ADMISSION INTO AND TREATMENT IN RESIDENTIAL CARE FOR PEOPLE WITHOUT LEGAL CAPACITY:

The Legal Framework

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Admission into and treatment in residential care for people without legal capacity: the legal framework.

EXECUTIVE SUMMARY
This paper aims to promote discussion about the legal protections available for people who need medium to long-term residential care, but who lack legal capacity (whether partial or total) and are not able to consent to this care. Many of these people are elderly and are suffering from one of the many forms of dementia. A proportion of them require admission, care and treatment in a secure facility, to ensure their own safety and possibly also the safety of other residents. The paper reviews the current legal options for authorising the admission of these people into a residential care facility and provides for their on-going treatment in the facility, when they cannot themselves consent to that care.

The paper reviews both those who require detention in a secure care facility due to the behavioural complications of their underlying disorder, as well as those who can be cared for in “open” residential care facilities. However, the distinction between groups is blurred due to the evolution of a person’s illness and behaviour, but also due to a UK Court decision finding that residential care for those without legal capacity even in open facilities can be seen as a deprivation of their liberty.

The background to the discussion, including international treaties, common law principles and specific legislations is reviewed. Important amongst these are the New Zealand Bill of Rights Act 1990 (NZBORA) and the United Nations Convention on the Rights of Persons with Disabilities (2007) (CRPD). Also discussed is the Habeas Corpus Act 2001.

An ideal framework is proposed, by which the relevant legislation might be judged.

The specific pieces of legislation which might be used to authorise admission and treatment into residential care are reviewed. This includes:

1. The Mental Health (Compulsory Assessment and Treatment) Act 1992. This authorises the detention and treatment of those suffering from Mental Disorder, as defined in the legislation. It can be used as a means of authorising short-term admission and care in a residential facility, but only for a maximum period of six months. It cannot authorise the funding for this care (by accessing the person’s finances or assets), and cannot be used for treatment of physical health disorders unrelated to the Mental Disorder.
2. The Protection of Personal and Property Rights Act 1988 (PPPR Act). This legislation provides authorities for both the care and treatment of a person in residential care, as well as the financing of this. The forms of authority are various, including Enduring Powers of Attorney (EPOA) and Court appointed Personal Orders. The PPPR Act is most useful in this situation, but suffers from being cumbersome, time-consuming and expensive. It is also inconsistent with the CRPD, in that it facilitates substituted decision-making rather than fostering the autonomy of the person with disability.
3. The Code of Health and Disability Consumers Services Rights (1996). Right 7(4) of the “Code” authorises clinical staff to provide care for a person lacking competence, if they are acting in the person’s best interests and have attempted to ascertain the views of the person or their supporters. It can be viewed as codifying the doctrine of Necessity, a common law principle. But, as it is written, Right 7(4) appears to offer authority for most forms of treatment for people without legal capacity. However, its role in authorising medium- to long-term care
for people in residential care is untested. It is agreed by commentators that it is unsafe to rely on Right 7(4) to authorise such care, where that care is disputed by the family or there is no family. It is also viewed as unwise to use this for detaining people without capacity in secure facilities. Right 7(4) has no procedural requirements and little protection for the person. There is no approved documentation, and no external independent body providing approval for the actions taken by the clinicians on the person’s behalf. Right 7(4) does not authorise the funding of care.

My view is that the PPPR Act should be employed to authorise the care of all people who lack legal capacity and who are admitted into medium- to long-term residential care. This is most easily achieved if the person has previously donated EPOAs which can be activated by health professionals. However, where these have not been made, Court orders will need to be sought. This is viewed as essential in those people being admitted into secure facilities, but my opinion is that even those in open-door facilities who are lacking legal capacity, should be under the same authorities due to the effective deprivation of their liberty. If orders need to be obtained from the court, it is likely to take three or more months for this to occur. Practical considerations dictate that admission and care in residential care can proceed, once the applications are made to the court, under the authority of either the Mental Health Act or Right 7(4) of the Code. However, the Mental Health Act cannot authorise long-term care, and is not suitable for providing authority for any interventions for the person’s physical health needs, nor for approving the financial arrangements. Right 7(4) can be used short-term, but it is my view that it should not be used in the medium- or long-term, because it lacks due process, representation, oversight or appeal to any independent body such as a Court. Nor does it provide for organising the funding of the person’s care.

