



Operational Review of the Northwest Territories Public Guardian Office

Executive Summary

Introduction

In June 2016 the Minister of Health and Social Services directed that an external review of the Office of the Public Guardian (OPG) be undertaken. Concerns had been identified that the Public Guardian's caseload had been increasing steadily over the past five years, without commensurate budget increases, and that applications for guardianship orders were backlogged and could take more than a year to process.

The OPG operates under the authority of the NWT *Guardianship and Trusteeship Act*. Under this *Act* the Public Guardian, on application to the Supreme Court, may be granted substitute decision-making powers on behalf of individuals who for various reasons of incapacity are unable to make decisions for themselves. The OPG also assists individuals and families in making application to the court for private guardianship orders. Both public and private guardianship orders are typically time-limited and require judicial review on a periodic basis.

The OPG consists of two staff members – the Public Guardian and an administrative assistant. The Public Guardian is appointed by the Minister of Health and Social Services, and serves at the Minister's pleasure. At the time of the review the Public Guardian reported administratively to the Executive Director, Territorial Social Programs, in the Department of Health and Social Services.

Methodology

The Terms of Reference for the review included: examining the legislative and policy framework under which the OPG functions; examining the business practices and office procedures utilized by the OPG; and examining the current, historical and forecasted caseloads.

Mark Arnold and Peter Dudding undertook the review. Both Mr. Arnold and Mr. Dudding are former Public Guardians in Nunavut, and have significant northern experience and program review experience. Oversight to the review was provided by a steering committee of senior officials from the Department of Health and Social Services.

The review was undertaken between July and November, 2016. The review utilized a mixed methodology approach which included document and case file reviews, key informant interviews and survey questionnaires distributed to all regional health and social services authorities.

Key Findings

- The OPG is intended to be guided by standards and procedures contained within an Operations Manual. This manual has not been updated since its inception, which occurred sometime prior to 1999. It would appear from this review that the manual is not consulted during the daily operations of the OPG.
- The manual makes reference to there being Public Guardian Representatives (PGRs) in each region, to whom the Public Guardian's duties can be delegated at the regional level. There were no PGRs operative at the time of this review, nor have there been any operative since the current Public Guardian was appointed in 2006. There is no documentation as to why PGRs are not currently utilized, but the net effect appears to be that the Public Guardian shoulders all responsibilities, and that public guardian functions have become centralized.

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- The manual makes reference to regional (PGRs) audits on a semi-annual basis, and central (OPG) audits on an annual basis. At the time of this review audits were not taking place at either operational level, which fact may raise liability concerns.
- The business practices of receiving, processing and forwarding guardianship applications to court are for the most part paper-based and not automated. The reviewers concluded that the lack of an automated, electronic system for tracking and processing files was a contributing factor to the increasing backlog of applications.
- In large measure key informants, including the court, were satisfied with the work and professionalism of the OPG. Mention was made of the problematic lengthy wait for assessments. The reviewers noted that administrative procedures within the office could be improved.
- The OPG tracks files in three categories: inactive, being processed, and pending. These categories are not formally defined. As of September 20, 2016 there were 38 inactive files, 28 files were being processed, and 11 files were pending, for a total of 77 files.
- Of the 38 inactive files, 36 were opened prior to 2016. Of the 28 files being processed, 17 were opened prior to 2016. Of the 11 pending files, 9 were opened prior to 2016.
- As of November 2016, of the total 77 files open in September 16 have been closed, 4 have received a court order, 4 are ready to go to court, 26 are waiting for assessment, and 27 require action prior to being ready for assessment.
- The clientele of the OPG tends to be of a younger age, predominantly with cognitive issues associated with fetal alcohol syndrome.
- The reviewers concluded that the availability of assessment resources (or rather the limitation thereof) contributes significantly to the backlog.
- Beyond the 61 files awaiting a court order as of November, 2016, the Public Guardian is currently responsible for 69 individuals with existing guardianship orders. The OPG is also responsible for monitoring and supporting 77 private guardianship orders. These orders are subject to periodic court review and renewal, adding to the caseload of the OPG.
- There has not been a noticeable increase in requests for guardianship orders in the past few years. The backlog accumulated approximately three to five years ago, and has remained relatively constant since then.
- The budget for the OPG is just under \$300,000. Actual expenditures for the past four years have ranged from 8% to 40% over budget. Projected expenditures for 2016/17 are close to 50% over budget.
- Finally, The *Guardianship and Trusteeship Act* came into force in 1997, and has not been amended since then. Compared to similar legislation in other jurisdictions, it is relatively out of date and does not reflect current best practices in guardianship.

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- The report makes 16 recommendations for improvements to the OPG. These include modernizing office procedures, developing an electronic information system, reviewing the delivery model, and making other changes to operating procedures for greater effectiveness and efficiency. The recommendations also include additional training for assessors and improvements to how assessors are contracted.