**GUARDIANSHIP AND ADMINISTRATION BOARD**
**HOBART**

**E R on the application of Able Australia**

No xxxx of 2008

**REASONS FOR DECISION**

Anita Smith (President)
Malcolm Schyvens (Member)
Anne Parker (Member)

Guardianship – health care – role of Disability Services Ethics Committee – role of medical practitioner – consideration of wishes, freedom of decision and action and best interests for incapable person for whom smoking gives life purpose and focus
*Guardianship and Administration Act 1995*, ss 6, 20, 31, 41, 44
*Disability Services Act 1992*, s 10

1. For E R, acquiring and smoking cigarettes gives each day meaning. It is a skill and a habit that he learned as part of the informal curriculum of a life spent mostly in State Government institutions. He has not learned to speak and has few, if any, other interests in life. His relentless efforts to obtain cigarettes define E as a member of his community.

2. At 52 years of age, E has chronic lung disease. His medical practitioner has recently advised the staff members who provide support in his home that his smoking must be curtailed. Those staff members are uncertain about their rights or abilities to restrict E's access to cigarettes. They have sought the appointment of a guardian to give directions about E's consumption of cigarettes and the lawfulness of their actions in providing or restricting access to cigarettes in his home.

3. In assessing an application for guardianship, the Board must examine whether E has a disability, whether that disability renders him incapable of making reasonable decisions and whether there is a need for a guardian.

4. To make that assessment, a hearing was convened on 26 September 2008 which was attended by E, two representatives from Able Australia, E's Disability Advocate and the Deputy Public Guardian, Margaret Colville. The investigation process included collation of relevant documents which are listed in appendix "A". The Board decided each of the above questions in the affirmative and decided that a guardian was required to promote E's quality of life, primarily making decisions that acknowledge the importance to him of acquiring and smoking cigarettes.

*Can E Make this Decision for Himself?*

5. Dr N. reported that E has an intellectual disability. He has no language skills, but recognises his name. Dr N also reports that E is unable to understand the nature and effect of medical treatment. He is occasionally physically impulsive, lashing out at support workers, breaking windows and will engage in negative behaviours to receive attention or gain his own way.

6. The Board concludes from this report and from the experience of meeting E at the hearing that he is unable to assess the medical evidence related to the questions at hand, unable evaluate the level of risk in continuing to smoke, or to apply any limits to his own smoking behaviour. Therefore the Board was satisfied that E lacks the ability, by reason of his disability, to make reasonable judgments about his person and circumstances.

*Is There a Need for a Guardian?*

7. Dr P., E's general practitioner, provided a brief report to the Board which indicated that E has a chronic lung condition and that continued smoking makes a negative contribution to his health. She believes that from a medical point of view it is best to prevent him smoking again.

8. According to the applicant, E has been a smoker for most of his life. A support worker from the Day Options service (an agency of the Department of Health and Human Services) reported in writing to the Board that she has known E for 23 years during which time numerous attempts to have E stop smoking have been

attempted and invariably failed. She and a number of other witnesses described E's habit of collecting cigarette butts littered on the streets. It is also E's habit to seek cigarettes from persons on the street, many of whom oblige to avert his need to collect and smoke cigarette butts from the ground.

9. There are two aspects to these acquisitive behaviours that are self-injurious. The first is that collecting cigarette butts is unhygienic. The second that in asking for cigarettes from strangers, E is at risk of abuse, particularly because he can become insistent if refused cigarettes and this can provoke negative reactions from some members of the community.

10. Some other observations regarding E's acquisitive behaviours would support the continuation of his smoking. Firstly, he has an established but loose social network of local residents who see him as a local identity and customarily provide him with cigarettes. Secondly, the activity of acquiring cigarettes has been E's occupation for decades. The experience of denying this to him has led him to misbehave in ways that put him and other persons in danger.