There is a discussion of who should be responsible for organising the authorities to allow for admission and care of a person in a residential facility. Often families are not willing to make applications to the Court for authorities to allow for admission and care of the person lacking capacity or there is no family. In these situations, responsibility for applying for orders often falls onto the shoulders of the DHB clinical staff, either for practical reasons or because they have the necessary skills and resources to undertake this.

A number of other recommendations are made in the paper, such as:

1. That Welfare Guardians should be preferred to section 10 Personal Orders.
2. That a section 10 placement order should be always supplemented by a treatment order.
3. That Public Guardians should be created to act on behalf of those who have no family.
4. That efforts are made to increase the numbers of people who have donated EPOAs.
5. Right 7(4) should be made more explicit in its operation and application, including specific documentation.

It is hoped that this paper will contribute to the wide-ranging and important discussion around the care of those who lack legal capacity, whether due to dementia or some other disorder. This discussion may lead to some consistency in the way that the existing legislation is applied in respect of this population. Moreover, it may also contribute to the review of those Acts, so that they work better for those who lack capacity and their families, as well as for health and disability staff who provide the care.
Admission into and treatment in residential care for people without legal capacity: the legal framework.

1. INTRODUCTION

This paper aims to promote discussion about the legal protections available for people who need medium to long-term residential care, but who lack legal capacity (whether partial or total) and are not able to consent to this care. Many of these people are elderly and are suffering from one of the many forms of dementia. A proportion of them require admission, care and treatment in a secure facility, to ensure their own safety and possibly also the safety of other residents. The paper reviews the current legal options for authorising the admission of these people into a residential care facility and provides for their on-going treatment in the facility, when they cannot themselves consent to that care.

People with preserved legal capacity will make decisions about entry into residential care and on-going treatment on their own behalf, in keeping with the principles of autonomy and self-determination. As part of this decision, they will be able to organise their financial matters in order to fund that care, whether that be through signing over their Superannuation, making their investments available or selling their house. They are then able to make their own decisions about the issues that come up during their time in residential care, such as medication changes, hospital admissions or a change in their level of care (which may require a move to another facility).

People with cognitive disability who lack legal capacity, are not able to safely make decisions without external assistance. This assistance may take the form of support or guidance, perhaps from a trusted family member, where the person still has some ability to participate in the decision. However, for those more profoundly impaired, the support they receive is more often substituted or proxy decision-making, ideally by someone that they trust, who knows their wishes and who has been nominated before they became disabled.

This paper looks at the various forms of legal authority that can authorise these forms of supported or substituted decision-making, permitting the person’s admission into residential care, and their subsequent treatments. The paper focusses on the medium- to long-term care of the person. It is not primarily concerned with the authorities that allow treatments of people without legal capacity in acute or emergency situations, as these authorities are more clearly defined in legislation and common law.

There is concern that there are numerous people, who lack legal capacity, and who are being looked after in permanent residential care, and for whom no formal legal authority has ever been established. Some of these people were admitted into care, often from the local hospital, without having consented to this, and with no formal orders having been obtained. Other people, may have consented to residential care at the point of admission, but have lost their legal capacity in the interim, due to progression of their dementia or some other medical cause. However, the care facility may not have clearly established formal authority for their ongoing care, now that they are no longer able to consent. Some of this population may be passively assenting to the care and to their placement, but this should not be confused with the consent of someone with intact legal capacity. All too often, when interviewed, these people have minimal awareness of their disabilities, cannot explain why they were “required” to leave their home and enter residential care and
frequently cannot even identify the place in which they are now residing. That is, their assent to care is meaningless.

In the United Kingdom there has been considerable discussion about the legal safeguards for this group, those lacking legal capacity who are being cared for in health and disability settings, but are passively assenting to their care. There was recognition, following a judgement in the European Court of Human Rights, that this group lacked appropriate legal protections under UK law. This lack of protection has been labelled the “Bournewood gap” after the mental health trust in which the young man in the case was detained.¹ ²

This discussion is even more relevant for that group, who have been or are about to be admitted into secure forms of dementia residential care for their ongoing treatment. This group is undeniably detained by the facility, and are in these forms of care because of the behavioural challenges they pose for their carers. Some require a secure environment because of the risk that they will wander away and come to harm. However, others may require some degree of physical restraint, in order to provide them with ordinary personal cares, and they can be aggressive towards clinical staff or other residents. Most, if not all, are not able to consent to their admission or ongoing care, as they lack legal capacity with respect to their care and welfare. This group, in particular, requires a robust legal authority for their admission and care, including their detention and restraint.

