were many of these acts of self-harm in front of others, but also on occasions Jane also threatened staff at hospitals with her infected blood etc. Thus Jane presented an ongoing risk to the Hospital Accident and Emergency (A & E) Departments' staff.

### **3.13 Case 3 (Bill):**

Bill rated a very high score of nine on the level of self harm and received a score of ten, on the effect on others.

Bill engaged in significant acts of self harm. He regularly violently threw himself to the ground and head butted the concrete. As a consequence, he endured fractured collar-bones, sub-dural haemorrhages, and retinal

detachments. In addition, to self-harming in front of others, Bill was also extremely violent to his fellow residents where he resided.

#### **3.14 Case 4 (Dave):**

Dave received a very high score of nine on both the level of self-harm and the effect on others rating.

Dave was also a diabetic. Following surgery for an appendectomy, he inserted foreign objects into his wound, which resulted in wound contamination. He was subsequently non compliant with the prescribed antibiotics and continued to interfere with his wound, such as the insertion of bark, razor blades etc. Dave also swallowed glass, damaged his eyes with applications of household chemicals, and was non compliant with recommended treatments. Dave would also regularly self-harm in front of others, and threatened those with whom he resided by lighting fires. Furthermore, he made physical and indeed homicidal threats to staff at a rural A & E Dept.

#### **3.15 Case 5 (Chris):**

Chris also rated a very high score of nine on both the level of self-harm and effect on others rating.

Chris was also an insulin dependent diabetic, and his treatment required careful management and daily monitoring. He engaged in the denial of food and water, and regularly overdosed on his insulin. Chris provided false Blood Sugar Level (BSL) measurements to his carers, and often refused to follow an adequate diet. He engaged in extreme self-neglect, which resulted in amputations of some of his extremities. Although not physically violent to others, Chris inflicted significant psychological trauma on his carers, as on occasions they found him unconscious in his unit due to his self-neglect and abuse.

### **3.16 Case 6 (Nigel):**

Nigel demonstrated extreme levels of both self-injurious behaviours and its effects on others with a score of ten on each rating.

Nigel engaged in extreme self-harm including setting himself alight, object insertion (such as knife tips, blades, screws, etc.), and subsequent wound interference and contamination. He had great difficulty in enabling wound recovery as he was non compliant with prescribed medications. Nigel not only self harmed in front of others, but was also involved in the criminal justice system for attempted armed robbery, and damage to property.

### **3.17 Case 7 (Andre):**

Andre also demonstrated extreme levels of both self-injurious behaviours and its effects on others with a score of ten on each rating.

Andre engaged in extreme levels of self-harm and was paralysed following a previous suicide attempt. He demonstrated extreme self-neglect and refusal to care for himself and/or to allow others to provide appropriate care and wound management. Andre had extreme pressure wounds which were large and exposed his bones, he sat in his faeces which enveloped these pressure wounds and became maggot infested. In addition, Andre had an extensive criminal history due to his threats and acts of violence against others.

### ***3.2 Objective 2: To enhance our understanding of the mental health service response/s prior to the application before the Victorian Civil and Administrative Tribunal (VCAT).***

Case file data was examined to address the specific responses utilized by the health system which had resulted in their inability to adequately address the needs of the person with a BPD. This objective initially identified the responses made by the mental health groups, and then evaluated these. Finally the reasons given by the tribunal member for the appointment of a

guardian, within the particular service provision context were also identified. Each case is examined in turn.

### **3.21 Case 1 (Joe): 1990**

The intriguing features of this case were that in spite of being previously admitted to a major city psychiatric facility and being known within the psychiatric system, it appeared that no mental health services were ever afforded Joe. The most assistance was provided by his solicitor, who in desperation sought assistance from the local Community Policing Squad (CPS). They consulted the police surgeon who advised he would not assess Joe as he had previously been in a psychiatric facility and “was kicked out as he was driving everyone else mad”. The police surgeon nevertheless suggested that Joe be taken to a local clinic. As had so often been the case, he refused.

There is no mental health system response to evaluate. By contrast, the main people who sought help for Joe were his solicitor, the local police, and his aunt and uncle, who advised an OPA staff member at the hearing “he desperately needs help and treatment, ...it is not for our lack of trying... we are at the end of our tether...”

At the Guardianship & Administration Board Hearing, (as was the case in 1990), the single panel, male member, made a 21 day temporary order with decisions limited to healthcare and accommodation. The member was extremely concerned about Joe’s welfare, and wanted a thorough assessment to occur. Furthermore, the member also requested the OPA guardian notify the local CPS of the OPA involvement, and queried whether Joe’s uncle could advocate for his nephew as needed.

### **3.22 Case 2 (Jane): 1991**

Jane was the subject of three guardianship orders. She came from a disrupted and disturbed family, and had been effectively institutionalized for the whole of her late childhood, adolescence and early adult life. Jane’s first

admission to a psychiatric facility was four years prior to the first application to VCAT, and since that time she had numerous admissions. Many of these hospital admissions were of her own volition, as Jane recognized her level of self-harm was not only affecting her, but those around her. The initial applicant was the medical director of a regional hospital; his staff believed that Jane “would die if she did not receive urgent medical attention” for her self-inflicted wounds.

In spite of Jane's insight into her chaotic existence, there is no evidence to suggest that a mental health case worker was ever assigned. It appeared that the local A & E Department staff had more concerns for her welfare than did the mental health services staff.

The male President sat alone at the first GAB hearing. He made an urgent temporary order for decisions limited to healthcare and accommodation. He expressed concern at the apparent critical extent of Jane's injuries. The review hearing was heard before a three person board comprising one female and two males. The plenary order was made for 12 months. At this hearing the board considered making a reference to the Supreme Court as to “whether BPD constitutes a mental illness” (under s.64).

The appointed guardian consented to Jane's surgery. Prior to her discharge Jane advised ward staff, she would “do something to get back to prison”, as she believed they cared for her. Upon discharge Jane broke numerous shop windows and was charged with criminal damage.

Before the first order and in subsequent orders it appeared that the psychiatric system was at a loss as to how to respond to Jane. She was moved to a rural psychiatric facility but this exposed a variety of political sensitivities regarding both philosophical and financial arguments. Although Jane's self-harming continued it appeared to ease somewhat, and some staff appeared to seek ways to provide her with psychological relief. Detailed management plans included: night walks to assist with her sleep, local volunteer work, the purchase of a dog and outings on the weekends. Her

situation unfortunately escalated when the doctors at the rural hospital appeared unable (possibly due to safety reasons) to treat Jane for her medical wounds. She was then transported 90 minutes from one hospital to another to receive medical care.

The situation was untenable, and Jane was advised she would be returned to Melbourne. This information triggered significant regression in her self-harming behaviours. The Melbourne facility had detailed management plans in place, but none of their interventions appeared beneficial. The psychotropic medications had no apparent effect, and there were added complications with Jane's substance dependency and abuse of these medications. Her self-mutilation appeared to reach new heights, with regular visits to the Ophthalmology Department with insertion of foreign objects into her eye balls. While at this facility, and due to previous physical assaults, Jane was sentenced to serve time at the then Pentridge Prison. Jane believed jail to be less restrictive than the city psychiatric facility, and advised that she would do whatever she believed necessary to be returned there. Upon release and discharge back to the psychiatric facility Jane continued with her self-mutilation, with the insertion of blades into her vagina and urethra which necessitated hospital treatment. Once hospitalised Jane threatened the staff, and police were then utilized to protect both staff and fellow patients.

At the rehearing of the 3rd order, another three member panel (which comprised two males and one female), again continued with the plenary order. They stated there was neither a less restrictive option nor an alternate guardian available. Moreover, the guardian was commended for "doing a great job". The order was continued together with a recommendation to maintain the existing guardian as he had established numerous contacts and had been a constant in her life.

A trial at a home on the grounds of this psychiatric facility occurred. This too appeared to have had a positive affect for Jane; unfortunately the land had been earmarked by the State Government for rezoning and so her use of

this home was limited. As had seemingly always been the case for Jane, another loss again triggered a downhill spiral into further imaginative acts of self-harm. With the eventual agreement of the Office of the Chief Psychiatrist, and a carefully planned discharge complete with management plan, a unit was located for Jane in the community. Very shortly after this move Jane was found dead. The coroner found her cause of death was heroin toxicity and other combined drug toxicity. Jane was 30 years old.

With regard to the mental health responses for Jane after Guardianship orders two and three, it would seem that a multitude of responses were tried, with the vast majority having a very minimal effect. Sadly Jane was caught up in the politics of managing her, and it seemed that when she found a degree of security with resulting symptom reduction, the system around her was altered. For example when she felt comfortable and understood by the rural team, she had a renewed sense of purpose in her life, that is, volunteer work and going on weekend outings and so forth. Then later in Melbourne when she lived in a unit on the grounds of a facility she was reportedly happier, but both options were considered no longer viable and were taken away from her. Ironically the mental health interventions which had the most beneficial effects were removed, and not surprisingly, any imposed change on Jane corresponded to increased and more extreme methods of self-harm.

### **3.23 Case 3 (Bill): 1993:**

Bill was the subject of two guardianship orders, and he never attended the hearings. He was residing at a state run facility, and had no family. Bill had numerous interventions following comprehensive psychiatric assessments. These included programs to foster his independence and he attended day placement programs which assisted with his daily life skills. Bill's challenging behaviours were monitored by the Behavioural Intervention Support Team (BIST) from Disability Services, and on occasions when he engaged in extreme behaviours, chemical restraints were used.

With regard to responses made by the mental health services, it would seem that the Disability Services (DS) of the Department of Human Services (DHS) acted in his best interests. They were fully aware of Bill's dangerous behaviours and closely monitored him when his behaviours escalated, with an increased staff ratio to assist in minimizing his harm to self and others.

The initial applicant was DS, as Bill required medical and dental treatment. A single, female member heard the matter and appointed a guardian limited to decisions for healthcare, for 6 months. In 1993, a guardian was required to satisfy the legislative requirements.

Bill's behaviours were monitored and modified as required by the BIST recommendations. In addition, as was requested by the guardian, a psychologist was also involved with Bill's treatment to assist in reducing his self-harm behaviours. Again it would seem that the DS responses were completely adequate to handle his behaviours.

In late 1994, a second application was made to VCAT. Bill again required dental treatment. As at the first hearing, the matter was heard by a single, female member. The guardian was appointed for 6 months.

### **3.24 Case 4 (Dave): 1999:**

Dave was the subject of four guardianship orders, and never attended any hearings. His case files indicated that he reportedly had a difficult relationship with his family in his childhood. Dave's criminal history commenced at 19 years, and for the next six years he was involved in numerous serious criminal offences which resulted in him being incarcerated for almost three years.

Dave's initial involvement with mental health services commenced after his involvement in the criminal justice system. He received numerous assessments in the detention facilities, complete with programs and recommendations on how to assist him. After a lengthy stay in a forensic residential program, Dave was returned to reside in a community facility in his

rural area. This was considered appropriate to maximize his rehabilitation chances. Over the next six months, Dave increased in episodes of self-abuse, (which included numerous presentations to the A & E Dept), the lighting of fires and an increase in his suicidal ideation. The OPA became involved in an advocacy capacity eight months after Dave was moved to the rural community house. Key stakeholder meetings were held monthly which involved staff from Spectrum who provided strategies to assist him.

The following brief description details dysfunctional responses which occurred within the service system. During the annual leave of the OPA advocate, (known to all stakeholders), the rural psychiatric team refused to comply with the agreed plan. The plan formulated in conjunction with the Justice Plan, was a continuation of ongoing treatment that had been introduced while Dave was in the forensic program while in jail.

An urgent application was brought before VCAT by Disability Services(DS) as the psychiatric team believed they could not return Dave to their facility should he abscond.

The first hearing was presided over by a single member board. Without any OPA notification of hearing, and therefore no OPA attendance, the member was persuaded by the psychiatric argument that Dave's accommodation was in jeopardy without the appointment of guardian. The order was made for 12 months, with decisions limited to accommodation.

With regard to responses made prior to the application, it appeared that the DS responses had been appropriate and in keeping with Dave's best interests. They recognized that Dave was indeed challenging, and sought assistance of many groups. The response by Psychiatric Services (PS) on the other hand, was inappropriate and curious because until the appointment of a guardian they had not been directly involved in any service delivery.

The second VCAT application occurred 2.6 years later. Existing management plans for Dave and key stakeholder team meetings had been ongoing. Dave nevertheless, engaged in significant self-harm to his eyes, and

he refused to comply with his medical management. Psychiatric services were on this occasion the applicant, as they believed a guardian could assist Dave's medical compliance. This hearing was heard before the Deputy President, who made an urgent 21 day order with powers limited to health care and an additional power to enforce (GAA, s.26). The power to enforce enables the guardian to request police and ambulance members to transport Dave against his will to receive medical treatment.

At the rehearing of the second order, a senior female member continued with the healthcare order for a further three months, as she believed the guardian "may assist" with Dave's compliance with medical treatment. The guardian introduced no new programs or interventions during this order.

A further two years later, a rural Disability Services, (the same one as in order one) again applied for a fourth guardianship order for Dave. Although programs had continued, Dave's self-harm had again escalated with significant burns to his leg and his refusal to receive medical treatment. The same member as in order three heard this matter. On this occasion, the member made an urgent 21-day order for healthcare, and added a power to enforce order, and stated the orders were made, as there were no other options available. The guardian advocated strongly for a discharge plan (which included Royal District Nursing Service [RDNS] and Hospital in the Home), to assist with Dave's wound management. The order was then revoked at the subsequent hearing, 21 days later.

### **3.25 Case 5 (Chris): 2004**

Chris was the subject of two guardianship orders, and never attended either hearing. Chris had been living alone without any family contact.

Chris had been admitted to a psychiatric facility some 30 years earlier, and said staff and those in authority while there had abused him. After his discharge, there was no evidence of any current involvement with any mental health services. He had been living independently in a unit and had been

receiving ongoing RDNS care with regard to his diabetes and vascular disease. As Chris's medical conditions were considerably disabling, he also received some level of in-home assistance, and Meals on Wheels (M-O-W's).

In the first VCAT order, the applicant was a doctor from a major city hospital. Chris came to the hospital with the assistance of the RDNS nurse, who believed that his toes had become gangrenous and required urgent attention. The Deputy President presided over the hearing, and made an urgent 21 day, Temporary Order limited to healthcare decisions. The reasons given were for the urgent provision of medical care as the hospital treating team was concerned with the presence of gangrene in Chris's feet, particularly his left foot.

Chris had surgery but was discharged without the guardian's consent, and without any discharge plan or involvement of any support services. When advised of what had occurred, the guardian lodged an official complaint with the Health Services Commissioner, and Chris was immediately re-admitted to the hospital.

At the rehearing of the first order, Chris was still in hospital following complications from the surgery. A senior, male, member presided over this hearing and continued the order for a further 6 months, limited to decisions of healthcare, medical and dental. The reason provided was the member was not satisfied that the guardian had had enough time to implement any changes in Chris's environment. In addition, he was most concerned that the hospital had discharged Chris without the consent or involvement of the guardian.