11. In April 2007, E had a hip operation which required the use of a wheelchair for a period of time during recovery. On medical advice, the staff members at his house used this physical restriction to impose limitations on his smoking. They administered nicotine patches for three months and stopped the usual routine of providing one cigarette to him per hour. However once E was able to walk again he resumed the acquisitive behaviours, rendering the experiment futile.

12. From January to March 2008 house staff administered Champix medication also in an attempt to reduce E's desire for cigarettes, again on medical advice. This also had no effect upon E's acquisitive behaviours. Further the Day Options staff reported an increase in negative or self injurious behaviours when E's access to cigarettes was restricted. It was clear to the Board that E's behaviours regarding cigarettes are ingrained to a very significant degree and are entrenched personal traits which go beyond a chemical addiction.

13. On instructions from Disability Services, a referral was made to the Disability Services Ethics Committee for endorsement of the practice of restricting access to cigarettes. According to Able Australia representatives, the representative of the Ethics Committee advised her that the Committee would most likely only act to endorse the recommendations of E's medical adviser. However the Manager of Investigations and Liaison, Anne Perks, noted that it was on the advice of the Ethics Committee that an application for guardianship was made. There was a significant level of confusion about the interaction between the guardianship jurisdiction and the role of the Ethics Committee. It was also unclear whether the Committee had actually made a determination. The Board is of the view that E's smoking issue is completely beyond the domain of the Ethics Committee and that the referral by Disability Services was misguided and inappropriate for the following reasons:

*The Role of the Disability Services Ethics Committee:*

14. The Disability Services Ethics Committee is established under section 10 of the *Disability Services Act 1992* which states:

"Functions and powers of Ethics Committee

(1) The Ethics Committee has the following functions:

(a) to monitor programs and services relating to persons with disabilities to ensure that they are designed and administered so as to be as free as possible from aversive, restrictive and intrusive treatment practices;
(b) to report, or give recommendations, to the Minister in respect of such programs and services generally or in relation to specific treatment practices;
(c) such other functions as the Minister may determine.

(2) The Ethics Committee has power to do anything necessary or convenient to perform its functions."

15. The role of the Committee is to review and monitor programs and services. As an administrative committee, it has no charter to adjudicate individual rights and it has inadequate legislative machinery to do so. The Committee has no apparent authority to give any kind of advice or direction regarding E.R.'s situation, except perhaps in a report to the Minister. Any advice it might give to a group home

regarding treatment of individuals like E may therefore be *ultra vires*, meaning the referral to that Committee is not only futile but possibly a breach of E's right to privacy.

16. The Board is concerned that Disability Services and the Disability Services Ethics Committee have overstated the role of the Ethics Committee to group home managers as an arbiter of individual matters, like E's. The only legislative role that is imbued with authority to approve of restrictions being placed upon an adult with a disability is a guardian appointed either under an enduring guardianship or by the Guardianship and Administration Board.

17. To the extent that an unauthorised agency is purporting to have authority over decisions about E's smoking activities, the 'advice' of the Ethics Committee does go some way to establishing a need for the appointment of a guardian if only to ensure that decisions about E's future are made by a person with actual authority, not by a misguided Committee that is acting *ultra vires*.

*The Role of the Medical Practitioner:*

18. The Board also held concerns about the power that the medical adviser has exerted over E's carers. E has no 'person responsible' (having no record of contact with family members) therefore consent for his medical treatment would emanate either from an application to the Board pursuant to section 44 of the *Guardianship and Administration Act 1995* or from the operation of section 41 of that Act. No application has been received for consent to treatments on E's behalf. This would normally lead to an assumption that E was being treated pursuant to section 41.

19. While it may be arguable that E did not object to the imposition of anti-smoking treatments as would be required for section 41 to apply, it is difficult to accept that he did not object to the restrictions on his smoking. The Board is concerned that Dr P has also exceeded the authority of a medical practitioner in imposing the treatment regimes without appropriate consideration as to the source of consent to treat E in the manner described. Dr P's vigorous role in imposing smoking

restrictions appeared to go beyond the role of a professional medical adviser. Her actions also appeared to the Board to establish a 'need' for a guardian, again to ensure that those who purport to exercise authority over decisions about E may be subject to some appropriate checks and balances.