Throughout this discussion, it needs to be remembered that many people with dementia are amongst the most vulnerable of adults. People with moderate to severe dementia will almost certainly lack legal capacity for most decisions. Should they disagree with, or take offence at the actions taken by other people, supposedly in their best interests, they have little ability to take any steps to redress this. They frequently would not be able to make a formal complaint, seek outside assistance or legal advice, or even effectively seek help from their family. As a result, they readily become victims of abuse, including sometimes from those appointed to serve their interests.

This paper is also prompted by an awareness that neighbouring DHBs and clinical services are interpreting the law differently, and therefore using different forms of legal authority to justify medium- or long-term admission into residential care. On occasion this has led to dispute, with one District Health Board (DHB) wanting to admit a person into a residential facility in another area, and the receiving DHB refusing to accept the ongoing care of the person because of their perception that there was no legal authority for that care.

For those people with dementia (usually mild) who may have retained some degree of legal capacity or understanding, such that they might be said to have partial legal capacity, the issues are similar. However, it can be expected that in time, their dementia will progress and thinking and reasoning will have deteriorated to the extent that they will not be able to contribute to decision-making to any great extent.

My intention was to promote discussion amongst the DHBs in the hope that the approach can be reconciled between different DHBs. For the DHBs, this is mostly in relation to the admission of people who lack capacity into residential care, mostly from the public hospital. Public hospitals are under pressure to discharge people quickly in order to cope with the demand for beds, and therefore look to legal mechanisms to approve the admission into residential care that are quick and easy to process.

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However, in the process of being written, my focus has broadened to consider the issue of whether the larger group of people living in residential care, have appropriate legal protections where they lack capacity to make decisions on their own behalf.

A major issue confronting health services is that most people with dementia, often inpatients, have made no legal provision for the possibility of losing their legal capacity, and have not donated an Enduring Power of Attorney (EPOA). They have not identified someone who can act as their Attorney, and, once this EPOA is activated due to their loss of legal capacity, who can make help to make decisions that will protect their best interests. Consequently, the health services are increasingly confronted with people who lack capacity, need residential care or some other form of treatment, but there is neither an Attorney nor any court order that can authorise these on the person’s behalf.

The discussion is also relevant for the residential care providers, who, once the person is admitted, are responsible for the person’s care and their detention. It is critical that these providers protect their clinical staff, and their organisation, by ensuring that there is legal justification for the care and detention of every person who is lacking legal capacity. There appears to be a huge variation between different providers in their awareness and attention to these issues. Depending on the ultimate consensus regarding the minimum necessary legal authorities for caring for those without capacity, some residential care providers may be vulnerable to being accused of illegal detention for a proportion of their residents.

I aim to review the relevant legislative framework and international treaty obligations surrounding human rights and detention as they relate to people who lack legal capacity to consent to their residential care. It is hoped that the concluding recommendations balance the protection of patients through a robust legal framework and the practical challenges of placing patients into residential care promptly, once this is deemed to be in their best interests.

While this paper is primarily about people with a diagnosis of dementia for whom residential care is proposed, the same principles apply to those lacking legal capacity for other reasons – for example, severe mental illness, intellectual disability and non-progressive cognitive issues such as stroke or traumatic brain injury - and these discussions will equally have relevance to the sectors that provide residential and other care for these groups of people.

It hardly needs to be stated that this problem will escalate over the next few decades, with the numbers of people with dementia likely to triple in NZ by 2050. It is also a pressing problem for DHBs, where large numbers of medical ward inpatients (40%) are found to lack legal capacity. For some, this situation is temporary, with their capacity returning upon treatment of their medical problem. However, many have persisting or permanent problems.

It can be noted at this point, that many clinicians are uncomfortable with assessing capacity and are not overly familiar with the different forms of legislation. It is rare to find a formal assessment of capacity in a person’s clinical file or specific reference to any legal authority, even where clinicians have proceeded to provide care for a person who cannot consent to that care. Even when there is an appeal to the “duty of care” that each clinician has in respect of the person, it is rare to see an actual statement about the person’s legal capacity.

