

Detention of people with dementia in secure facilities in State care in Tasmania

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Liberty is universally and fundamentally valued by human beings. We value our own liberty and the liberty of others. Australians collectively value freedom for strangers in our country and in foreign countries, particularly where there is a concern that the detention is either contrary to legal principles or that the conditions of the detention are inappropriate.¹ Human concern for the physical and spirit crushing mental effects of captivity is both ancient and modern.² Such is our recognition of the cruelty of captivity, that we extend our concern to our livestock, even when they are destined for slaughter³.

Society also recognises that some people sometimes require removal of their liberty either for the good of society or the good of the individual. Hence the legal system establishes processes for the sanction and restriction of the use of detention. Liberty can only be lawfully removed by order of a Court or tribunal (for instance remanded or sentenced prisoners, asylum seekers, mental health orders) or with the consent of a duly appointed guardian.⁴ Subject to the operation of mental health and guardianship laws, an adult's right to liberty applies no differently to an adult with a mental illness or an adult with dementia than to a person without a disability.

Provision of care for a person with dementia within a "secure setting" is relatively common in Australian Residential Aged Care Facilities, meaning the resident is detained in a limited geographical area for their safety or the safety of others or, in other words, their liberty is denied. In very few cases, such restriction may have been approved by a guardian duly appointed in accordance with State and Territory guardianship or under mental health laws. Mostly a guardian is only appointed for a person who is non-complaint and incapable. It is the detention of compliant but incapable persons that has attracted recent debate because it is rare for there to be an application for a guardian in those circumstances.

More often, an elderly person with dementia is detained in a secure setting, either against their will or without their informed or active consent, because their medical team and their family members have agreed that without these arbitrary restrictions on the person's liberty, they may come to some harm due to a tendency to 'wander' or other behaviours negatively associated with dementia. Entry and exit from secure settings is controlled by the Facility, meaning a resident cannot leave without permission. If residents with dementia attempted to leave such settings they would be restrained. In such cases, it is often assumed that the person's dementia makes them incapable of

¹ Consider the collective interest in the detentions of Nelson Mandela, Aung Sang Suu Kyi, Schappelle Corby, Chen Guangcheng, debate about asylum seekers and the raison d'être of Amnesty International

² Consider Psalm 137, report of the Royal Commission into Aboriginal Deaths in Custody

³ Consider the push towards free range chicken, eggs, beef and pork and the concern about the export of live cattle to Indonesia

⁴ A duly appointed guardian means a guardian appointed by a court or tribunal or a guardian appointed under an enduring guardianship. It does not include a 'person responsible' or a self-nominated party with an interest in the resident's wellbeing.

feeling the negative mental or physical effects of being detained or that such negative effects are outweighed by the benefits. Perhaps it is because of this assumption that the arbitrary restrictions on the liberty of elderly persons with dementia do not attract the collective concern that one might expect. But such assumptions may well be false.

Apart from a Court, Tribunal or a duly appointed guardian, no person has the ability to agree to detention on behalf of another adult. Therefore, adult children of elderly persons with dementia have no authority to consent on their behalf to detention in a secure facility, even though their consent is frequently sought and recorded by Residential Aged Care Facilities as faux authority to admit a resident to a secure facility or a secure part of a facility. Thus, unless the detention has been approved by a court, tribunal or a guardian, a facility detaining an adult with dementia is potentially unlawfully depriving that person of his or her liberty.

Because of the importance of human liberty, the deprivation of a person's liberty without lawful authority is an assault under criminal law⁵ and in civil law⁶. A deprivation of liberty can occur even where a person is not detained in a confined space.⁷ Furthermore, for a deprivation of liberty to be established, there need only be established that there exists no reasonable means of escape.⁸

As with all assaults, it is usually a defence to a charge of deprivation of liberty that such an act took place with the consent of the complainant/plaintiff.⁹ Where a person lacks capacity to understand the circumstances of their deprivation of liberty because of a disability, such as dementia, it is not a defence to say that the person consented, as the quality of their consent is impaired. Similarly, acquiescence of a person without capacity to understand what they are acquiescing to is also no defence.

In some circumstances, a Residential Aged Care Facility might have a defence to a charge or claim of unlawful detention out of necessity¹⁰. Such necessity may be related to the treatment of patients, including action taken in order to save the patient's life, or to ensure improvement to, or prevent deterioration in, the patient's physical or mental health. Until now, Australian Aged Care facilities have relied upon the possible but uncertain common law defence of necessity. The application of that defence may now be watered down by the effects of ratifying the United Nations *Convention on the Rights of Persons with Disabilities* (UNCRPD).

Australia ratified the United Nations *Convention on the Rights of Persons with Disabilities* (UNCRPD) on 17 July 2008 and the treaty entered into force, internationally, on 16 August 2008. Australia has

⁵ *Criminal Code Act 1924* Section 182 Definition of assault "(1) An assault is ... the act of depriving another of his liberty."