During the life of the second order, the guardian obtained involvement from the local Crisis Assessment Treating Team (CATT) seeking their assessment of Chris regarding his cognitive capacity. Chris also harboured a strong belief that the local hospital despised him. The guardian negotiated a detailed response plan with the ambulance services to avoid a re-admission back to his local hospital, and if it was at all possible, would seek admission to

another hospital. The local mental health service did not believe that Chris fulfilled their criteria for ongoing case management. Moreover, Chris would not voluntarily engage with them due to his earlier history with similar services. Five months into this order, Chris was found unconscious on the floor of his unit. The guardian requested and received a power to enforce order (GAA, s.26) which enabled his transportation to hospital for urgent medical care. The order was later revoked.

### **3.26 Case 6 (Nigel): 2000:**

Nigel was the subject of four orders, and only attended hearings three and four. He had a fraught relationship with his parents, and spent much of his adolescence in boys' homes. His criminal history commenced at 18 years, when he was charged with attempted armed robbery.

In the first order, the applicant was a team leader at a group home where Nigel resided. Nigel had just moved and during the first weekend began exhibiting self-harm behaviours, such as inserting metal objects into burnt scar tissue in both his arms and abdomen. Nigel told the local CATT team he did not want their assistance, so none was provided.

An urgent Temporary Order was made on the weekend by a female member with powers limited to healthcare, accommodation, access to services, and a power to enforce order (GAA, s.26). The member's reasons were to ensure that Nigel received necessary medical treatment.

The order was extended for six months with the same powers as in order one. The member believed the guardian needed additional time to introduce interventions to assist Nigel.

During the second order, the guardian sought assistance from the regional Disability Service (DS) manager to find suitable accommodation for Nigel. In addition, the local psychiatric team believed that Nigel did not fit within their criteria, so never admitted him to hospital. His self-harming behaviour escalated. Nigel often presented himself to hospital, but declined

object removal. Furthermore, he was non-compliant with antibiotic treatment and infection ravished his body. The guardian involved Spectrum and the local dual disability support team for assistance. At one stage during the medical crisis, the medical team believed an amputation of Nigel's arm was imminent. The guardian involved the Public Advocate who also engaged the Office of the Chief Psychiatrist to intervene. Nigel was subsequently provided with a 48-hour psychiatric admission. His self-harming behaviours continued on the ward, with ongoing wound and scar object insertion. Upon release from Hospital, Nigel then presented himself to two other A & E Departments. One hospital provided IV antibiotic assistance while another told him he was depressed. Nigel voluntarily returned to his local hospital and was prescribed antidepressants, which he took. His behaviour subsided somewhat, and he completed his course of antibiotics, though objects still remained in his arm.

Three months into the order an urgent case meeting was conducted at the local hospital, with fourteen professionals in attendance (an additional three people were unable to attend). Nigel refused to participate so was not present. At this meeting, the extraordinary nature of Nigel's behaviours was fully discussed. Five key management outcomes were agreed. These included:

- (1) that guardianship was not assisting and should be revoked,
- (2) a notification outlining Nigel's presentation to be sent to all A & E Departments and CATT teams, advising that upon his presentation he was to be re-directed back to his local hospital;
- (3) if Nigel presented to his local hospital, staff would advise him of the recommended treatment,
- (4) if Nigel declined to receive treatment he would be asked to sign a medical form acknowledging that he was offered medical treatment but declined, and he would then be asked to leave the premises, and

- (5) Spectrum to provide training for staff at the A & E, and Plastics Departments on how to manage people who suffered BPD.

Discussion ensued regarding the guardianship order and it was agreed that the order had been a considerable stressor to Nigel and had unwittingly contributed to some of his escalating behaviours. The decision of when to return this matter to VCAT was referred to the guardian.

This plan held. The guardian chose to let the order run its course. For the remaining life of the order, Nigel still had objects in his arm, and had recommenced wound interference on other burn scar sites on his body. Residential staff believed they were now better equipped to manage and care for Nigel.

Almost 4.5 years later, his DS case manager brought another application to VCAT. Nigel had returned to live with his mother at her home. This application was made at a re-hearing of an administration order for Nigel. Disability Services had maintained ongoing involvement with Nigel, and appeared to be aware of the stressors in his life, and of apparent triggers that preceded his self-harm. Nigel commenced interference on scar tissue on his leg. At the subsequent guardianship hearing, the single member appointed a guardian for three months with decisions limited to healthcare. The Office of the Public Advocate (OPA) VCAT Liaison Officer was present at the hearing and was able to offer counter opinions to those put by the DS case manager. During this time Nigel had continued to escalate his self harm toward his leg, he inserted screws and sewing needles, and had tied a shoelace as a tourniquet. Medical advice indicated surgery was required, or his leg may be lost. The guardian sought and received power to enforce (GAA, s.26). to accompany his order. The guardian advised Nigel that he could enforce treatment but hoped Nigel would make the right choice for himself. Nigel voluntarily took himself to his hospital and had the surgery. However as had been the previous situation, he recommenced wound interference.

At the fourth hearing, Nigel's self-harming pattern had again returned following similar patterns to those he had previously adopted in orders one and two. This time however, on some occasions he voluntarily presented to his local hospital and received treatment. The single, senior male member congratulated Nigel on "making good decisions", but continued the order for a further six months. The guardian sought additional involvement with counselling for Nigel, CATT assessments and the involvement of a hospital care coordinator. In addition, the hospital enlisted the assistance of a local suicide alliance group who visited Nigel at his home. Again as in the earlier order, a hospital team meeting was held and 13 professionals attended. The team re-activated the management plan which was distributed to all A & E Departments, and CATT teams. This plan also held and the order was revoked.

### **3.27 Case 7 (Andre): 1993 then again in 2001.**

Andre was the subject of three guardianship orders, and only attended order one. His first order was made in 1993, and both the second and third guardianship orders were made in 2001. Andre had a very difficult childhood. He became a paraplegic following a suicide attempt at 18 years; this also heralded his involvement into the criminal justice system.

His administrator (a person appointed by VCAT to make financial and legal decisions) made the first Guardianship and Administration Board (GAB) application. At this time, Andre had received compensation following his suicide attempt and there was legal discussion regarding his ability to live independently. A guardian was appointed limited to decisions concerning health care and accommodation for 12 months. Andre received case management from a local psychiatric services team, home care and attendant care services. At the rehearing, the order was revoked. It appeared that Andre received appropriate mental health services to assist him in living in the community.

At the time of the second order, Andre was still residing alone. However, his medical and psychiatric condition appeared to have dramatically deteriorated. He had extensive pressure wounds to his buttocks and legs, which required urgent medical treatment; however, he refused to have them attended. Andre was receiving case management from a local community team and ongoing psychiatric assistance from the psychiatric services. The applicant was the manager of the care team. At the hearing, an urgent 21-Day Temporary Order was made limited to decisions concerning health care and accommodation and a power to enforce (GAA, s.26). The member's reasons were to improve Andre's quality of life.

It seemed that Andre was afforded many services but he vehemently refused to utilize most and was both aggressive and hostile when he believed his decisions were being ignored.

At the rehearing some 21 days later, Andre had refused to comply with the requests made by the police and ambulance officers to enable them to transport him to the Spinal Unit for medical treatment. They refused to "break his door down" without express legal advice. The tribunal was urgently contacted to address the question of seriousness of life threat, versus the use of excessive force. Given Andre's level of hostility, the ambulance officers concluded his death was not imminent. Ten days later and with the assistance of his carer, Andre willingly admitted himself to the Spinal Unit for wound treatment.

The single, female member continued the order for three months with decisions limited to healthcare, accommodation and access to services. The member's reasons were that Andre was exhibiting unreasonable behaviour and demonstrated a clear need for the appointment of a guardian. This decision was made despite the guardian's provision of two medical reports. The first was from a Consultant Psychiatrist, who had previously treated Andre, and had recently visited him at his home. In correspondence to the guardian he wrote,

it is my opinion that he has the capacity to make informed decisions regarding his treatment for his health...it has been documented in the notes regarding his dislike for authority and in speaking with his treating doctors it would appear that he responds best when he is in control of his treatment....He became angrier when I informed him that I came there at your request....It is likely that any directive has the potential to make matters worse (Name withheld for anonymity).

A second Consultant Forensic Psychiatrist wrote a report based entirely on reviewing written material, as Andre refused him a home visit or any personal discussion. He added that his opinion must be cautiously viewed in this light, but wrote,

“the underlying ethical issue is obviously to do with control...he appears to react badly when too much control is taken away from him...” (Name withheld for anonymity).

During the order, Andre continued to remain non-compliant with the guardian's requests. He was found at his home by a carer with maggot infested pressure wounds, two large wounds on his hips the size of a fist and deep to the bone, together with wounds on his heels and penis. While Andre willingly went to the hospital, he assaulted a doctor by spitting and punching him. The hospital sought his immediate discharge home, but the guardian refused, as no services would support him. Due to his challenging behaviours, Andre remained at the A & E Department, and five city hospitals refused to admit him.

At the third hearing, presided over by the Deputy President a plenary order was made, to enable the guardian to allow Andre to “die with dignity”. Due to his subsequent deteriorating health, Andre appeared to lose his ability to fight, and was then transferred to the palliative care unit in the hospital where he remained until his death some two months later. Andre died at 34 years of age.

### ***3.3 Objective 3: To extend existing knowledge of system responses for people with BPD.***

After I examined the responses provided by the mental health or service systems, I then considered what appeared beneficial and ineffective in dealing with the study participants. A summary of these responses is discussed.

#### **3.31 Case 1 (Joe):**

No mental health responses were provided to Joe. The most compassion offered him was by members of the Victoria Police, who transported him to local hospitals to receive treatment for his self-injurious behaviours. It is significant that the board member instructed the guardian to advise the local police of his involvement. I assumed that the member also believed that the police had Joe's best interests in mind.

#### **3.32 Case 2 (Jane):**

At the time of the first hearing, the records do not suggest that in spite of Jane's personal history, she had an assigned caseworker from the mental health services. This was in spite of her frequent voluntary and involuntary admissions to a rural hospital for her self-destructive and aggressive behaviour. When Jane was admitted to a rural unit, it would appear that she had been more stable than at any other time. She too expressed optimism and a sense of security. Sadly, this facility appeared unable to keep her, and she was relocated to "a more therapeutic environment" in the city. No psychiatric interventions appeared to have any positive effect, and it appeared that Jane developed a medication dependency whenever these were trialled. Another successful intervention was when Jane lived in a unit on the grounds of the city facility. Unfortunately, this too had to be halted, but the case files revealed both staff and Jane alike agreed that she had made some gains. Jane's final move to true independence, i.e. living alone in the community with supports, was tragically too short lived and she succumbed to the effects of illicit and prescription drugs. This result is not surprising as all previous reports

suggested that when Jane was on prescribed medication she was unable to manage and/or would quickly develop dependence to them.

### **3.33 Case 3 (Bill):**

It would appear that Disability Services (DS) provided appropriate responses for Bill's behaviours. They seemed to have a very good understanding of his behaviours, and when these escalated staff introduced other strategies. These included an increase in staffing both to assist Bill and to reduce his harm to self and others. DS engaged a psychologist as well as utilizing the BIST team to tailor responses to Bill. In addition, at the suggestion of the guardian, DS commenced programs to desensitize residents to stressful situations such as going to the dentist. These programs were then implemented service wide.

### **3.34 Case 4 (Dave):**

In the first order, DS provided a very comprehensive program to assist Dave, and gave a commitment to do so, which largely occurred. The file notes revealed that Dave sought an increase in their involvement, so he too must have been comfortable with their involvement.

Following the guardianship order, Psychiatric Services (PS) placed an importance on documentation, which included the number of medications, programs attended, challenging behaviours exhibited and visits to A & E Dept.

The second order saw a continuation of all existing programs and case meetings. Psychiatric staff still believed that the guardian could effect Dave's compliance, which did not occur.

Approximately two years later, a third order was made together with a power to enforce order. Dave took himself to hospital and received treatment. Of benefit to Dave was the advocacy by the guardian which ensured that both RDNS and Hospital in the Home provided ongoing care of his wounds.

**3.35 Case 5 (Chris):**

It did not appear that any mental health services responses were effective. When professionals came into Chris's home to assist, he regularly withheld information or deliberately provided misinformation. It would appear that his earlier experiences with psychiatric services had determined his future behaviours in dealing with any service providers.

**3.36 Case 6 (Nigel):**

While it is difficult to determine what was beneficial for Nigel, as he achieved 4.4 years without the need for a guardian between orders two and three, it may suggest that the interventions put in place during order two were beneficial. In addition, Nigel told the guardian that he "liked" his case manager, so perhaps being case managed by someone who is liked may also be beneficial in that it provides a more secure base. During orders three and four, it appeared that an escalation in behaviours indicated that old habits die hard, and Nigel returned to his familiar ways of repeating previous patterns of behaviour.

**3.37 Case 7 (Andre):**

In the first order, psychiatric and in-home services appeared to have been of assistance to Andre. At the time of the second order, some eight years later, it appeared that there were no effective mental health responses. Andre was determined not to engage with any services, and only to accept assistance when circumstances were dire. Forensic Psychiatric advice was that ".....he reacts badly when too much control is taken away from him, but left to his own devices he appears to do badly". Perhaps advocacy for his needs in his palliative care stage was the most effective intervention that occurred.

**3.4 Objective 4: To enhance our knowledge as to whether guardianship was an effective intervention for people with BPD.**

This objective was approached via three aims, to:

1. review the decisions made by the guardian;
2. evaluate the guardian's decisions to determine whether the decisions achieved an improved quality of life for the person with BPD; and
3. evaluate the decisions made by the guardian when the guardian asked for: (a) a continuation of the existing order, (b) an extension of the order whereby the guardian sought an alteration in some way, and (c) a revocation of an existing order.
4. These answers should determine whether guardianship achieved: a change in behaviour of the person with BPD, thus no order was considered necessary; a limited change necessitating a further guardianship order sometime following the revocation of the original order; and long term outcomes for the client after the guardianship order. The results for each case are discussed.

**3.41 Case 1 (Joe):**

The guardian sought to have psychiatric services' involvement for Joe, and sought further understanding of Joe's life by speaking to a variety of people known to him that is, staff at the local butcher shop, (whose shop was directly below Joe's unit), the local CPS squad, and his aunt and uncle. The guardian also determined that advocating and assisting Joe in making decisions was the most beneficial method of engagement. For example the guardian sought additional finances from his administrator so that Joe could visit his family in NSW, as he indicated that being away from them was a significant negative issue.

In determining whether the guardian's decisions achieved an improved quality of life it appeared that Joe refused to have anything to do with

psychiatric services, and as he was not *certifiable* within the meaning of the Mental Health Act, it was impossible to get their assistance. The guardian obtained an increased understanding of Joe, by speaking to those who knew him. Staff at the Butcher shop recognized that when Joe was depressed he went on “binging drugs and alcohol”, and confirmed that he missed his family, and supported the guardian’s view that he should return to Sydney. The guardian also contacted Joe’s family in Sydney and advised them of the current situation. The guardian was also mindful that with the level of alcohol and drug taking that Joe engaged in there was a risk of accidental death by overdose. When Joe returned to Sydney, he chose to remain with his family. The order had no jurisdictional authority, so the case was closed.