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This paper is written by a clinician and from that perspective. However, I am grateful for the advice and comments from Brigid Mills, Legal advisor, CMH, Andrew Finnie, Barrister, Alison Douglass, Barrister and Adjunct Senior Lecturer, University of Otago,5 and Janet Anderson-Bidois, Chief Legal Advisor, Human Rights Commission. I would also like to thank colleagues Drs Richard Worrall, Chris Perkins, John Scott and Sue Nightingale.

2. THE CLINICAL SCENARIOS
The First Scenario
Mrs A is a 78-year-old European woman who is brought to the hospital after her neighbours found her having fallen over outside her house. She is treated for delirium secondary to infection, but during the course of admission it becomes clear that she has an underlying dementia of at least moderate degree. In the medical ward she is agitated, wanders and resists care. On one occasion she flees the ward, apparently concerned that she was in imminent danger. She is subsequently admitted to the psychogeriatric inpatient unit under the Mental Health Act (MHA). Her diagnosis is delirium superimposed on underlying moderate dementia.

Mrs A settles on the ward, but remains at risk of falls and wandering. A visit by staff to her home reveals stockpiled prescribed medication and that she has been incapable of looking after herself or the house. Mrs A has little real appreciation of her mental and physical problems and the risks associated with returning home; that is, she lacks legal capacity to decide where she lives. Nonetheless, she is asking to be discharged home and does not want care provided into her home.

Her family, from another town, attend a family meeting on the inpatient unit and agree that residential care, most likely in a Dementia Care facility, will be necessary after discharge from the hospital. There is no Enduring Power of Attorney.

The inpatient team regard Mrs A as being ready for discharge and have identified a suitable facility, visited and approved by the family. The facility requires that Mrs A be under some legal order, as she will be detained and cannot give consent to the admission. They are also concerned as to how the costs of her care are going to be paid, and who will organise this. The family undertake to make an application for court orders under the Protection of Personal and Property Rights Act (1988) (PPPR) to facilitate Mrs A moving into care. However, after two weeks, they have seemingly not taken any action, possibly deterred by the cost of the application ($2000-$5000).

The hospital is therefore confronted with having to seek and progress the application for court orders, and to bear the costs of this process. Due to pressure on beds and the lengthy delays before any court hearing, the hospital looks to using other legislation to effect the admission into secure care, in the hope that the facility (and family) will be happy with the interim arrangement.

- On what legal basis can Mrs A be discharged from the hospital into care?
- Who should take responsibility for organising the legal authorities?

5 Alison Douglass is the recipient of the New Zealand Law Foundation 2014 international research fellowship. She has undertaken a legal research project on the mental capacity law, including the introduction of deprivation of liberty safeguards under the Mental Capacity Act 2005 (England and Wales), and will be publishing a report with recommendations on how New Zealand could its update the law and practice in this area: A Douglass, “Mental Capacity: Updating New Zealand’s Law and Practice”, 2016, New Zealand law Foundation (in press).
The Second Scenario
Mr B is a 74 year-old widowed Maori man who is admitted to hospital following a left-sided hemiplegic stroke. This is managed in the hospital and he spends four weeks in the rehabilitation ward. Unfortunately, he makes only a modest recovery and continues to have weakness, and needs assistance with his personal cares. He accepts admission into Residential care and is assessed as having capacity to make this decision. His cognition is only mildly affected. He has no family/whānau and there is no Enduring Power of Attorney.

Mr B settles into a local Rest Home well, but continues to have medical issues, including difficult-to-control diabetes and a number of TIAs (mini-strokes).

Three years after admission, Mr B’s personal care needs have increased and it is becoming obvious to the clinical team that his memory and orientation have deteriorated. He is formally assessed by a DHB community geriatric nurse, who finds significant cognitive impairment consistent with dementia. A CT scan shows progression of his vascular disease. He is assessed as now needing Private Hospital care, and needs to be transferred to a new facility. But he is also assessed as no longer being able to meaningfully consent to this move.

- On what legal basis can Mr B be transferred to another residential care facility?
- Who should take responsibility for organising the legal authorities?

3. THE LEGAL FRAMEWORK
Criteria for an ideal legal framework of detention
Below are suggested criteria to evaluate the different legal options for providing people lacking legal capacity with on-going care, which may also include their detention.

1. A recognised and tested legal framework for detention
2. The legal order legitimises the varieties of care being provided
3. The legal process is flexible and responsive to the changing needs of the person
4. The processes are clear, and can be instituted quickly
5. All the person’s needs are met under the same legislation
6. Reviews of the person’s status is a built in requirement
7. Legally mandated right of appeal and other layers of protections, such as independent legal representation, are included in law
8. Legal framework is not onerous or expensive, for either family or health sector.