⁶ Meaning a person can issue a writ for damages suffered as a result of the detention.

⁷ See for example *Gold v Healco Services (Vic) Pty Ltd*, unreported, Supreme Court of Victoria, No 713 of 1983, 15 April 1988.

⁸ *R v Macquarie* (1875) 13 SCR (NSW) 264; *Burton v Davies* [1953] QSR 26 per Townley J.

⁹ See again, section 182 *Criminal Code Act*

¹⁰ *In re F (Mental Patient: Sterilisation)* (H.L.(E.)) [1990] 2 A.C. 1 at 73-74

since ratified the Optional Protocol, meaning that enforcement measures with respect to the Convention apply in Australia. As with any international Instrument, a litigant would have to exhaust all domestic remedies before using those enforcement measures – meaning that they would be required to pursue criminal and civil actions in Australia before resorting to the United Nations procedures for a determination. However, the Convention becomes an interpretive tool for courts and tribunals in relevant areas of law and will be applicable to the care of persons with dementia as dementia clearly falls within the definition of a ‘disability’. As a result of the ratification of that treaty, detention of people in Aged Care in Australia most likely now falls into what has been termed the “*Bournewood* gap” discussed below. This is the term frequently coined to refer to the lack of sources of lawful authority for the detention of submissive but incapable residents in care.

Article 14 of the Convention requires that people with disabilities are:

“... not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that **the existence of a disability shall in no case justify a deprivation of liberty.**” (Emphasis added.)

Article 14 requires that if persons with disabilities are deprived of their liberty through any process, other human rights protections will also apply. Similarly, Article 12 requires that where a person’s legal capacity, especially their ability to make independent decisions, is supported (for instance by the appointment of a guardian, or under a mental health scheme) such measures:

“... respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person’s circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body.”

Bournewood relates to a series of decisions culminating in two conflicting decisions by the House of Lords and the European Court of Human Rights about the detention of a compliant but incapable patient. The House of Lords applied common law defence of necessity to the deprivation of liberty of the person. The House of Lords determined that that the informal admission to a psychiatric hospital of a compliant but incapacitated adult was not false detention because of a distinction between *actual* and *potential* restraint¹¹. However, the European Court of Human Rights did not reach the same conclusion. When examining the same case, the European Court of Human Rights in *H.L. v the United Kingdom*¹² found that the informal admission was in contravention of Article 5 of the European Convention on Human Rights (which is similar to Article 14 of the UNCRPD mentioned above) and that the distinction between actual and potential restraint was immaterial to that Convention. As the provisions in the European Convention and the UNCRPD are similar, Australian Residential Aged Care practices examined in light of the UNCRPD are likely to be judged the same way. In other words, the interpretation of the Convention is unlikely to be swayed by traditional common law defences. Of particular interest is the fact that the House of Lords took into account the ‘floodgates’ argument relating to the large number of people in secure care and the

¹¹ *L, In re* [1998] UKHL 24; [1999] AC 458

¹² 45508/99 [2004] ECHR 720

administrative burden of meeting the 'gap' in lawful authority for their detention. The European Court of Human Rights gave no such concession.

Despite all of the above, Residential Aged Care Facilities continue to systematically detain people with dementia without clear authority to do so and in circumstances where the establishment of a requirement to do so under their duty of care might be questionable, or in other words, in circumstances where the defence of necessity to a charge or claim of unlawful detention might not exist or, at best, be limited. It seems that most facilities are prepared to 'risk it' that no-one will bring criminal or civil proceedings in relation to unlawful detention.

The Roy Fagan Centre has adopted an approach of seeking the appointment of a guardian or a mental health treatment order for all residents to that facility. The Roy Fagan Centre is in a different position to other Aged Care providers because it is a State Government run facility. As such, it has a responsibility to be a model to other providers and has fewer resource or knowledge based excuses for not complying with the law.

The practice at the Roy Fagan Centre reflects national, if not world's, best practice because it (a) recognises the residents as being 'subjects of rights' rather than 'objects of care', (b) provides a clear source of lawful authority for the detention of all residents, (c) gives an opportunity for external scrutiny of the decision to detain, (d) gives the resident and their families and friends an opportunity to attend a hearing to put their perspective regarding the detention and (e) sets in place an automatic system for review and monitoring by an external person or agency regarding the ongoing detention of people with dementia. In other words, it does not take advantage of the residents' lack of understanding of their detention and it does not 'take the risk' that no-one will complain.

The practice of the Roy Fagan Centre is highly consistent with criminal, civil and human rights laws. However, this practice has been criticised by the Public Guardian as being a: "colossal waste of our collective time to spend so much time writing reports, attending hearings, writing further reports, having orders made, reviewed and revoked".¹³

Under the *Guardianship and Administration Act 1995*, in addition to a general duty to perform her functions "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", the Public Guardian is charged with the specific function: 'to promote, speak for and protect the rights and interests of [persons with a disability]'.¹⁴ But she does not have a statutory role in reducing the administrative burden of care providers. While there is no doubt an administrative burden in affording people their human rights, is that a reason not to take the human rights and liberty of incapacitated persons into consideration?