### **3.42 Case 2 (Jane):**

The guardian agreed to transfer Jane from rural Victoria, when the consensus was that the facility had progressed as far as it could, coupled with the difficulties of Psychiatric Services in delivering supports and agreed resources for her management. The guardian also sought involvement of the State Forensic Psychiatry Service in her transfer, and ensured that the transfer minimized any potential destructiveness, and obtained in writing that the aim of transfer was to provide her a more appropriate therapeutic environment. In addition, and in recognition that change for Jane leads to regressive behaviours, funding for external psychotherapy was also obtained. Furthermore, the Public Advocate and the Chief Psychiatrist were involved when the situation appeared more alarming and chaotic. The guardian together with the staff and Director of Forensic Psychiatry Service believed that unless Jane in the long term could accept herself and survive in the world, she had no chance whatsoever. This tragically proved to be the case.

It is very difficult to evaluate the guardian’s decisions. The guardian remained the one constant person, who worked and fought tirelessly for Jane. In addition, the guardian’s work was also commended in a VCAT hearing. The

case file reflected the guardian's aim as "attempts to ensure that Jane lives", and are consistent with the best interests philosophy.

### **3.43 Case 3 (Bill):**

In the matter of Bill, at that time there existed a legal requirement for a guardian to consent for medical treatment. However, the additional referral to the OPA advocacy program for Bill and his fellow residents resulted in a clear benefit for all with the provision of desensitizing programs. Specifically for Bill, assistance was made through a referral to a clinical psychologist who assisted in tailored behaviour interventions.

A clear improvement in the quality of life for Bill was achieved. The referral to the OPA advocacy program, rather fortuitously led to the assigned advocate being involved in the relocation of all residents of this facility to the community. Bill moved from a partitioned shared bedroom and sharing a bathroom with 13 others, to moving to a house where he had his own bedroom and resided with three others. As the advocate was already familiar with Bill's behaviours, she ensured that he lived in the community rather than in another institutional setting.

The guardian sought a revocation at the end of each order. It is significant that some 11 years have elapsed since the last order, and Bill has not been referred to the OPA for any matter. It is perhaps safe to assume, therefore that Bill has an improved quality of life.

### **3.44 Case 4 (Dave):**

In reviewing Dave's decisions, his three orders need to be assessed. In the first order, the decision was limited to accommodation, yet the guardian made no decisions pertaining to accommodation, but was involved in all professional meetings. Perhaps the guardian was more beneficial in an advocacy rather than guardianship role. In order two, the guardian did not affect any substitute decision-making capacity. In fact, Dave voluntarily attended psychiatric reviews. The guardian reluctantly agreed to a relocation

of Dave from a rural to a city location, as he believed that Dave was being seen as a problem. In order three, the guardian did consent for medical treatment but Dave willingly attended and so the power to enforce order was not required. It appeared his strong advocacy skills were most beneficial in ensuring that appropriate services supported Dave at home post hospital discharge.

To determine whether the decisions achieved an improved quality of life, in order one, no decisions were made and Dave's self-injurious behaviours appeared to escalate. Similarly, in order two, Dave rather than the guardian made his own health care decisions. His self-harming continued, as did his non-compliance with medications and recommended eye treatments. However, the change of location may have been a good decision, as no further order was needed for another two years. In the third order, again, the guardian made no health care decisions, and Dave took himself to hospital. The advocacy for services to the home appeared highly beneficial.

In identifying the decisions made by the guardian, in each order the guardian sought a revocation, which was granted. For order one, as OPA initially was involved in an advocacy capacity, the guardian maintained that a substitute decision maker was not required rather case management, appropriate behavioural strategies and community supports were essential. In addition, Dave did not want the involvement of the guardian. Similarly, in order two, the service providers falsely believed that a guardian could effect Dave's compliance to medical treatments, which he could not and did not achieve. The guardian continued his earlier argument ensuring that appropriate service responses were provided. In the third order, while a power to enforce was made, Dave willingly attended his medical treatment, indicating he could take control and thus demonstrated a guardian was not needed.

### **3.45 Case 5 (Chris):**

In reviewing the guardian's decisions, it is necessary to review the two orders. In the first order, the guardian consented to urgent medical

intervention, to enable the amputation of Chris's toes and part of his left foot, due to gangrene, as no other options were available. In order two, the guardian did not consent to Chris's hospital discharge. When Chris was eventually discharged, multiple consultations with carers and the hospital ensued, to avoid any further medical emergencies. Furthermore, the guardian liaised with the ambulance service to seek readmission to another hospital rather than to the one that Chris believed held feelings of animosity toward him. The guardian sought Chris's involvement in decision making but when his carers found him unconscious, the guardian applied for and received an urgent power to enforce to enable Chris's urgent medical attention. All these decisions appeared appropriate in the circumstances. The guardian further compiled a complete list of contacts for all carers to enable them to feel supported in their care of Chris. In both orders, the guardian recognized that there was no alternate decision maker and combined with Chris's level of self-neglect, both orders were continued until the medical emergency was addressed.

### **3.46 Case 6 (Nigel):**

Nigel had four guardianship orders. In reviewing the orders, order one was an urgent order, and the guardian believed the medical advice that the objects had to be removed from Nigel's arm. In hindsight to remove the objects against his will however triggered more self-harming behaviours. In order two, Nigel's behaviours continued to be very destructive. The guardian sought assistance from all relevant stakeholders, and even sought to relocate Nigel when staff believed they could not manage him. The whole of system approach seemed the most beneficial, with detailed management plans, and the provision of training to hospital departments, whose front line staff could then deal with Nigel in a more effective manner. Orders three and four were almost a repeat of orders one and two, however with the wisdom of reviewing previous practice, the guardian chose not to intervene, and ensured that all necessary legal documentation was in place should it be required. The

adoption of this position was more appropriate and the re-activation of the best practice procedures utilized in order two, that is, a whole of system response, was the most effective response.

In determining the guardian's decisions to determine if they achieved an improved quality of life, in order one, the guardian was advised by medical staff that surgery was required. This advice was heeded. In hindsight as Nigel's injuries were not immediately life threatening, the surgery should have been postponed. Rather than weekend surgery, waiting until the Monday morning would have resulted in a full complement of medical staff with psychiatric expertise to examine Nigel's situation in detail. Only after such discussions had occurred should any medical treatment decision have been made.

In order two, the strategies implemented involved a whole of system response and appeared to have achieved an improved quality of life for at least a short time.

In orders three and four, I believe the guardian learned from what occurred in the earlier orders, and so took a more considered and cautious approach rather than responding in a reactive manner. The fourth order was also for a very short time, that is, three months versus 12 months (as in order two), and limited only to healthcare.

In identifying and evaluating the decisions by the guardian, order one: given the level of chaos in Nigel's life, the order had to be continued. In order two, the situation had altered; a whole of system response was implemented. The guardian sought a revocation, which was also supported by the service system, and this was obtained. Orders three and four were very similar to orders one and two, with order four being an extension of the urgent temporary 21 day order three. Order four was only for three months, and the guardian effectively argued for, and received a revocation at the end of that time.

**3.47 Case 7 (Andre):**

Andre had three guardianship orders. It would appear that in order one; the guardian ensured that appropriate services assisted Andre to live independently, as there had been no further OPA involvement for seven years. In reviewing the decisions by the guardian, in order two; an urgent order was required to get Andre to hospital for urgent medical treatment. However, in spite of receiving a power to enforce order, the police and ambulance refused to break the door down. The guardian sought a further determination from VCAT, who subsequently ruled against using excessive force to implement the guardian's decisions. Therefore there were no decisions to evaluate. In order three, some three months later, the guardian requested to remain involved to achieve "death with dignity" for Andre. The guardian ensured that he had hospital care until his death, and spoke with Andre's family from whom he had been estranged, to advise that his death was imminent. The family chose to re-engage with him. Moreover the guardian advised his family that Andre's circumstances may have been a matter of public interest for the coroner. The family acknowledged their anger and bitterness, but declined to pursue this option particularly after their previous experiences with the media following Andre's earlier suicide attempt.

To evaluate the guardian's decisions to determine whether the decisions achieved an improved quality of life, it appeared that order one achieved an improved quality of life and enabled Andre to live independently for some years. In orders two and three, Andre opposed everything, and even refused to acknowledge the guardian. Nevertheless, the guardian still advocated on his behalf when both hospitals and service providers refused to assist him. To assist with her decision making the guardian engaged the Office of the Chief Psychiatrist, Forensicare and the local mental health services. The final order, did achieve his dying in relative peace and the reunification of Andre with his family.

**3.5. Whether guardianship has achieved change by:**

1. a change in behaviour of the person with BPD, and as a consequence a guardianship was no longer necessary;
2. a limited change in the person's behaviour necessitating a further guardianship order sometime following the revocation of the original order; and
3. long term outcomes for the client after the guardianship order.

**3.51 Case 1 (Joe):**

As Joe returned to Sydney and did not return to Melbourne, it is therefore impossible to answer these questions.

**3.52 Case 2 (Jane):**

The guardianship order was maintained until the death of Jane. Jane attempted to live in the community but it was short lived.

**3.53 Case 3 (Bill):**

Long-term outcomes were achieved for Bill. After his last order, there was no further involvement in guardianship and with the involvement of good advocacy, he achieved integration into the community without the institutional care he had previously only ever known.

**3.54 Case 4 (Dave):**

It would seem that as there had been little OPA involvement with Dave since the last guardianship order it may be argued that either guardianship achieved a limited response for him, or that a change in location, complete with different staff (and different personal beliefs and views on people with BPD), may have been beneficial. It is difficult to quantify how much of the change in Dave can be attributed to guardianship and/ or to change in location.

**3.55 Case 5 (Chris):**

It is hard to argue what guardianship achieved in this matter. Chris appeared to have ongoing issues with all hospital staff and they had similar views of him. Throughout both orders, Chris continued to sabotage all care put in place and behaved “as he pleased”. No change was affected in my view, just another person involved in his care. Consent was needed for Chris’s amputations, but no other change in his behaviours/s occurred. The order only had a life due to medical and health care issues; once these operations occurred then the order naturally ended within the stipulated timeframe.

**3.56 Case 6 (Nigel):**

It could be argued that guardianship achieved some change in Nigel’s behaviour/s, as the time that lapsed between orders two and three was over four years. Perhaps what occurred was that services maintained their involvement rather than moving out once the situation appeared manageable. In addition, at order four, the hospital had utilized a care coordinator to visit Nigel at home and enlisted help of a suicide harm prevention group for Nigel as well. Since the last order, there has been no further OPA involvement.

**3.57 Case 7 (Andre):**

Apart from the first order, guardianship did not achieve any change in Andre’s behaviours and he remained opposed to the guardian until he could no longer fight. The guardian wanted to enable him to die with dignity. Furthermore, Andre had a very fraught relationship with his family, which included the taking out of intervention orders by them against him, due to his threats of harm to both them and their children. Andre initially would not allow the guardian to tell his family of his situation. However, when advised that Andre had two weeks before death the guardian informed his family. They visited Andre and seemed to reconcile. This may have been an unexpected

consequence, and in itself may have enabled a degree of closure for both Andre and his family.

## **CHAPTER 4: Phase 1: Integration of Findings and Discussion.**

### ***4.1 Objective 1: To enhance our knowledge of the contributing factors which led to the appointment of a guardian for people with Borderline Personality Disorder (BPD).***

As Table 2 indicates, each case presented before VCAT, portrayed a person in either a high degree or an extreme state of self-injurious behavior, coupled with a corresponding high level of distress for those associated with them. In addition, the person with a BPD had been described in the application as either having: a) received some degree of treatment and refused the recommended treatment regime, or b) refused assistance altogether. Moreover, the behavior/s in which each person engaged were extremely confronting, and would have engendered within any person hearing his or her plight a strong desire to render assistance. Examples of case material advanced at the VCAT hearing will be next discussed.

In all cases, the VCAT member appointed a guardian to instigate change for the person with BPD. The Guardianship and Administration Board (as it was at the time), believed there were no alternatives for Jane and identified the guardian as the one constant person in her life, and commended him for his effort.

In the matter of Bill, a guardian was appointed to satisfy the legislative requirements for medical consent. This requirement is now subsumed in new legislative amendments (GAA, s.42 - amended).

Psychiatric Services (PS) influenced the member on the first and second occasions in the matter of Dave, and significantly provided arguments that a guardian can assist with medical treatment compliance. Although this is not the case, these same arguments were then utilised by Disability Services (DS) at a later hearing as it would appear that either members or senior members were then convinced that the guardian “may assist” with his behaviour.

Chris refused to consent for any medical treatment and urgent medical treatment was considered the only choice to save the spread of gangrene on his extremities.

In the matter of Nigel, others could not tolerate his self-injurious behaviors. In addition the VCAT members believed a guardian could impose medical interventions on him, and that such actions would assist Nigel.

For Andre, the member believed that he was exhibiting unreasonable behavior, and thus demonstrated a need for a guardian, with a power to enforce.

For the legally trained VCAT member, with at best limited knowledge of BPD, and almost certainly no theoretical understanding of BPD - he/she is faced with a significant dilemma. Without psychological knowledge of the BPD diagnosis and its various manifestations it may be considered unreasonable of any member to deny an offer of assistance, particularly in these matters when the assistance being sought was the appointment of a guardian. To refuse such an appointment may be interpreted by others that VCAT was rejecting assistance. Thus, the member would be placed in an invidious position, which would be further heightened when the applicant argued that a guardian is the last resort to alter the individual's course of action. While acknowledging the despair in such cases, there is nevertheless much more to the story of BPD, than is presented by the applicant and in the application process to VCAT. Psychoanalytic and psychodynamic theory has much to offer in this area.

With regard to the individual's refusal of treatment, there is little doubt that such behaviors would mobilize a strong sense of frustration in those seeking to assist this person. This sense of frustration is consistent with Kleinian theory, which identified the paranoid-schizoid condition for the borderline personality (Klein, 1948). The theory posits that in the paranoid-schizoid condition, splitting occurs, where the person with BPD views others as either idealized or denigrated, without any sense of guilt over such actions. These feelings are so intensely experienced by the person with BPD, that communication is not mutual and the other person involved is manipulated, being almost forced to take on unacceptable aspects of the person with BPD. Bion (1962) expanded the theory

to suggest that the process of splitting is full of envy and hate, which results in an early disabling of the psychic processes needed for understanding both the cognitive and affective aspects of interpersonal relationships. Other psychoanalytic thinkers (e.g. Bollas, 1987; Fonagy 1991; Fonagy & Target, 2003), have further developed the theory and believe the characteristic sadism and masochism behavior/s of borderline patients reflect split aspects of the self. Clinically a common experience of individuals with BPD is they can both resent and fight attempts of help (Fonagy & Target 2003). Thus for the person with BPD, his/her desire for care can also simultaneously be met by the need to maintain a sense of autonomy and control of the situation, and as a result seemingly overwhelming feelings of internal conflict are established, which are then externalised.