4. ETHICAL AND LEGAL CONTEXT
This section of the paper summarises the legal and ethical context relevant to the care of those who, due to lack of capacity, are unable to give true informed consent. The specific legislation relating to detention in care is covered in the next section.

New Zealand has layers of legislation, treaty obligations and common law principles that protect the human rights of vulnerable people and ensure the autonomy of all citizens. The most relevant are outlined below.
Autonomy and Liberty
As a democracy, our society is founded on the ethical principle that each citizen is the author of their own destiny, and that each citizen has the right to make decisions on their own behalf. Furthermore, each person is to be protected from external restrictions on their autonomy; that is their personal liberty is protected. The State only allows interference with these principles of liberty and autonomy where it is socially mandated, either for the benefit of the whole of society, or where the person is not able to exercise those principles on their own behalf, due to disability of some form.

The New Zealand Bill of Rights Act 1990
The New Zealand Bill of Rights Act 1990 (NZBORA) outlines the rights and fundamental freedoms to be enjoyed by all New Zealand citizens. It applies to acts done by the government or any person performing a public function, power or duty and thus applies to the publically funded health sector. Sections 4-6 of the NZBORA makes clear that the legislations is not entrenched law, in that it is not supreme over other legislation. However, the Act states that any other legislation must be interpreted in a manner consistent with the NZBORA where possible. It also states that any limits placed on the rights guaranteed within the NZBORA (such as freedom from arbitrary detention) must be justifiable.

The following rights are pertinent to placement of people into care or detention:

1. Section 11 - Freedom to refuse to undergo medical treatment;
2. Section 18 - Freedom of movement;
3. Section 19 - Freedom from discrimination; and
4. Section 22 – Right not to be arbitrarily detained.

Human Rights Act 1993
The Human Rights Act also promotes and protects human rights. Section 21 outlines the forms of unlawful discrimination against which protection should be offered:

Section 21: Prohibited grounds of discrimination

(1) For the purposes of this Act, the prohibited grounds of discrimination are—
   (h) disability, which means—
      (i) physical disability or impairment:
      (ii) physical illness:
      (iii) psychiatric illness:
      (iv) intellectual or psychological disability or impairment:—
      (i) age...

The Human Rights Act mandates that people with intellectual or psychiatric disabilities, and older age (e.g. dementia) are afforded the same rights as any other citizen. The Human Rights Commission promotes and protects human rights in New Zealand. It provides a dispute resolution service to assist parties to resolve complaints of discrimination. If that mediation fails, a complainant may make a claim in the Human Rights Review Tribunal which may make a determination that there has been a breach of the antidiscrimination provisions in the Human Rights Act. A complainant may also go to Court to resolve issues under this legislation.

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United Nations Convention on the Rights of Persons with Disabilities (CRPD)\(^8\)

New Zealand is signatory to this newest international convention relating to human rights, all of which are expressions of the Universal Declaration of Human Rights. The CRPD promotes, protects and ensures the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities (including dementia). The implementation of the CRPD is independently monitored by the Human Rights Commission and the Office of the Ombudsman.\(^9\) New Zealand signed the CRPD in 2007 and ratified it in 2008. Some of the CRPD articles that are particularly relevant to those with dementia are:

- **Article 12** – equal recognition before the law
- **Article 14** – liberty and security
- **Article 15** – freedom from torture or inhuman or degrading treatment or punishment
- **Article 17** – integrity of the person
- **Article 19** – living independently and being included in the community
- **Article 22** – privacy

An important part of the CRPD, in relation to this discussion, is Article 12. In particular, the following right and obligations are listed in the CRPD:

12(2) States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.

12(3) States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity...

The CRPD requires that all people with disability should be supported such that they can exercise their legal capacity in decision-making.\(^10\) This goal of supported decision-making requires that those with disability are given every opportunity and assistance to make choices based on their own will and preferences. This is in contrast to a process where various forms of substituted decision-making are organised for those with disability, which is seen as a paternalistic solution to those with degrees of impairment in their legal capacity. The decisions made with supported decision-making will reflect the person’s preferences and will, whereas those under substituted decision-making are likely to emphasise the person’s best interests.\(^11\)

There are concerns that New Zealand, despite being a signatory to the CRPD, has not honoured its responsibilities under this convention. The various forms of legislation that cover those with impairments in their legal capacity tend to grant substituted forms of decision-making, and there is no real structure or resourcing to ensure that people can be supported in making their own decisions, as far as this is possible.\(^12\)

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\(^9\) These independent mechanisms include monitoring and reporting on the implementation of the CRPD to the United Nations, and advising on legislation, policy and practice affecting those with disabilities.