20. The Board was satisfied that E is in need of a guardian. The only person proposed as guardian was the Public Guardian and the board considered that appointment to be appropriate. The Board also indicated to the guardian that it would supply some indication of how the guardian's authority might be exercised.

*Application of the Basic Principles by a Guardian:*

21. A guardian appointed by the Board must apply the principles established by section 6 of the Act. Section 6(c) requires the Board and a guardian to perform their functions so that:

> *" … the wishes of a person with a disability or in respect of whom an application is made under this Act are, if possible, carried into effect."*

Applying section 6(c) to E's situation his wish, as demonstrated by his habits and actions, is to have access to cigarettes, and possibly unlimited access to cigarettes. It is possible, for the purposes of section 6(c), to carry his wish to continue smoking into effect. It is not possible to give him unlimited access to cigarettes for practical and financial reasons.

22. Section 6(a) states: requires the Board or a guardian to perform their function so that:

> *"…the means which is the least restrictive of a person's freedom of decision and action as is possible in the circumstances is adopted"*

E has very little freedom of decision and action. His accommodation, day support options, diet and medical treatment are all controlled by Government funded agencies or professional persons. His finances are managed by the Public Trustee. Therefore finding the least restrictive means to promote E's freedom of decision and action requires a review of the areas where he acts freely. In effect, the only freedom he has exercised is to frustrate all attempts to stop him smoking.

His strict adherence to a routine of acquiring cigarettes is undiminished despite attempts by well meaning persons to distract him to healthier pursuits. For the purposes of section 6(a), it must be acknowledged that E's smoking is his only act of personal expression in a life otherwise totally controlled by others.

23. Section 6(b) requires that the Board and the guardian exercise their functions so that:

> *" … the best interests of a person with a disability or in respect of whom an application is made under this Act are promoted."*

The Board interprets this provision to apply more broadly than E's medical health. Having said that, the Board accepts that E already has chronic lung condition and it is clear that his compulsive smoking is extremely bad for his health. We also accept that his coughing was reduced when he was not smoking. The Board accepts that continuing to smoke will most probably will kill E. However, given his dedication to smoking thus far, the chance that E will die of anything other than a smoking related illness is extremely slim. The Board was not in receipt of any evidence that suggested that E's chronic lung disease might be reversed or that his life expectancy will be increased significantly by ceasing smoking at this point. Neither did the Board have any evidence that E's death might be less painful is he ceases smoking now.

24. Conversely, we did have evidence that a reduction in smoking leads to deterioration in E's behaviour. When E's behaviour deteriorates, house staff members are reportedly afraid of him and the occupational risk of being hurt should he lash out at them. This presumably means that the care provided for him is diminished when he misbehaves. In any event, efforts to reduce smoking in the home only intensified his acquisitive behaviour outside the home, which creates other risks for him. It is in E's best interests to promote consistency of care inside his home and to moderate his desire for cigarettes outside the home.

25. Primarily the Board considered E's best interests from the perspective that the acquisition and smoking of cigarettes gives his life its focus and purpose.

Although it seriously harms his bodily health, it seems probable that it is the only measure he applies to his own quality of life. Quite likely E will only be capable of smoking for a little while longer before physical illness again prevents his doing so. Until that time, the Board believes that the most compassionate thing to do is to acknowledge that the damage was done to E a long time ago when Governments and the medical profession thought it appropriate to use cigarettes as behavioural control mechanisms in psychiatric wards. To belatedly attempt to impose these restrictions and control at the end of an institutionalised life is not only hypocritical and supercilious, but an attempt to make it appear that the hand now trying to close the stable door was not the one that left it open.

26. The Board encourages the guardian to assess the restrictions currently imposed upon E's access to cigarettes and to review the imposition of anti-smoking medications. Having done so, the Board then approves the guardian implementing a plan that outlines the rate of consumption of cigarettes that is acceptable for E so long as that plan includes permission to continue to smoke at home at some acceptable rate. Given all of the above, the Board would not approve any plan that bans E from smoking in his home as we are not satisfied that this would be in his best interests.