This psychological understanding of the intrapsychic world for the person with BPD was elucidated by the two senior psychiatrists involved in reviewing Andre's prognosis (refer chapter 3.27). They independently raised the issue of control as a central feature, and foreshadowed potential negative outcomes should his sense of personal control be removed.

In all cases, the tribunal members were understandably shocked at what was both presented and described to them. Jane's case was the only one presided over by a three-member panel, which included a legal and a medical representative as part of its composition; single member panels presided over all others. The tribunal members believed the appointment of a guardian was in the best interests of the person. Furthermore, a guardian was appointed even if the member believed the guardian "may assist" with treatment compliance, yet this is fallacious. A power to enforce (GAA, s.26). normally accompanied orders in these matters. The appointment of a guardian, while being compassionate, could perhaps be counter to the best and most appropriate assistance provided to the individual with BPD.

**4.2 Objective 2: To enhance our understanding of the mental health service response/s prior to the application being made to VCAT.**

The mental health responses are firstly identified and then evaluated. Finally the reasons provided by the VCAT member for the appointment of a guardian are discussed.

Prior to the initial application being made to VCAT the individuals who were given a dual diagnosis, that is, diagnosis of BPD and intellectual disability, had received ongoing case management from DS of the Department of Human Services (DHS). Bill and Nigel had an assigned person to assist in their daily lives. Dave also had a designated worker, but this was possibly due to an earlier diagnosis of intellectual disability when he first entered the criminal justice system. A forensic psychiatrist involved in Dave's program management later challenged this diagnosis, but the initial diagnosis remained. This proved to have unexpected favorable outcomes for him and will be later discussed (refer chapter 5.1).

Andre, diagnosed with another psychiatric illness as well as BPD, was the only person assigned a mental health worker. Andre's rather unique situation was possibly due to his highly publicized and successful legal action brought against PS following his suicide attempt while an involuntary patient at one of their city facilities. The remaining cases, Joe, Jane and Chris were all given a psychiatric diagnosis but were not provided case management from PS, in spite of being well known to mental health services.

At subsequent hearings, Bill, Dave and Nigel, still retained DS case management and service provision. Dave's case requires further explanation as PS appeared to wield significant power with regard to his management. In spite of neither providing case management nor any treatment services, PS applied for and was successful in securing a guardian. Thus, it can be concluded that their persuasive arguments had considerable influence over the VCAT. Psychiatric services argued that without a guardian they were unable to accommodate Dave. Guardianship was subsequently granted.

After guardianship, Jane resided in psychiatric facilities and was afforded a variety of treatments, including ECT, psychotropic medications and behavioral therapy, all to no avail. When Jane lived where she believed she was understood, and commented that staff “cared for her”, gains in her behavior were observed. After one hospital release, Jane advised she would behave antisocially to deliberately have her placed back in jail, where she felt safe. This indicated that she found the world a frightening place, so again feeling secure and being understood brought the best behavioral outcomes for her.

Chris apparently did not meet psychiatric service case management criteria so did not receive any. In his situation, PS was only provided at the request of the guardian and this involvement was linked to a specific function, such as an assessment of Chris’s capacity. Andre denied all attempts at any offer of assistance by psychiatric services.

The file material reveals that service responses were fragmented. If comorbidity exists, particularly with BPD and intellectual disability, then DS provides case management and remains involved in service provision. By contrast, it is difficult to obtain case management from psychiatric services. If available, they provide specific functions often at the request of another (such as the guardian), and then cease involvement. Thus, it would appear that psychiatric services do not establish an ongoing relationship with the person with BPD.

The apparent lack of ongoing involvement by PS seems at odds with considered best practice in outpatient treatment. Belnap, Iscan and Plakun (2004) discussed that a person with BPD in spite of his/her difficulties, must have the capacity to form a stable attachment to the assigned therapist (or case manager), and this needs to be secure enough to sustain the necessary disruptions and conflicts between sessions that enable patient development. Perhaps the PS reluctance to pursue longer-term work with the BPD individual further serves to create a distancing, which makes future work even more problematic.

### ***4.3 Objective 3: To extend existing knowledge of system responses for people with BPD.***

Responses provided by the mental health or service systems were examined and those treatments that appeared to be beneficial and ineffective are discussed.

For Joe, there was no service system responses offered in spite of his numerous hospital presentations for his wounds. Of most benefit was the compassion extended by members of the police, who recognized his vulnerability and predicament and seemed genuinely concerned for his welfare.

For Jane the only time she made tangible gains, that is self-harm reduction and corresponding self-reports of “feeling secure”, was when she lived in the grounds of psychiatric facilities. On both occasions due to differing reasons she had to be moved, which resulted in further extreme acts of self-harm. The guardian did not assist in changing Jane’s behaviors, though remained the one constant person in her life. Jane died as a result of suicide when she lived independently in the community.

Disability Services staff had a good understanding of the needs of Bill, and implemented programs with a psychologist to assist with his self-harming. The staff appeared to work in collaboration with the guardian. Thus, staff appeared to have an understanding of Bill’s disability and its effects on his behaviour/s. Such an understanding was considered extremely beneficial to Bill’s welfare.

Disability Services staff followed the management recommendations after Dave’s discharge from a detention facility. This appeared to be useful and significantly, Dave requested their increased involvement. By contrast, psychiatric services placed a strong emphasis on documentation, and sought the involvement of a guardian. The guardian was unsuccessful however, in achieving a change in Dave’s self-harming behaviors. What appeared of most help was the guardian’s insistence on ensuring a thorough discharge plan at his last hospital admission, which included health care professionals visiting Dave at his home.

There were no effective services for Chris. He appeared too distrustful of people's motives, and withheld critical information from professionals who visited him. There was no change in Chris's behaviors with the appointment of a guardian.

The guardian advocating for a whole of system response appeared to be the most beneficial for Nigel, as more than four years lapsed between his guardianship orders. The guardian did not achieve a reduction in his self-harming behaviors. Nigel stated that he liked a case manager, thus a sense of being understood appeared helpful.

In Andre's first order, in-home supports and case management were effective. In his last two orders nothing was effective in facilitating any change, Andre was determined to do what he wanted. Perhaps advocacy at his palliative care stage was effective.

All the participants' needs were quite diverse. What appeared to be the common thread of what was beneficial was the participants' needs being either understood or kept in mind by those familiar with them or entrusted to their care. Jane and Nigel articulated this as helpful. For Joe it was curiously the police who showed the greatest empathy, and for Bill it was the staff at his residential facility. Both Chris and Andre (particularly in his later orders), appeared not to engage in a meaningful way with anyone involved in their care.

Being understood provides a foundation for the structural characteristics referred to as ego identity (Erikson, 1956), and these are characterised by an integrated concept of the self and of significant others. The integrated view incorporates the realisation of his/her desires but also the capacity for an emotional investment in others, while maintaining a sense of autonomy. This integration is something people with BPD struggle with and this struggle may be manifested in the extreme positions sometimes taken in relation to autonomy, as demonstrated by the study participants. The elements of care, acceptance and understanding in therapy may assist the person towards a more integrated position, and are a working premise for Dialectical Behaviour Therapy (DBT) and other schools of psychotherapy (Linehan, 1993).

***4.4 Objective 4: To enhance our knowledge as to whether guardianship was an effective intervention for people with BPD.***

To determine whether guardianship achieved a change in behaviour of the person with BPD the guardian's decisions are: 1) reviewed, 2) evaluated to determine whether the decisions achieved an improved quality of life, and 3) assessed as to whether the guardian requested a continuation, an extension or a revocation of the order. In the course of this, an emerging issue is whether the guardian's role had two aspects, one of guardianship and one of advocacy. These two roles will be examined from the case files.

For Joe, the guardian assisted by advocating and supporting him in his desire to return to his family in Sydney. This decision was reasonable and supported by all who knew Joe. He reportedly missed his family and when depressed engaged in excessive alcohol and drug taking which exacerbated his self-harming behaviors. Joe returned to Sydney and had no further involvement with Victorian guardianship. No review mechanism occurred.

In Jane's case, the guardian agreed to her relocation when there was no possible option left in the psychiatric system for the delivering of supports and agreed resources for her management. Furthermore, the guardian sought involvement at the highest levels for assistance with Jane's welfare. The guardian's aim was to ensure that Jane lived - consistent with her best interests. On balance, the decisions made for Jane appear logical and sound. Based upon the guardian's decisions, Jane's quality of life was as good as can be expected in the circumstances and limits provided by the system. The guardian requested a continuation of the plenary orders to ensure there was a degree of quality of life for Jane. There was never a sustained change in Jane's behavior. Tragically, independent living was unsustainable and she died because of suicide.

The guardian consented for Bill's medical treatment but also referred him to the Office of the Public Advocate (OPA) advocacy program. This resulted in desensitization programs available to Bill and all residents at his facility. The assigned advocate was responsible for the relocation of all residents at Bill's facility into the community. Bill now resides in the community in a house with

three others, as opposed to previously living in a dormitory with 13 others. The guardian's decisions produced an improved quality of life. It is debatable however, whether an improved quality of life was achieved solely at the hands of guardianship - as his integration into the greater community would have exposed Bill to increased life experiences compared to those at the residential facility.

In the matter of Dave, in order one, the guardian did not make any decisions, but attended all professional meetings convened. In order two, the guardian did not effect any substitute decision making and Dave voluntarily attended psychiatric and medical appointments. The guardian believed that Dave was negatively labeled where he was residing so he reluctantly agreed for him to relocate. In order three, the guardian again did not effect any decision making as Dave continued to receive and attend treatments. Significantly, in this order Dave agreed to a hospital admission.

In each of Dave's orders, the guardian sought a revocation, which was granted. Dave's self-harming continued to a greater and lesser degree throughout the life of the orders. Throughout each one, the guardian maintained a substitute decision maker was not needed and argued that case management was essential together with behavioral strategies and community supports. In addition, the power to enforce was never used. Furthermore, Dave never wanted a guardian appointed.

The guardian's advocacy skills ensured that a comprehensive hospital discharge plan incorporating in-home services was agreed. With regard to an improved quality of life, an argument can be made that Dave achieved an improved quality of life evidenced by minimal OPA involvement with Dave since his last order. However, it is very difficult to establish that an improved quality of life has occurred as a result of guardianship. The guardian consented for Dave's relocation, as the guardian believed the rural service system was struggling to manage him, and that he was labeled as difficult. The relocation and all that this entailed, (new staff, and their willingness to accept Dave) has assisted Dave altering his perspective towards life. Dave's experiences are further explored in the interview section (refer chapter 5.1).

For Chris, the guardian consented to medical treatment for amputations due to his inability to do so. The guardian ensured a variety of consultations was held with professionals to minimize medical emergencies. Moreover, the guardian also attempted to bypass a major city hospital where Chris felt unwelcome. The power to enforce was utilized when Chris was found unconscious by carers, and rushed to hospital. It would seem for decisions concerning Chris's healthcare the guardian had no alternatives. In spite of no alternate decision maker available for Chris, the guardian remained unable to institute any changes in his behaviors.

In the matter of Nigel, it appeared that the guardian acted on medical advice that objects he had inserted into his body must be removed. In hindsight, the decision to transport Nigel to hospital by utilizing a power to enforce and the associated havoc that ensued at the Accident and Emergency Department for all concerned, was at best unhelpful and at worst further damaging for Nigel. The best decision and most successful intervention by the guardian was the whole of system approach, which included all relevant stakeholders involved in achieving an outcome for Nigel. In this instance, the first order was continued as insufficient time had passed to demonstrate any outcome/s.

A revocation was sought and granted after order two. Significantly in later orders (three and four), Nigel continued with the repetition of earlier behaviors, that is, an escalation of his self-injurious behaviors. The guardian re-instigated a whole of system response and correspondingly empowered Nigel by appealing to him to make the correct treatment decisions. This approach was successful. The order was then revoked.

For Andre, it appeared his life had altered dramatically between orders one and two. In order one, he attended his hearing. A guardian was appointed and ensured he was provided appropriate services to live independently. It would appear that the guardian's decisions assisted Andre to live independently.

In order two, some eight years later, Andre's physical health deteriorated and his self-care was appalling. Andre failed to acknowledge a need for assistance, especially if he had not sought it. He rejected all that was offered and refused to recognize the legitimacy of the guardian. The guardian nevertheless

involved the Office of the Chief Psychiatrist and Forensicare to assist with decision making. Andre remained obstructive to any interventions. Irrespective of this, the guardian remained involved to assist Andre to “die with dignity”. I believe advocacy could have achieved the same outcome.

Two files are quite unique in this study, and required the appointment of a guardian. A guardian was required for Bill to comply with the legislative requirements of that time for the appointment of a guardian to provide consent for medical treatment. I would also argue that guardianship was essential for Chris. He had suffered immeasurably at the hands of the psychiatric system, and is now rendered psychologically and permanently unable to provide consent for any medical treatment. In all other files it is doubtful that guardianship in its own right was a successful intervention for people with BPD. For these matters, guardians were most effective as advocates.

It should be restated that the OPA is empowered by the Guardianship and Administration Act (GAA) to provide advocacy for a person with a disability apart from its role as a guardian. Advocacy is work intended to support people in asserting their rights and interests. Advocacy not guardianship for these cases would be in keeping with the intent of the GAA legislation that is least restrictive of a person's freedom and in a person's best interests. This finding is also consistent with Earlam and Kennard (2007) who argued that the appointment of a guardian is often useless and sometimes inflammatory. With the exception of Bill and the matter of Chris, who was unable to provide his own medical consent, in all other matters, choosing not to do something should not fall within the domain of guardianship; guardianship should be a tool for protecting people's rights, not a vehicle for social control.

#### **4.5 Limitations of the Study**

The limitations of phase one will be discussed jointly with phase two and will immediately follow the discussion from phase two (refer 6.5).

## **CHAPTER 5: Phase 2: Results**

Three participants were interviewed for their experience of being diagnosed with BPD and on having been the subject of guardianship order/s. They were chosen as they were alive and their whereabouts were known (see Table 2). Each participant will be discussed in turn.

### **5.1 Dave**

Dave was a 33-year-old male, who resided alone in a community home with daily residential care. Historically he had had difficulties with co-residents, due to his threats of physical harm towards them and his lighting of fires.

As Dave resided 70 minutes from my home, I telephoned prior to leaving to ensure that he was still comfortable with the planned interview. His carer (who acted as the intermediary) informed me that Dave had to attend an outpatient appointment at the local hospital. In addition, Dave had received notification of the change of hospital appointment following my telephone discussion the previous day. Notwithstanding this change of plan, Dave said he still wished to proceed with an interview, and a new date was arranged.

The interview was conducted after lunch, and the temperature was in the mid 30°C.'s. When I entered the home, a wall of heat emanating from the gas heater immediately hit me. Dave was seated at the table, and though dressed in a singlet and shorts, he explained that he had problems in maintaining his body heat so the gas heater was on most of the time. When Dave stood to shake my hand, I was surprised at his height and physicality. In my estimation, Dave was around 6ft 3in and heavily built.