The Public Guardian has also suggested that:

"The simplest thing to do would be to amend the Guardianship legislation to have a person responsible consent to a person's accommodation, in exactly the same way that they can currently consent to medical treatment on their behalf. NSW has done this, so we have an

¹³ Email by Public Guardian, Lisa Warner, to "Everyone", 1 June 2012

¹⁴ Section 15(1)(d) of the *Guardianship and Administration Act 1995*

Australian precedent (plus their legislation is very much like ours). It would be good to meet up to plan a strategy around this, and develop a submission which can go to both the Health Minister and Attorney General, so that there are two informed champions when the submission goes to cabinet.”

The writer has examined the *Guardianship Act 1987* (NSW) and consulted with the President of the NSW Guardianship Tribunal and has concluded that the above statement does not reflect NSW law.

This exact situation was considered at length by the Victorian Law Reform Commission in its recent report into Victoria’s guardianship laws¹⁵. It was clear from their consideration that merely extending the authority of a person responsible is insufficient to meet the requirements of the United Nations *Convention on the Rights of Persons with Disabilities*. The Commission listed these cogent reasons for strong community concern:

- Medical treatment decisions currently made under the person responsible scheme are governed by medical professional norms, whereas accommodation decisions may not be.
- Medical treatment decisions currently made under the person responsible scheme are generally discrete short-term decisions, whereas accommodation decisions may involve ongoing responsibility for decisions.
- Medical treatment decisions currently made under the person responsible scheme are generally focused on a single issue, whereas decisions about a person’s accommodation may involve multiple factors leading to insufficient focus on considerations about limitations on freedom.
- The person responsible may not be the most appropriate person to make this decision and automatic appointments may inappropriately prioritise some family relationships over others.
- There is potential for a conflict of interest between the person responsible and the person to whom the decision relates.
- It is inappropriate to give decisions that are currently made informally, and have the potential to compromise the rights of a person with a disability, elevated legal status.¹⁶

The Commission has recommended a legislative ‘collaborative authorisation process’ which is supported by safeguards set up in the Office of Public Advocate (equivalent of the Tasmanian Public Guardian) and the Victorian Civil and Administrative Tribunal (equivalent of the Tasmanian Guardianship and Administration Board). That process, if adopted in Tasmania, would still require a significant administrative burden on the Public Guardian, persons in charge of facilities, medical practitioners and health decision makers both in the original decision and in monitoring and reviewing decisions periodically. It is not guaranteed that the Commission’s suggestion would be

¹⁵ Victorian Law Reform Commission *Guardianship Final Report 24* Chapter 15 pages 318 - 348.

¹⁶ Ibid at page 335

sufficient to meet the requirements of the Convention for the protection of the liberty of person with disabilities.

It has also been asserted that the writer has said that “all people without capacity who are admitted to any bed in the Roy Fagan Centre need to be under Guardianship or the Mental Health Act”. What I have said is that it is a matter of policy for the Department of Health and Human Services to decide whether they run the gauntlet of a possible criminal, civil or human rights claim that they have deprived a person with dementia of their liberty and that there may or may not be defences to such a claim. Neither the writer nor the Guardianship and Administration Board have any authority to *require* that agencies apply for guardianship on behalf of incapacitated residents. However, I have said that the practice of the Roy Fagan Centre has been exemplary and a model to the rest of the community. If it is considered only an administrative luxury to observe the human rights of residents with dementia and to protect their liberty, then that practice may change.

Relying on the advice of the Public Guardian, the development of the draft *Royal Hobart Hospital Clinical Protocol on the Transfer and Care for Adult Patients Who do not Have Capacity to Consent* sets up a dichotomy between (i) a patient who is assessed as not having capacity to consent to transfer but is agreeable to transfer to the Roy Fagan Centre (in other words compliant but incapable) and (ii) patient who does not have capacity to consent and is agitated, opposed to transfer, or requiring physical/chemical restraint (in other words non-compliant and incapable). The word ‘transfer’ appears to be a euphemism for ‘transfer and detention’. The compliant but incapable patient will be ‘transferred’ on the agreement of the patient and the ‘person responsible’. The non-compliant and incapable patient will require the appointment of a guardian.

The draft Clinical Protocol returns to the practice of only applying for a guardian where the patient expresses objection and relying upon false authority of an incapable person and an unauthorised person for the detention of those who do not express objection. For the reasons expressed above, this draft protocol does not meet human rights standards and does not afford adequate protection for the liberty of people with disabilities. The more appropriate course is to retain the current practice of ensuring that all residents are either the subject of an enduring guardian, a guardianship order or a mental health order to protect their rights and to ensure that their detention is lawful.