**Conclusion:**

The Board was satisfied that the represented person, is a person with a disability, and is unable by reason of the disability to make reasonable judgements in respect of his person and circumstances and is in need of a limited guardian.

**THE BOARD ORDERS:**

1. That Public Guardian be appointed as the represented person's guardian.
2. That the powers and duties of the guardian are limited to decisions concerning consent to any health care that is in the best interests of the represented person and to refuse or withdraw consent to any such treatment
3. That this order remains in effect until the 25 September 2009.

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| Anita Smith | Malcolm Schyvens | Anne Parker |
| PRESIDENT | MEMBER | MEMBER |

Date of Written Decision: 10th October 2008

**ANNEXURE "A" – Documents available to the Board**

1. Application for guardianship received 21 August 2008
2. Health Care Professional Report completed by Dr N 28 February 2008 (supplied for previous administration application)
3. Report dated 23 September 2008 by Dr P
4. Report dated 24 September 2008 by Day Options Service
5. Report dated 18 September 2008 by Anne Perks, GAB Manager Investigation and Liaison
6. Copy of DSEC Referral form completed 28 June 2007
7. Undated Aversive Restrictive Treatment Practices Review Document regarding E R
8. Instruction sheet dated 2 July 2007 regarding E R

## ANNEXURE "B" – Relevant Legislative Provisions

**6. Principles to be observed**

A function or power conferred, or duty imposed, by this Act is to be performed so that –

> **(a)** the means which is the least restrictive of a person's freedom of decision and action as is possible in the circumstances is adopted; and
>
> **(b)** the best interests of a person with a disability or in respect of whom an application is made under this Act are promoted; and
>
> **(c)** the wishes of a person with a disability or in respect of whom an application is made under this Act are, if possible, carried into effect.

**20. Guardianship order**

**(1)** If the Board, after a hearing, is satisfied that the person in respect of whom an application for an order appointing a guardian or an order appointing an administrator is made–

> **(a)** is a person with a disability; and
>
> **(b)** is unable by reason of the disability to make reasonable judgements in respect of all or any matters relating to his or her person or circumstances; and
>
> **(c)** is in need of a guardian–

the Board may make an order appointing a full or limited guardian in respect of that person and any such order may be subject to such conditions or restrictions as the Board considers necessary.

**(2)** In determining whether or not a person is in need of a guardian, the Board must consider whether the needs of the proposed represented person could be met by other means less restrictive of that person's freedom of decision and action.

**(3)** The Board must not make an order under subsection (1) unless it is satisfied that the order would be in the best interests of the proposed represented person.

**(4)** The Board must not make an order appointing a full guardian unless it is satisfied that an order for limited guardianship would be insufficient to meet the needs of the proposed represented person.

**(5)** Where the Board makes an order appointing a limited guardian in respect of a person the order to be made is that which is least restrictive of that person's freedom of decision and action as is possible in the circumstances.

**(6)** Two or more guardians of a person, each with different functions, may be appointed under one or more limited guardianship orders.

**31. Advice or directions as to guardianship orders**

**(1)** A guardian may apply for advice or direction by the Board on any matter relating to the scope of the guardianship order or the exercise of any power by the guardian under the guardianship order.

**(2)** The Board may require notice of an application under subsection (1) to be given to any person that the Board directs and may exercise its powers under this section without a hearing.

**(3)** The Board may –

**(a)** approve or disapprove of any act proposed to be done by the guardian; and

**(b)** give such advice or direction as it considers appropriate; and

**(c)** vary the guardianship order or make any other order that it could have made on the original application.

**(4)** The Board of its own motion may direct, or offer advice to, a guardian in respect of any matter.

**(5)** A guardian who contravenes a direction given to him or her under this section is guilty of an offence and is liable on summary conviction to a fine not exceeding 20 penalty units.