Dave was initially quietly spoken and appeared almost shy. As the interview progressed he spoke of his beloved Geelong Football Club and became relaxed. After the interview concluded, Dave asked if he and I could write a book together, and said, "I have a story in me, it needs to be told..."

Dave began by speaking about guardianship, how he was uncertain how long he had a guardian, but felt it had been “on and off” for a number of years. He was also unclear as to the reasons why a guardian was appointed, though he acknowledged he had “trouble in making health decisions” at a rural hospital.

Dave spoke of his time in various detention facilities, and of his very bad health. He then described one stage in prison where, “I never thought I’d live”. Dave stated that he needed the help of his guardian while he was in jail, but this did not occur.

Genuine happiness appeared in his voice, when he described his current situation, with staff who have “helped me out heaps...it’s been the best three years of my life”. Dave said he had been “supported” by the staff and they had taken him on outings, and allowed him to keep two dogs. He credited the staff and his dogs with having improved his health.

In a rather monotone, somber voice, Dave detailed some bad experiences and discussed how he had suffered at the hands of staff at a rural correctional facility, which included being hosed down as a form of punishment. Similarly, he was quite angry when he described the use of excessive force by the staff at a rural psychiatric facility. It appeared that force was used as a management tool. Dave made a variety of allegations of severe mistreatment he had received and showed me the scars to prove it. He further indicated that those in authority chose to ignore these allegations. Dave also alleged that on occasions some staff had supplied him and others with illicit drugs or non prescribed medications, and then had refused to take any responsibility when his behaviour became aggressive, and/or he damaged facility property. He recalled that he had “picked up a chair...but had no intentions of hurting nobody...I just self-harm, self-harm”. Dave said his mother referred to him as “Baby Huey... to the family...I’m a gentle giant”.

Conversely, he detailed why he believed the local corrections team had “been great”. Dave attributed their “coming and visiting you at your house...no pressure... and they don’t put pressure on you...that’s really good” as examples of how he had found them helpful. Dave believed if these styles of interaction had occurred earlier, his circumstances may have altered.

Dave then became quite reflective. He spoke about depression and how he believed it was not considered a major issue eighteen years ago. Dave said he commenced his self-harm when he was 15 years of age, and attributed this to his depression. It seemed that two incidents occurred almost simultaneously for him, the death of a close cousin, and his struggling at school. Dave did not alert his mother or family to his problems. When he left school, he obtained manual work at a local textile firm. Some two to three years later, his best friend was killed in a motor vehicle accident. Dave said, "I just lost it...I became an alcoholic". He believed that he has now beaten his alcohol problem, and has only had two drinks in three years. Dave returned to the problem as it appears to him of, "not (being) sure what goes on inside my head".

Dave described his feelings of depression, and of thoughts of self-harm, and stated, "I still get depressed now, even though I've had three really good years. I still think about putting bleach in my eyes...I've had all chemicals in my eyes, bleach, everything". He said he tries his hardest every day. He uses thoughts of his dogs and of his "good" parents and brother, to get him through the dark times. Dave believed that night times are his most difficult, but could not elaborate on why this was so.

With regard to his diabetes, Dave believed it was not well managed and knew he required tablets to keep it somewhat manageable. He also knew that he needed to control his diet carefully but said almost fatalistically, "...I don't really take care of my diet and all that. I think something is gonna (sic) hit you one day".

When I re-directed the conversation back to guardianship, Dave recognized that his health was a problem, but he did not feel that guardianship had assisted. Almost prophetically, Dave said, "all I want is people to trust me". With the removal of guardianship, "it would be better,...I'd be feeling more people trust and I'd listen to people". Dave listed his family and his solicitor as those whose opinions he would seek. Dave said he initially needed a guardian for his poor health, and acknowledged that he was young at the time. He believed that his circumstances have now altered, he has changed and commented, "everyone changes you know". Dave acknowledged it would have been beneficial to have

attended the VCAT hearings, and he had never done so. Dave could list neither advantages nor disadvantages of guardianship, but concluded, "I reckon I can do better without a guardian".

## **5.2 Nigel**

I need to declare that I was the first guardian appointed for Nigel, some years earlier. In all discussions with Nigel, he never indicated any memory of me. I decided therefore that I would not remind him of our earlier meetings unless he questioned me. This never occurred.

Nigel was 36 years old at interview, and was living with his mother at her home. When I telephoned Nigel on the morning of the arranged interview, Nigel stated he had been badly sunburned the previous afternoon, so it could not proceed. Nigel expressed a desire to be interviewed the following week. On this second occasion, the interview occurred after lunch. It was about 35°C.

As was the case with Dave's interview, the weather had been exceptionally hot, and I was hoping that Nigel would not be in too great discomfort, with possibly peeling, itching skin. I parked my car around the corner from Nigel's home. My gaze was soon focused on a man walking up the street toward my car. He was carrying something in one hand, of which I could not determine, but it was not the object that took my attention, rather it was how this man was dressed. As he came into view, and passed my car, the man was wearing a tuxedo complete with tails, cummerbund and bow tie.

After I walked up the front steps of his home, Nigel's mother, who was seated on the shaded balcony smoking, greeted me. Following introductions, she gestured that I walk inside and meet Nigel. Nigel came to the front door wearing a tuxedo.

Nigel appeared very eager to talk, and initially spoke about his diagnosis of BPD. He believed he had had the diagnosis for 5 years, and thought a DHS psychologist had made this. He did not know what the diagnosis meant.

Nigel said he had received numerous services from DHS, and believed they had “been a great support...by helping me with things I need...like after a fall out with Mum they will actually take clothes to the place I am staying...”. He also spoke of seeing a private psychiatrist when he got depressed, but thought it had been unhelpful as he still gets depressed.

Nigel continued his discussion about “feeling low and depressed”. He said he received assistance from his case manager but identified the CATT team as unhelpful. He became quite animated when he spoke about the CATT team and said, “they reckon it’s attention seeking”. Nigel disputed their views and said, “I’ve got a serious illness, like more than depression,... I could be wrong schizophrenia or something”. He said he had never been given a diagnosis of schizophrenia. Nigel continued, “the way I’m acting with my temper and the way I’m lashing out at people and doing these things to myself, it doesn’t seem normal”. He detailed examples of self-harm by putting nails and other objects into his legs and arms, and attributed these acts to feeling “out of control”.

Nigel stated these feelings subsided after a few days and he found that talking to his Mum was beneficial. At the same time, however he felt he was a burden to her, and said he would then turn to his case manager. Nigel had also contacted Crisis and Life Lines, but had found them of no assistance. Again he had turned to the CATT team and said, “...(I) want them to admit me...but they keep saying it’s attention seeking...”. They refused. Nigel stated that on occasions when he hears the words “attention seeking”, and if something happened “it would be on the CATT teams’ head”, for example “if like one day I went too far, and I killed myself, topped myself, it would fall back on them, they are not really doing the right thing by me. They’re not really looking into it, helping properly”. He described having moods like a roller coaster. Nigel admitted he is not easy to understand, and would again be willing to see a psychologist to help him because, “sometimes I tell the hospital I wish I was dead. But sometimes I wish to Christ they could figure out what’s really going wrong with me...get me back on the straight and narrow...I know there is no magic pill...”

Specifically with regard to guardianship, Nigel remembered the first occasion a guardian (this was me) was appointed. He recalled living in a residential facility and the staff being unable to stop him from self-harming. A guardian was appointed, "for my own safety". He could not recall the gender of the guardian but felt he was put under "pressure from them...came down way too heavy, so I thought I don't need this shit...". Nigel recalled the police and ambulance services were used to take him to hospital, to have an operation (to remove objects in his arm). With regard to the guardian enforcing the medical treatment, Nigel said, "it made me more determined to say, well stuff it, I'll just go as far as I can with this...". He admitted to then escalating his behavior by placing objects into his stomach. Nigel acknowledged that the guardian perhaps should have had the objects removed but he felt he was "way too heavy". He remembers the guardian then "pulling out", and the staff advising him that he had to make decisions for himself, which he did. He recalled his case manager as "more of a support than the guardian", and said he told him that when a guardian is used it will make him "even more frustrated and angry". It did.

His second experience with a guardian, occurred because I "kept self-harming", and his case manager said, "it's in your best interests". Nigel believed this guardian approached him in a "better way...this one leaved (sic) it to me...you know you need treatment, go to hospital...I knew I wasn't pressured...so I took myself". When asked how he felt after willingly taking himself to hospital, Nigel said, "I felt good that I went". As his objects were deeply inserted into his leg, Nigel required surgery. He gave consent to this as well.

After his discharge however, he continued to insert objects into the wound. When asked to consider why he did this, he said, "once the thoughts get into my head or something...if once I set my mind on something I'll do it and nothing stops me". He then detailed how at one stage he drank "drain clean" and was then rushed to hospital for his stomach to be pumped. Nigel provided consent.

Nigel also detailed how on one occasion, he continued to self-harm with a nail and he called the police to assist. It seemed the members were quite upset at his behavior and used capsicum spray to subdue him. They took him to the local

police station and contacted the CATT team. The police then drove Nigel to the local hospital. The CATT team met Nigel in the car park and said, “ you don’t have an illness”, and refused to admit him. In desperation, Nigel then kicked the police car so that he could be arrested and given “treatment”. This did not occur.

When asked to think about the advantages and disadvantages of guardianship, Nigel believed the second guardian, was “a little supportive, I think he did the best he could, in terms of trying to make the best effort he could...”. With regard to the disadvantages, “I think about having a guardian back...(it) would probably be non-effective because...I should try and you know...I think change my ways and make the most of it and try and to sort things not with having a guardian in place...”

Nigel stated that if he could help people with BPD, he would, “try to get them the proper support that they needed, rather than letting them suffer for the rest of their lives...having someone like the CATT team understand what they’re really going through...to give them the treatment they need”.

Nigel also believed that if the person needed an admission then it should occur. Before concluding Nigel was asked to consider the role of guardianship, and discuss what he felt was important. Nigel stated, “the guardian should speak with the CATT teams getting them a fairer go...there’s got to be a second or third party who can actually stand up for people like me, and say, I feel this person is telling the truth”. When asked if this was something he may wish to take up with his case manger, Nigel responded, “I feel at times I’m sort of banging my head against a brick wall ‘cause that’s just how it seems”.

### **5.3 Chris**

As Chris was still in a large city hospital, I rang the hospital and spoke with the Nurse Unit Manager, who cleared Chris for an interview. I then requested that she confirm this with Chris, who indicated his preparedness for the interview. I initially met Chris in his room. He and I then walked to the meeting room for our interview.

Chris appeared very eager to talk. He started by detailing his early experiences with psychiatric services. Chris stated that at 12 years of age, he was admitted to a major city psychiatric facility and resided there for another 10 years. He detailed appalling acts of cruelty that he and others were subjected to, such as being hosed down, given injections so that he had to crawl in order to get around, and being placed in industrial clothes dryers, to name just a few. Chris said, “we were punished and tortured” by the nurses, and some patients needed hospital treatment for the brutality. He believed those in authority knew of these acts but did nothing.

From both his personal experiences and observations of the treatment of others, Chris said, “we were classed as sub human... we were only good enough for medical experiments so that healthy normal people can benefit from us”. He said the nurses confirmed his opinions. Chris attributed his current problems regarding surgery and medical treatment to his previous ill treatment and said, “...that’s why I couldn’t give permission to have my toe amputated, that’s why I’ve got X (and named the guardian), we were conditioned for this”.

Chris said he was adopted by a woman, who he referred to as Mum, as a very young child. When she became too old, her daughter cared for him. Chris did not like her daughter and believed she felt the same about him. She became abusive to Chris if he called her mother Mum. Chris said Mum died when he was 16 years of age, and he missed her greatly. He referred to his childhood as, “a rough childhood, all I’ve known is torture, I’ve never finished school right, how can you put it, um, we were treated very badly”.

Chris described feeling, “angry and bitter” about what had transpired. He stated that when he was recently in another psychiatric facility, a nurse had raised the idea of his receiving compensation. Chris said, “I’m told I can take the department to court, and I’m told I could get millions right, some money will help me for the trouble that I am in, but will it give me back what I’ve lost?”

Chris recalled a particularly nasty incident, which involved a fellow resident at the psychiatric institution. After investigations, he stated that some of the

parties involved were charged, sacked, and sent to jail. Chris believed that he was discharged shortly after these investigations.

Chris maintained because of what occurred at the psychiatric facility, he was “conditioned”, not to have “operations” without the authority of the “chief” of the facility. When this conditioning was further explored, Chris said he was conditioned not to make “medical” decisions for himself, as he had learned that to do so, was to incur some form of punishment.

After discharge, he was placed on a disability pension, and has largely remained on a pension since. Chris then resided at a number of boarding houses. He acknowledged that he possibly needed the assistance of Psychiatric Services (PS) but was not “offered any”. Furthermore, “after I left X (and named the facility) I never went to a general doctor or anything right. And when social security used to send me to see a psychiatrist, I used to panic like, oh, they’re gonna put me back in again, and that sort of,... and I remember one of them said, I should be back at X (and named the facility), and I just took off”.

Chris also believed that he had been abused at psychiatric facilities over the past two years, specifically after he deliberately overdosed on insulin. When asked why he overdosed? Chris stated, “‘cause I wanted to die, ‘cause of the pain and everything else”. He said the pain was both medical and psychological in nature.

With regard to his diagnosis, Chris stated staff had never told him, and of the current hospital staff, he said, “(they) don’t tell me very much, and even then (when they do) they are reluctant to tell me”.

Chris then detailed his last experience at a psychiatric facility and his displeasure with a nurse. He refused to take a diabetic medication, which he believed caused an allergic reaction. As a result, he contacted a Community Visitor (volunteers recruited and trained by the Office of the Public Advocate who can advocate and assist people at facilities at the individual’s request) to intervene. After the Community Visitor’s intervention, Chris did not have to take

the medication but stated the particular nurse involved and some others then singled him out for different, less favorable treatment.

The overwhelming sense for Chris is that if he seeks and receives assistance in getting his needs met, he ultimately suffers consequently by those who are in authority.

Specifically with regard to guardianship, Chris believed a guardian was initially appointed because of his diabetes and problems with an infected toe. He maintained he did not want surgery and would die if that were the outcome. Chris believed the guardian was not helpful, as he had consented to the surgery. Moreover, the guardian according to Chris, “has too much power over me, he can decide if I can go to an SRS (Supported Residential Service) or things like that, and I’ve said to my guardian, if he lets me go to an SRS he’s sign (sic) my death certificate”. He maintains he has suffered at SRS’s as well. Chris believed that he would not want to continue with a guardian. Conversely he recognized both his current and former case managers would want a guardian, “they would say I would probably need it for the rest of my life”. Chris then reflected, “I would probably have to agree but reluctantly...”.

Chris could not concede that a guardian had improved his health, and repeated again, if left to his own devices, “I won’t be here. I’d rather die”. The interview was stopped for the taking of Chris’s Blood Sugar Level (BSL). His BSL result was reported to be favorable. Chris reported feelings of confusion with regard to his BSL results, and said, “I don’t know how to feel if the readings are good or bad anymore...”

When asked to consider what has been beneficial, he nominated a woman who came into his home and provided care. He liked her and said, “...she could see what I had been through, and she was prepared to give me a bit more...bend a little bit”. He recalled that even when he was in hospital, she had either visited or arranged for a day visit home for him.

Returning to the question of guardianship, Chris became quite agitated and said, “it has given the hospital a way out, they’re not put into a catch 22

situation... or then they say society cares for you...I turn around and say, society cares, what happens to people when I needed them at X (names the facility), and they tortured and abused me in there? Oh that is a different matter...". He also offered the view that some people believed that guardians, "...have overstepped the mark...power goes to their head...some can still keep a level head...". Chris felt his current guardian has sought his views, but if the guardian did not support them the guardian's decisions would override his views. This has occurred for Chris and he has felt uncomfortable about it. The example he provided, was the surgery for the removal of a big toe. Chris opposed the surgery, but the guardian provided consent. Prior to his toe surgery, the surgeon asked Chris, "are you happy with having it taken off?" I said, "no,...but I don't have a choice do I..."? His toe was amputated.

## **CHAPTER 6: Phase 2: Discussion**

The interviews from Chapter 5 were conducted with individuals who had a diagnosis of BPD and been the subject of a guardianship order, to elicit an understanding of their experience of guardianship specifically, but also their lives in general. A number of themes emerged from the interviews these are; an apparent lack of understanding of their diagnosis and its impact on their lives, a misunderstanding of the role of the guardian, opinions on services and people that make a difference, and individuals' view of the system response. Each theme will be discussed.

Following discussion of each theme, limitations of the whole study are discussed.

### ***6.1 A Misunderstanding of the Diagnosis of BPD***

It appeared that for all participants, they had negligible understanding of the diagnosis given and if aware of the diagnosis, they questioned it. Either way it seemed the diagnosis was devoid of meaning or understanding.

Dave spoke of struggling with depression since the age of 15 years. For him his self-harm was linked to his depression, and of being troubled by intrusive thoughts. His desire to self-harm was still very real and was something he contended with on an almost daily basis. He utilized positive images such as those of his family and dogs to combat his negative thoughts.

Unlike Dave, Nigel was aware of his diagnosis of BPD, but had no understanding of what it meant. He believed that BPD was not considered a serious illness and therefore he possibly had schizophrenia. Significantly, for Nigel, fuelled by alleged statements made by CATT team members, his diagnosis was not an illness, and therefore precluded him from gaining a hospital admission. A diagnosis of schizophrenia offered a more plausible explanation for his temper, his acts of self-harm, and his frequent overwhelming thoughts.

Chris believed that in spite of residing in psychiatric facilities for many years, he had not been given a diagnosis. Furthermore, he believed that such information was possibly withheld. He attributed his health care problems and his choice of not adhering to recommended treatment regimes to his years of being conditioned.

## **6.2 The Role of a Guardian**

The role of a guardian though legally defined, is perhaps a difficult concept for many individuals to grasp. Moreover, the ability to understand guardianship and its implications are perhaps further diminished when an individual is undergoing some form of crisis, and further cognitively compromised. In each of the three cases, (Dave, Nigel and Chris respectively), their initial involvement with a guardian was when their situation was considered by others to be in a crisis, and so a guardian was appointed as a matter of urgency.

Dave recognized he had trouble in making health decisions but was unable to articulate exactly what his health care issues were. He acknowledged that he was young at the time of the appointment of his first guardian, and indicated that his circumstances had now altered, and he now no longer needed one. Dave nevertheless did not believe the guardian had ever been of assistance.

His case file revealed that it was his guardian however who had consented for him to move from his rural house to the city. This relocation provided him with a different experience of life and he reflected this time as being, "best three years of my life". In a further demonstration of Dave's lack of understanding of the guardian's role, he expressed disappointment that the guardian failed to provide assistance when he was in jail. The guardian has no legal standing however when the represented person is in jail. When any person is incarcerated in a Victorian jail, The Office of Corrections provides support and assistance considered necessary.

Dave also stated that he had never attended any VCAT hearing. Perhaps if encouraged to attend, or provided the opportunity to speak via a telephone to the member during the hearing, he would have been afforded a conversation that

explained the role of the guardian, and of what is possible within the scope of the order.

Nigel recognized he was self-harming and his behaviours had caused the residential care staff significant distress at being unable to stop him. He was aware that the guardian had the power to enforce a decision, and could utilize both the police and ambulance to assist. Nigel was resolute that the use of the guardian's power to enforce made him even more determined to continue his self-harming behavior/s. On the second occasion when a guardian was appointed, Nigel did not believe this guardian pressured him and therefore he made treatment choices for himself. Furthermore, Nigel seemed to understand any change had to come from him rather than through another enforcing change or treatment.

Chris also had a full understanding of the reasons for the appointment of a guardian, and recognized it was for his health. He believed that due to the brutality he endured at the hands of those who were entrusted with his care, he had been rendered seemingly forever incapable of making any health decisions. Chris did not see his circumstances altering, and almost lamented that if any surgery was required, a guardian would always be needed to provide consent as he was incapable of doing so. Chris discussed the concept of the power imbalance between the guardian and himself. He further highlighted the conceptual dilemma between his expressed wishes and his best interests. Chris concluded that his opinions were regarded as secondary to those of the guardian. He also stated that he had never attended or been party to a Victorian Civil and Administration Tribunal (VCAT) hearing. Sadly, it appeared that his wish was to choose to die, and that he should be allowed to make it.

### **6.3 What Makes a Difference?**

The human qualities of the person providing assistance of being non-judgmental, having a respectful attitude, and displaying acts of kindness were considered highly valued by the participants. Each one identified the individual experience of being provided help and support, and of feeling trusted by others

also made a difference in their lives, and had a corresponding positive effect on their view of themselves.

Dave detailed being supported by staff, and gave examples of being allowed to keep his two dogs and of being taken on outings as helpful. In addition being visited by his local corrections group and not feeling pressured by them was also beneficial. Finally, Dave believed that if others could trust him, this would be of assistance as well as enhancing his view of himself.

Nigel stated staff was most helpful in the provision of assistance when it was most needed. For example, when he had been in dispute with his mother, staff had provided practical assistance by taking his clothing to his interim residence. Moreover, staff was available to listen to him when he felt overwhelmed by his feelings, which was also viewed as beneficial.

Even Chris who seemingly had a complete lack of trust in others, nominated a woman as having been helpful. Her apparent recognition of what he had endured, and the provision of more than the normal paid care, that is, visiting him in hospital, demonstrated both understanding and caring for his needs.

These experiences expressed by the participants had a positive effect, which is not surprising as they recounted being understood and of not being separate from their environment. This is also consistent with Bowlby's (1988) thesis that humans have an innate biological drive for attachment. Feelings of isolation and not fitting in have been replaced by empathy and the knowledge that another has understood their pain or experience and has indicated that this experience has affected them, by being available and responsive to their needs (Jordan, 2004). Actually to matter to others is critical, when much of the participants' previous experiences have demonstrated being misunderstood, humiliated and or abused. To be understood further strengthens the sense of faith or trust in human relationships, which is essential for all but most critically this client population.

#### **6.4 Individuals' View of System Response**

All participants expressed extreme distress at what had been an inadequate and sometimes harsh and cruel system response.

Dave was angry at how he had suffered at the hands of a rural correctional facility, and described how he had been hosed down. Furthermore, the liberal use of force, which seemed to be used as a management tool for containing him, will have lifelong effects on his back. From Dave's account, it also appeared that some staff had their own problems in maintaining a professional stance, such as illicit drug and prescription medication use.

Nigel was very angry at how he believed the CATT teams had failed in their provision of assistance. Staff use of terms such as "attention seeking", and "he does not have an illness" when referring to him, both inflamed and aggravated his situation. A cry for help in whatever form it emerges should engender in the professional carer a degree of sympathy but firmness in their response. Any response tinged with disdain and hostility can be immediately detected in the recipient (in this instance Nigel), and further serves to damage Nigel's fragile sense of self (Erikson, 1956). In addition, Nigel's quite harrowing account of calling the police to assist him when he appeared to be struggling with disturbing internal conflict i.e. self harming but simultaneously seeking assistance, graphically illustrated his need for professional help. It is somewhat bizarre that the police, who are provided with limited training in the mental health area, acted appropriately and responded by seeking professional mental health support (the CATT teams). From Nigel's account and by stark contrast to the police, the professional mental health response was completely unhelpful and they refused him assistance. Their apparent inadequate response further alienated Nigel and as he appeared invalidated, he then deliberately damaged a police car. Fortunately, the police chose not to charge Nigel with willful damage. This scenario highlights that Nigel's rather desperate call for help, almost achieved a perverse outcome with a criminal justice response as opposed to the only appropriate response being that of mental health services. This incident highlights that the stigma of a label also exists within the mental health service system and

that once labelled, it is difficult for the individual to be considered to operate outside the parameters of the designated label.

For Chris, it appeared his late childhood and adolescence spent at a psychiatric facility, was experienced as one of ongoing suffering and torment delivered by paid carers. It is significant that Chris like Dave spoke of being hosed down by staff as a form of punishment. This abuse appeared so enduring that he used the word “conditioning” to explain why he now could not make any medical decisions for himself. Thus, the consequences of his experience appear to be lifelong, and now rather ironically the psychiatric and hospital systems both mandated to assist, have seemingly no effective tools in their armamentarium.

These interviews support previous knowledge (Gallop, 1992; Gutheil, 1985; O'Brien & Flote, 1997; Hinshelwood, 1999; Bowers, 2002) that many staff involved in working with people with BPD have negative reactions to them. This is not to say, that people with BPD's actions are not challenging, as they do bizarre things to themselves, and as a result arouse angry and fearful responses. To move from negative and rejecting responses to a more accepting and positive attitude requires staff training which encompasses education, supervision, a level of challenge, development and growth (Bowers, 2002). In addition, there should also be an examination of the “moral values” that underpin positive attitudes, and these need to be promoted by strong agency/organisational support and investment, to encourage staff to engage in this process (Bowers, 2002, p. 150). It also requires an ongoing commitment to acknowledge that BPD is a mental disorder and one that requires acceptance that treatment has superior consequences than not providing it.

### ***6.5 Limitations of the Study.***

There are a number of methodological issues that may have affected the results obtained. These are primarily concerning the source of data, but also extend to some general difficulties encountered with this type of research.

The small sample size and the fact that apart from one case all of the participants were male, means that the present findings are difficult to generalise

to the population of BPD sufferers, particularly females, likely to come to the attention of the VCAT and staff of the Office of the Public Advocate (OPA). The method of recruitment may have also contributed to the results. Current staff working at the OPA identified participants. Staff were required to nominate people they believed fitted within the study criteria, and it may therefore have resulted in a skewed sample, reflecting those participants who were clearly identifiable as having BPD. Furthermore, possible participants were also targeted from a previously identified list of difficult clients. These factors may have combined to produce a more disturbed sample. In addition, this study was limited by being based on file material review and therefore the data was based only on what has been recorded rather than what may have been actually said by the individuals. In this sense, it can only reflect an interpretation of what had transpired by the note taker.

Nevertheless, the data recording and capturing methods utilized at that time did not allow for another way of obtaining data for this current study.

Since 2007, an improved recording and data collection database has been established at the OPA including more accurate client disability diagnosis, which is consistent with the Diagnostic and Statistical Manual (American Psychiatric Association, 2000). Such a system should ensure that in future OPA data could be more readily accessible, and less reliant on staff memory.

## **CHAPTER 7: Conclusion and Recommendations**

### ***7.1 Conclusion***

BPD is clinically and conceptually a complex disorder. As this study attests, individuals with BPD have chronic functional impairment and create substantial costs for society (Ogrodniczuk & Piper, 2004), and are frequent users of health and social services (Bender et al., 2001). This research has examined some of the experiences of people with BPD, who have also been the subject of a guardianship order. As there is currently no research in this area from a Victorian perspective, this study has established an important first step in determining whether guardianship is of assistance for people with BPD.

The research questions may now be answered. The contributing factors which led to the appointment of a guardian are multifaceted. The person with BPD was engaging in a high level of self-injurious behaviour/s or self-neglect, and had refused or sabotaged the recommended treatment regime, or rejected medical treatment offered. The applicant to VCAT believed that the appointment of a guardian would achieve a reduction in the self-harming behaviour/s. The level of self-harm or self-neglect was so extreme, that the detailing of the behaviours at the VCAT hearing would have been difficult to comprehend without arousing a degree of emotional distress in the listener.

The service responses to people with BPD were diverse. This study found that it was particularly difficult to obtain ongoing psychiatric service case management for a person with BPD and severe self-harming behaviours. This did not appear to be the same for disability services. If co-morbidity existed, that is, a diagnosis of BPD together with a diagnosis of intellectual disability, then case management from disability services was maintained. Participants reported that an ongoing relationship with a service provider was beneficial, perhaps as this created a feeling of connection and by implication to community (Jordan 2004). In relation to the VCAT process, in the majority of cases, the matters were heard

before a single member tribunal. In some circumstances, the member appointed a guardian if he/she believed a guardian may assist with treatment compliance, but the guardian cannot enforce this, thus rendering the order futile. A power to enforce the decision of the guardian (GAA, s.26). , requesting assistance of the Victoria Police and Ambulance Service, was in most instances made simultaneously with the guardianship order.

The system responses were also diverse, but what was beneficial to each participant was either the belief that his /her needs were understood, or at least kept in mind by those entrusted with their care. Sadly, professionals could not always be relied upon for an empathic response, and support. Empathy came from unexpected sources, such as the police and not by those involved in direct service delivery.

A central question is whether guardianship was a successful intervention for people with BPD. In phase one, two of the case files demonstrated that guardianship was successful. One case complied with the legislative requirements at that time (prior to 2000), which required a guardian to provide consent for medical treatment. The second case (post 2000) also required a guardian to consent for medical treatment, however on this occasion the participant's earlier experiences with the psychiatric service system had rendered him forever incapable of consenting to his medical treatment. These aforementioned cases together with the five remaining cases in this study all revealed that advocacy undertaken by the individual guardian was the most successful intervention. Guardianship for many further exacerbated an already difficult situation.

Phase two, sought the opinions of three participants whose case files were examined in phase one, to determine what the individual found helpful from a system response, and to gain an understanding from their perspective of guardianship. All participants seemed appreciative of the opportunity to talk, but most importantly to have their voice heard. They appeared keen to speak of their experiences but indicated that the opportunity had not arisen before. Many of the concerns raised from the interviews were similar to those found from the case file

findings, namely stigma of diagnosis, lack of appropriate services, and problems with guardianship for example.

The research findings can be further categorised under three headings: (a) VCAT, (b) advocacy and (c) stigma. These headings were derived from both sections of the study and will be further expanded.

## ***7.2 Victorian and Civil Administrative Tribunal (VCAT)***

For persons with a mental illness or a mental disorder, the Guardianship and Administration Act 1986 (GAA) allows for substitute decision making and the enforcement of these decisions. The GAA covers people who are unable because of their disability to make reasonable decisions for themselves. While the GAA is human rights focused, that is, all functions that are performed should be by means that are least restrictive of a person's freedom and action as is possible in the circumstances, it also allows for significant intrusion and restriction of the life of a person. The intrusion must be on therapeutic or best interests' grounds.

In 1986, the tribunal for presiding over guardianship matters was the Guardianship and Administration Board (GAB). In these early days, and up to and including the mid 1990s, decisions were presided over by three member multi-disciplinary panels, comprising at least one legal member, a medical member and the third member with relevant experience and skills such as a psychologist, social worker or psychiatric professional. After this time, and possibly due to financial constraints, the GAB moved away from three member panels to a one member legal panel, with the possibility of co-opting another member (often medically trained) if the circumstances indicated this would be beneficial, such as infertility procedures and so forth (J. Billings, Dep. President VCAT, personal communication, August 13, 2008). In 1998, GAB became part of the Victorian and Civil Administrative Tribunal (VCAT). Currently the majority of matters heard before VCAT are presided over by a single member panel that is legally trained. This practice of a single panel I believe dilutes the knowledge of complex issues such as disability and its various manifestations, such as best practice treatment options and so forth.

Beupert (2007) questioned the wisdom of the New South Wales Mental Health Tribunal moving from a multi-disciplinary panel to a one-member panel and its impact on decision making. I also consider the VCAT experience in moving from a multi-disciplinary panel to a one-member panel has had a negative impact on the ability to balance the different legal, social and clinical considerations. This study revealed that guardians were appointed as “they may” engineer change for people with BPD; however the clinical evidence does not support these assertions. Moreover, when the person with a BPD vehemently opposes the guardian’s appointment, it is hard to argue that the appointment of a guardian is least restrictive of a person’s freedom and in a person’s best interests. Legal determinations have been made and conceptual dilemmas have been raised regarding these tensions and are next discussed.

In a Victorian Supreme Court decision, Justice Cavanough (*XYZ v State Trustees Limited & Anor* (2006) 4043), examined these issues and was persuaded by the arguments raised by Carson (1993), who was concerned regarding proposals to the Law Commission in England and Wales about mentally incapacitated adults’ decision making. Carson (1993) feared that a threshold test of (medical) disability would lead to unwarranted discrimination against people suffering from mental disorders. Moreover, he predicted it would lead to inappropriate decision making. Most pertinently he said,

It will be perfectly human, and understandable, when courts and tribunals take advantage of expert witnesses, to learn about how the disabled person has problems, which could so easily be sorted out by the court or tribunal authorizing someone to tidy up the individual’s life. It is a recipe for paternalism. It is very unfair to insist...that expert witnesses must only give evidence on their specialist area and then expect them to fudge that rule in order to help the legal system out with a difficult client group. It is unfair to criticize psychiatrists and other(s)...for ‘medicalising’ issues and then devise a scheme which encourages them to do it again (at 313).

I wholeheartedly support the arguments raised by Carson (1993), and believe to prevent the undue medicalising of issues the VCAT should and must co-opt suitably qualified medical and /or psychologically trained members to preside over matters for people diagnosed with BPD.

Assessing decision-making capacity provides a strong example that links ethical concern, legal judgment and health care delivery. While the judgment in determining capacity that is, to establish the presence or absence of legal rights is ultimately a legal one, medical or other health professionals are utilised for the final determination (Parker, 2008). This area is also somewhat unclear and murky. While some interpret capacity as a yes-no proposition (Parker, 2004; Stewart & Biegler, 2004) an argument exists that a risk-related standard should apply, while a counter argument is that a rigorously applied procedural standard should be reflected in the law (Parker, 2004). The Mental Capacity Act (2005) for England and Wales provided a statutory framework to both empower and protect people, and I argue offers a way forward. The Act is underpinned by five key principles, which are:

- A presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise;
- Individuals being supported to make their own decisions – a person must be given all practicable help before anyone treats them as not being able to make their own decisions;
- Unwise decisions – just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make their decisions;
- Best interests – an act or decision made under the Act for or on behalf of a person who lacks capacity must be done in their best interests; and
- Least restrictive option – anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms (Mental Health Capacity Act for England and Wales, 2005, s.1).

In a similar style, Purser, Magner and Madison (2009) stated that therapeutic jurisprudence (which promotes the three concepts of participation, dignity and trust), may provide the framework to re-evaluate the legal and medical approaches to current and future competency assessment. They believed that competency in the legal context, has four elements which are:

- understanding the information which forms the basis of the decision;
- appreciating the information;
- applying the information in reasoning to make a decision; and
- expressing consistent choices (Purser, Magner & Madison [2009], p.796).

Irrespective of which framework is established, a consistent and transparent system with respect to decision-making competency and capacity is needed. There does need to be greater synergy between the law and medical as well as mental health professionals, in determining when, and if, to infringe upon a person's rights.

The presence of a non legally trained member on the panel would not only provide a much needed bridge between the legal and mental health professionals but also provide a thorough understanding of the complexity of mental illnesses, and enable robust discussion and debate around mental illness to ensure that VCAT's inquisitorial and fact-finding role is upheld. In addition, VCAT should perhaps avail itself of clinical reports from independent clinical forensic agency and cross examination of authors, to aid VCAT decision making. Another option could be to also employ a VCAT member with dual legal and clinical qualifications to aid the process, since dual-qualified professionals exist these days.

### **7.21 Attendance at VCAT.**

Another area of concern arising from the current study was that in the majority of cases the person with BPD rarely attended the VCAT hearing. This

was so, whether the individual was the Proposed Represented Person (PRP) at the initial application, or again at subsequent rehearings when the person with BPD is referred to as the Represented Person (RP). How can the person express his/her wishes if not present? A number of possible reasons may be advanced by a non attendance, which may include: the individual is aware of the VCAT process and by not attending is indicating to the VCAT member that they do not wish to be party to the proceedings; the individual may be unaware that an application has been made; and the applicant may believe that the individual is currently experiencing significant psychological distress and does not want this to be further exacerbated by attending a hearing, for example. Whatever the reason, it is unacceptable on the grounds of natural justice for only the applicant and or other interested parties to the application to voice their concerns without enabling the individual a voice. Not attending the hearing may also explain why many study participants had limited, if any understanding of the VCAT process. The VCAT needs to be mindful that if it does not redress these issues of procedural fairness, it may be seen as being little more than a 'rubber-stamp' for some service providers who are trying to manage a difficult client population.

As identified by Cavanough, J, (*XYZ v State Trustees Limited & Anor* (2006) 4043), VCAT has obligations under the GAA so that the best interests of the person with a disability are protected and the wishes of that person are, wherever possible, given effect to. This cannot occur with any certainty if the individual does not attend scheduled hearings, and another expresses his /her wishes. Thus every effort should be made to enable the VCAT member to speak with the person preferably in person, or at the very least via telephone. This would be in keeping with the intent of the legislation, and should provide the individual some understanding of the VCAT process, and of the provision for an appeal against the guardianship order by means of either re-hearing or re-assessment process.

## **7.22 Wishes of the Proposed Represented Person (PRP) or Represented Person (RP).**

The wishes of the Represented Person (RP) are indeed critical. In a significant hearing in the Supreme Court, (*XYZ v State Trustees Limited & Anor*

(2006) 4043), Cavanough, J made findings with significant and wide reaching ramifications for the Guardianship and Administrative Act (Vic) 1986 (GAA).

These findings were that the wishes of a represented person be effected wherever possible. Furthermore, it re-enforced the findings of *Moore v Guardianship & Administrative Board* (1990) VR 902, when Gobbo J, said:

“Moreover, ...in the report relied upon by Parliament in framing the legislation (GAA) and referred to in Hansard, it must be a very rare case that will see an order made against the wishes of a represented person” (my insertion of the GAA).

This statement further asserts that when exercising its powers, VCAT has obligations under the GAA so that the best interests of the person with a disability are protected and the wishes of that person are, wherever possible, given effect to. In essence, this means that a compelling argument must be provided to VCAT so that another, either a guardian or an administrator is appointed against the wishes of a person with a disability.

### ***7.3 Advocacy vs. Guardianship***

In every case where the clients were interviewed about their experiences of guardianship, without exception each one believed guardianship was unnecessary. Notwithstanding the extent of suffering at their own hands, they still found the idea of another person making decisions on their behalf as unhelpful at best, and in some cases further exacerbating already chaotic situations. This is not to say that help for the individual is not required. What is helpful however is another person to assist, not in the role of a guardian, who is viewed as someone who will further erode their sense of control of any given situation, but as an advocate. As discussed by Parsons (1994), advocacy is needed not because people with disabilities are incapable of mounting a coherent argument for themselves, but rather because the power imbalance is so great. Currently and for the near future, the public health system is groaning under the weight of ever-increasing demands made on limited resources. Individuals deemed by service providers as needy, that is, those with a psychosis for example, are believed to

genuinely need psychiatric assistance. On the other hand, those individuals diagnosed with BPD, often evoke many negative reactions from all professions and have even been unfavorably compared to “psychological vampires fully responsible for their behaviour” (Bowers, 2002, p. 2). Thus, people with BPD need strong advocates to help them obtain much needed services, supports and treatment.

A thorough treatment for BPD would involve many levels. At a clinical level, treatment would result in changes in self-destructive behaviours and debilitating symptoms. On a functional level, the individual would develop increases in emotional regulation, and as a result hopefully engage and re-join relationships with others. Whatever change occurs, it should be self-sustaining. This serious mental health disorder, with its distressing and perplexing symptomatology therefore requires ongoing assistance from caring professionals and services. On occasions, necessary services may extend to planned hospital admissions, but when seeking an admission the individual should not be seen as being audacious or attention seeking, but rather a person requesting something that may be helpful and something to which s/he may be entitled. For many individuals supports and services that are requested are rarely given adequate attention, and, in other circumstances, individual requests are not considered part of the service delivery equation.

The task of advocacy has essentially three models, whereby the advocate stands beside, stands behind or stands in front of the person with a disability (Stone, 1999). The advocacy model I believe to be the most beneficial for a person with BPD would be the model with the advocate standing beside the individual. Such a model involves working in partnership with the individual and is based on a relationship of mutual trust and understanding. This model would have further benefits for the person with BPD as it allows the development of trust.

Two of the interviewees specifically raised trust as a quality of importance. They wanted others to believe them capable of trust, but just as importantly to be considered capable of being trusted by others. To know that others trusted them

also appeared to have a corresponding affirming effect as well. Such a response is consistent with the general state of trust as described by Erikson (1950) whereby one may trust oneself and be considered trustworthy, so that others will not be on guard. Although Erikson (1950) was referring specifically to the biting stage of a child, he believed this a critical developmental stage, which required mastery – to test the relationship between inside and outside the self. He further said that if this stage of development is not mastered, then the teething stage has a prototypal significance, and may set the imprint for the masochistic tendencies that assure cruel comfort by enjoying one's hurt whenever one is unable to prevent a significant loss (p.248). Masochistic tendencies displayed by the individuals with BPD highlighted within this study and for others given this diagnosis, together with an apparent inability to trust themselves and for trust to be reciprocated, may form a central part of the BPD puzzle. Study participants indicated that trust and ramifications of this, is a significant ongoing problem they encounter.

### **7.31 Guardian Providing a “Holding Environment”.**

An area that emerged from this study was the apparent use of the guardian to hold the system (Winnicott, 1965). In relation to guardianship, the guardian holds the system, that is, is mindful of the carers involved, being mindful of their capacity to tolerate ambivalence, to feelings of concern, and then to the acceptance of responsibility (Winnicott, 1965). This can be best demonstrated by the case study of Chris. The guardian established contact lists to enable paid carers to have discussions between the guardian and each other when they felt overwhelmed by their experiences. What was apparent was ineffective management from the carer agencies. Their managers appeared to be somewhat distant from their staff's face-to-face dealing with Chris and hence seemed oblivious to its corresponding impact on their feelings. What is definitely needed is for managers to contain the tension of their staff, and to offer them support and understanding. This is not the role or domain of guardianship.

Another case to illustrate this point was in the matter of Dave, when psychiatric services (PS) felt it necessary for the appointment of a guardian.

While the guardian did not affect any decision-making, it seemingly provided a psychological holding environment that contained PS anxieties, but perhaps most importantly, provided a “quasi legal protection” for their actions. While the PS seemed to place great emphasis on documentation, as discussed by Beaupert (2007) a written document outlining treatment does not provide any real assurance that effective treatment will be provided. Thus the guardian provided the PS with a sense of being held and that someone else, in this instance the guardian, was taking responsibility. However this raises issues about the duty of care of the service provider.

### **7.32 Duty of Care in Health System: Negligence**

A person who has suffered a physical injury to person or property and who wishes to take legal action to shift the loss to another by means of the law of torts, will more frequently rely on the tort of negligence (Luntz and Hambly, 1995). To succeed in an action of negligence plaintiffs must show that:

1. there was a duty of care owed to them;
2. there has been a breach of that duty; and
3. as a result of that breach, they have suffered damage which is not too remote.

The relationship of proximity was another element of the duty of care. Proximity was further elaborated by Deane, J, when elevated to the High Court in *Jaensch v Coffey* (1984) 155 CLR 549.

Historically, negligence initially was an element necessary for liability in a limited range of circumstances, then the range of situations expanded; and then negligence became a tort in itself. Once this occurred, there was a steady expansion to encompass more and more circumstances, such as products liability, and defective structures to name but two. The area of medical liability I believe could be the most fruitful in examining whether the actions of a particular doctor or nurse working under the organization of a hospital, can be held negligent in their duty of care for individuals with BPD.

The area I believe requires further examination is when a staff member (often a psychiatric registrar) from a local psychiatric services department, (usually auspiced under an organization such as a hospital) is named as the applicant to VCAT for the appointment of a guardian. The need for the appointment of a guardian for an adult with impaired decision making usually arises when there are no informal proxy decision makers (i.e. family or friends) or when there is conflict between the informal decision makers. An independent guardian from the Office of the Public Advocate (OPA) is appointed. The guardian is normally given a range of powers limited to specific areas of decision making. In the example described, as the applicant is a staff member from a hospital, then the powers of guardianship would incorporate healthcare. This is relatively straight forward, until the person requires a hospital admission for a medical condition, which may or not include a psychiatric condition. Following admission, and once the condition is considered stable, then the patient is discharged. Rarely is the guardian involved in any discharge plan, and in the circumstances the guardian is not informed of any arrangements or support services afforded to the discharged individual. Thus, what occurs if the individual is discharged against the knowledge of the guardian, without appropriate services to assist the individual?

Such a scenario could be seen as potentially contrary to the RP's best interests and would potentially leave the hospital at significant risk of being in breach of their "duty of care" owed to the patient.

The case of Chris highlights that hospital discharges occur without the guardian's knowledge. It is my contention that individuals from organisations such as hospitals cannot apply for the appointment of a guardian when the circumstances suit, and then ignore the legal standing of the guardian before discharge. I further believe if a compelling argument is made for the appointment of a guardian for a medical intervention at a hospital, then and only then should a guardian be appointed. Such an appointment by virtue of the legislation defers all health care decision-making to the guardian, incorporating all aspects of consent. The guardian's decisions are then made while the person remains in the hospital

environment, including the involvement of a guardian at any meetings involving patient care and discharge planning. Once the discharge has occurred, the guardianship order should then be revoked. The discharged individual should then have the ongoing involvement of an advocate, not a guardian. This position would be entirely consistent within the meaning of Guardianship and Administrative Act (Vic) 1986 (GAA). In addition, the current memorandum of understanding between the Chief Psychiatrist and the Public Advocate should be altered to reflect these arrangements.

### **7.33 Memorandum of Understanding between the Chief Psychiatrist and the Public Advocate (PA).**

In June 2006, a memorandum of understanding (MOU) between the Public Advocate and the Chief Psychiatrist was established. The purpose of the MOU is to provide guidance to mental health professionals and guardians where respective roles and responsibilities are either uncertain or overlap under both the Guardianship and Administration Act (Vic) 1986 (GAA) and the Mental Health Act (Vic) 1986 (MHA). The underlying philosophy is the principle that authority should be exercised in a manner that is least restrictive of a person's freedom and in a person's best interests. This is consistent with the philosophy in the GAA and the MHA.

The MOU was also established to be a useful resource and enhance co-operative working relationships between guardians and mental health professionals. Importantly, it was intended that such an MOU would promote a high level of quality care for persons with a mental illness or disability.

The MOU seeks to ensure that both the guardian and the mental health professional understands, and respects the legal context, role and organisational and professional independence of the other (Chief Psychiatrist & Public Advocate, 2006). The current study revealed that there existed considerable tension between guardians and psychiatric service professionals (refer chapter 3.22 for Jane; 3.24 for Dave & 3.25 for Chris). The MOU would have been beneficial in reducing some of the tensions particularly in the case of Dave where

a guardian was appointed for medication compliance while the MOU states "...a guardian does not have automatic access to services to monitor the represented person's taking of their medication" (Chief Psychiatrist & Public Advocate, 2006. p.10).

The MOU specifically addresses discharge planning from a mental health service. The wording around this process is ambiguous however and states, "The mental health service may consult the guardian in relation to the treatment plan" (Chief Psychiatrist & Public Advocate, 2006. p.8). As previously discussed I strongly argue that the guardian must be consulted not may be consulted, and any lack of information regarding discharge planning from the mental health service to a guardian, and subsequent consequences of this decision will ultimately reside under the duty of care provisions. This further demonstrates another contradiction regarding the role and responsibilities of the guardian in the role that they are seen to play in the psychiatric system. Perhaps the courts will be the final arbiter of this issue – to date no determination has been made.

#### ***7.4 Stigma of diagnosis***

The pejorative use of the word stigma, which reflected a mark of shame or degradation, is believed to have appeared in the late 16th to early 17th centuries (Stuart, 2008). Contemporary understanding of stigma and its effects stems from the seminal work of Erving Goffman, which was conducted in the early 1960s (Goffman, 1963). In Goffman's view, mental illness was one of the most deeply discrediting and damaging of all stigmas. Contemporary social theorists (see Link & Phelan, 2001) recognised the complex interplay of social-structural, interpersonal and psychological factors in the creation and maintenance of stigma. This perspective views stigma as pernicious and pervasive, and quite resistant to change. Link and Phelan (2001) suggested to appropriately reduce stigma, all anti-stigma programs must be comprehensive, multi-pronged and directed to individual, interpersonal and system levels.

Psychological theories, such as attribution theory for example, have provided a useful framework for understanding stigma and for targeting anti-

stigma interventions. Attribution theory traces a path from a label (signaling event) to a stereotype (attribution) to often a negative emotion, which results in a discriminatory behavioural response (Corrigan & Penn, 1999).

Over the past decade, there has been an increase in both the burden of mental illness and the recognition of the corresponding stigma (Stuart, 2008). This present study, revealed that the participants faced a high level of stigma and discrimination (refer Gerson & Stanley, 2002), not only from people largely untrained in the mental health area but significantly from mental health professionals, and this is consistent with earlier findings ( Beales, 2001; Gunderson & Ridolfi, 2001; Aviram et al, 2006).

Ongoing training of mental health professionals, including guardians and advocates from OPA, would enable a greater understanding that emotional disorders such as BPD are legitimate illnesses and not moral failings or a lack of willpower (Aviram et al, 2006). In addition, anti stigma interventions must not only change public attitudes toward the mentally ill, but “fundamentally change the stigma experiences of people who live with mental disabilities” (Stuart, 2008 p. 187). I believe that such a stance is critical for people with BPD.

An unexpected positive finding from this research was the Victorian Police dealings with people with BPD. The police are not mandated as mental health professionals but managed to deal with the research participants in a very compassionate manner. Their involvement in this process is further discussed.

#### **7.41 Use of police**

As identified by this research, the police have played a significant role when a guardian is appointed for a person with BPD. Sometimes it is because of the individual’s level of public disturbance, or at other times the police are involved in assisting in the transportation of individuals (refer GAA, s.26). This is hardly surprising, as police officers are usually the first point of contact with the criminal justice system, and as a result have become the gatekeepers of both the criminal and mental health systems.

In Victoria, and in recognition of the demands and opportunities presented by their interactions with people with a mental disorder, the Victoria Police nominated mental health as one of its priority issues for 2006/07. Furthermore, policing responses to people with a mental disorder formed part of its strategic service delivery commitments in the Victoria Police Business Plan 2006/07 (Victoria Police, 2007).

Police have a variety of interventions when interacting with people with a mental disorder, and some are mental health specific, such as the power to apprehend under the Mental Health Act, 1986 (MHA), the Disability Act 2006, and power to enforce under the Guardianship and Administration Act, 1986 (GAA). In examining some of the interventions, the police are not expected to exercise any clinical judgment, and therefore it is essential that they have timely access to clinical expertise. However, a 2006 review found that the provision of clinical expertise is a source of frustration among many police and mental health staff (Victoria Police, 2006). Another source of concern for members of the Victoria Police was in the transportation of people with a mental disorder. Significantly these concerns are shared by police Australia wide, and some police have accused mental health professionals of abdicating their responsibilities when dealing with people who are mentally ill (Chappell, 2008). In Victoria, Ambulance Services Victoria is the lead agency responsible for emergency transportation, and the police vehicle is used only as a 'last resort'. This study revealed that police are used to assist in the transportation of people with a BPD, particularly if the person is deemed aggressive or potentially violent (refer 3.21 for Joe, 3.22 for Jane, 3.26 for Nigel & 3.27 for Andre).

In the matter of Andre, the police who responded to the guardian's request to transfer him to hospital found themselves barred from entry to his premises. Andre's vehement opposition and objections, together with their own dilemma as to whether they should break his door down to gain entry, as well as their opinion that such a request was unreasonable, resulted in the matter being urgently referred back to VCAT for determination. The ultimate decision then resided with the ambulance members who determined his death was not imminent, so entry

was not forced – and they left. Thus, a high level of societal pressure by the police and ambulance members as to what determined reasonable action, resulted in changed actions. This rather unusual example highlights the extreme tension between best interests and expressed wishes, particularly when an individual feels his rights are being usurped. In a somewhat perverse scenario, the police acted as the societal conscience rather than the mental health professionals.

### **7.5 Recommendations**

This research has identified a number of issues, which should be remedied. The following recommendations are considered necessary to assist people with BPD in general with respect to the VCAT process.

- For VCAT to consider the following options:
  - (1) a return to the original composition of the Guardianship and Administration Board, which is three member boards, comprising legal and non-legal members, to provide greater balance than the current single panel structure. It may also assist in determining if the balance has swung too far in favor of paternalism or protection against individual autonomy,
  - (2) VCAT to engage psychological expert evidence to assist decision-making, and
  - (3) to also employ a VCAT member with dual legal and clinical qualifications to aid the process.
- To ensure that any Proposed Represented Person (PRP)/ Represented Person (RP) is in attendance at any hearing, or subsequent re-hearings or re-assessments, to enable input into the VCAT process. If this cannot occur, then as a minimum standard the member/s must speak to the individual by telephone to ascertain their wishes and views.

- In all matters before VCAT involving a person with BPD:
  - (1) the OPA VCAT liaison officer be notified, and
  - (2) an OPA advocate to be appointed, to determine if least restrictive options can be utilized (such as the instigation of a whole of system response management plan for example).
- If after the appointment of an advocate, the appointment of a guardian is essential, then the advocate is the applicant to VCAT. A guardian is then only appointed if the following conditions apply:
  - (1) there is immediate need for hospital medical treatment, and
  - (2) the individual is rendered incapable of providing consent due to a previous trauma.
  - (3) Once appointed, the guardian's decisions are limited to healthcare, and the duration of the order is self-executing at hospital discharge.
  - (4) The advocate maintains ongoing involvement with the individual with BPD, to ensure discharge plans and ongoing service provision is maintained.
- To update the MOU between the Chief Psychiatrist and the Public Advocate (2006) and amend the wording to reflect that the guardian must be consulted by the mental health service in relation to both the treatment and/or discharge plan.
- To ensure that all the OPA guardians and advocacy staff receive training on BPD. The training to be constantly updated and monitored to ensure optimum quantity and quality of content about BPD.
- To ensure that the OPA staff that work with individuals with BPD have expressed an interest in doing so, thus minimizing negative judgments.

- To ensure that the OPA is a party to service programs involving people with BPD.
- To ensure that the Public Advocate has ongoing dialogue with the Chief Psychiatrist to ensure that people with BPD are not further stigmatized by some staff working in the mental health services.
- To ensure that the Public Advocate has ongoing dialogue with the Victoria Police regarding the GAA and power to enforce legislation.

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*XYZ v State Trustees Ltd & Anor* (2006)4043, VSC (Cavanough,J).

### Legislation

Guardianship and Administration Act, Victoria, 1986.

Mental Health Act, Victoria, 1986.

The Mental Capacity Act, England & Wales, 2005.

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**Department of Psychology**  
**Human Research Ethics Committee**  
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**Footscray Campus**



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**TO WHOM IT MAY CONCERN**

Tuesday, 19<sup>th</sup> November, 2002

The project titled "The guardianship been an effective intervention on people diagnosed with borderline personality disorder?" conducted by Maree Withers under the supervision of Jenny Sharples received ethics approval from the Department of Psychology's Human Research Ethics Committee on the 19/11/02.

Please note recommendations made by reviewers.

This project is been undertaken as part of the Master of Psychology (Clinical psychology) program conducted at Victoria University.

Yours Sincerely  
Heather Gridley

Chair  
Department of Psychology  
Human Research Ethics Committee



## Department of Justice

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Research Ethics Committee

55 St Andrews Place  
GPO Box 43566QQ  
Melbourne Victoria 3002  
Telephone: (03) 9651 6972  
Facsimile: (03) 9651 6928  
DX210077

12 December 2005

Maree Withers  
PO Box 509  
Sunbury 3429

**Project No. EC/02/38 Has guardianship been an effective intervention for people diagnosed with borderline personality disorder (BPD)?**

Dear Maree,

The Department of Justice Research Ethics Committee considered your amendment request and granted full approval.

You must ensure that the Department of Justice Research Ethics Committee is notified immediately of any matter which arises that may affect the nature of the approved project.

Should you have any queries please do not hesitate to contact me on 9651 6972 or [gavin.murnane@justice.vic.gov.au](mailto:gavin.murnane@justice.vic.gov.au).

Yours Sincerely

A handwritten signature in black ink, appearing to read 'Gavin Murnane'.

Gavin Murnane  
A/Secretary  
Human Research Ethics Committee  
Department of Justice

Version 2, Dated 19 November 2005.

**Invitation to Participate in a Research Study**

Dear

My name is Maree Withers. I am a Clinical Psychology Doctoral Student, supervised by Dr Jenny Sharples, from the Department of Psychology at the St Albans Campus of Victoria University.

I am undertaking research on the use of guardianship legislation for people who have Borderline Personality Disorder (BPD). To date, there has been no research on the use of guardianship for people with a diagnosis of BPD.

I would like to seek your views on the services that you have been offered and specifically your opinion on what has been effective and what has not been helpful for you. I would also like to know if a guardian from the Office of the Public Advocate has been involved in your care and if so, how did the guardian assist. If you are willing to participate, I will need to speak to you for approximately one hour. Participation is voluntary and you can withdraw from the study at any stage without penalty.

If you have any concerns regarding the manner in which this research is conducted, please do not hesitate to inform the researchers directly, or the Victoria University Human Research Ethics Committee on ☎9688 4710.

Results will be available at the end of the project from the Department of Psychology. If you have any queries you can contact Jenny Sharples or me on ☎9365 2156.

Yours sincerely

Maree Withers

**CONSENT TO PARTICIPATE IN THE STUDY**

TO: Ms Maree Withers and Dr Jenny Sharples  
 Department of Psychology  
 Victoria University  
 St Albans

I:.....

**(GIVEN NAMES)**

**(SURNAME)**

Have agreed to participate in the research project titled:

**“Is guardianship a successful intervention for people diagnosed with Borderline Personality Disorder (BPD)?”**

**What does participation in the research involve?**

Maree will ask you questions about a number of matters including your diagnosis, guardianship, services that you have received, and what has been helpful and unhelpful. The interview should not take longer than one hour. Maree will audiotape the interview.

**What are the possible risks?**

If I become upset or distressed as a result of my participation in the research, Maree is able to arrange counseling or other appropriate support. Any counseling or support will be provided by staff who are not members of the research team.

**Do I have to take part in this research project?**

Participation in this research is voluntary. If I decide to take part and later change my mind, I am free to withdraw at any time.

My decision to take part or not, or to take part and then withdraw, will not affect my relationship with Maree or any services that I receive.

**What will happen to information about me?**

Any information obtained for this research that can identify you will remain confidential. It will only be disclosed with your permission.

During the project, all the audiotapes will be stored in a locked cupboard in the office of Dr Jenny Sharples, Victoria University. Only Dr Sharples and Maree Withers will have access to the audiotapes or other documentation. At the completion of the study, electronic copy of the data will be stored securely at the School of Psychology, and will be destroyed after seven years.

In any publication and/or presentation, information will be provided in such a way that you will not be identified.

**Consent**

- I have read the potential participant statement.
- Maree answered all questions I asked her, and I am satisfied with her answers.
- I freely agreed to participate in this research.
- My conversation with Maree will be audio-taped.
- I understand that I will be given a signed copy of this document to keep.

SIGNED:.....

DATE:.....

Any queries about your participation in this project may be directed to the researchers (Ms Maree Withers or Dr Jenny Sharples on 9365 2156). If you have any queries about the way you have been treated, you may contact the Secretary, University Human Research Ethics Committee, Victoria University, PO Box 14428 MCMC, Melbourne, 8001 (telephone: 03 9688 4710).