There is recognition that supported decision-making is not always possible, where the person is markedly impaired and not able to make or communicate any decision, even with support. Not all issues confronting a person are of equal complexity, and therefore a person with cognitive impairments may be able to make some less complex decisions with the support of a guardian or Attorney, whereas others decisions will prove impossible in spite of the same support. In the latter situation, the guardian or Attorney will effectively need to make decisions on behalf of the person, hopefully guided by an understanding of their likely personal preference. However, it can be wondered whether many guardians or Attorneys could meet the obligations to operate in this flexible manner dependent on the level of impairment in the person’s legal capacity. It is likely that for Attorney or guardians to operate in this fashion, they will need to be trained and supported themselves, which has resource implications. It is also recognised that there is a risk that through providing support in decision-making for a person with impaired capacity, that person is rendered vulnerable to undue influence.

In this paper, I have tended to use the language of supported decision-making, but I am aware that for many people with impaired capacity, the experience of is of having their autonomy reduced, rather than enhanced, through legal orders or authorities. And sadly, it is not uncommon for the person to experience neglect or abuse from their Attorney or guardian.13

Illegal Detention and the writ of Habeas Corpus
The NZBORA confirms a person’s right to have the validity of their detention determined without delay by way of a writ of habeas corpus and immediate release if that detention is unlawful: s23(1)(c). This protection derives from English law and is enshrined in the Habeas Corpus Act 2001.

When a detainee applies to the High Court for a writ of habeas corpus, the High Court must hear the application within three days and prioritise it over other court matters. Because there is a presumption of liberty, the State bears the burden of demonstrating the detention is legal. The habeas corpus process is a summary procedure designed for instances where the unlawfulness of detention is clear on the face of the record; where there is a complete absence of legal authority or where there are clear and material defects in a warrant. A habeas hearing therefore focuses on the documents which provide the basis for detention (often referred to as “warrants”).

The habeas procedure is not amenable to cases requiring legal or factual analysis due to the short time frames involved.14 Such matters are better resolved through appeals under the relevant legislation or by way of judicial review of the decision. The Court may decline a habeas application if the incorrect procedure has been used and an appeal or application for judicial review of the decision is more appropriate way of challenging the detention.15

Applications by people detained under the MHA for a writ of habeas corpus involving Auckland and Counties Manukau DHBs have occurred recently. There has also been one local case recently involving a detention under the Protection of Personal and Property Rights Act (PPPR Act). Although the detained patients were ultimately not released, the DHBs were required to demonstrate that the legal process required under the MHA had been followed and there was associated MHA documentation evidencing this legal process. Similarly, for the PPPR Act case. However, the High Court did not closely consider any dispute around the grounds for detention, as this was seen as

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15 Habeas Corpus Act, section 14(1A)(b). This occurred in the case cited above.
being more appropriately handled by the relevant court under the rights of appeal within each piece of legislation.

Any legal framework used to detain people without legal capacity should be able to withstand a challenge under the Habeas Corpus Act. This would require the care provider being able to defend the legality of the detention by showing that correct legal process was followed, and that there was appropriate documentation relating to the grounds for detention.

**Monitoring places of detention**
In addition to the above mechanisms, the HRC and the Ombudsman monitor places of detention under the Crimes of Torture Act, giving effect to New Zealand’s international obligations under the United Nations Optional Protocol to the Convention against Torture (OPCAT). OPCAT establishes regular visits to places of detention such as hospitals and secure facilities to prevent cruel, inhuman or degrading treatment. The most recent report by the HRC highlighted the issue of detention of persons with disability in the estimated 138 locked facilities in New Zealand. The Ombudsman has responsibility for examining and monitoring the treatment of people detained in hospitals and secure facilities and providing yearly reports, while the HRC coordinates the process and liaises with the United Nations. However, these bodies cannot release people from detention through their processes.

**Defining “Detention”**
Detention has usually been interpreted by clinicians to mean secure locked-door facilities, where the person is clearly unable to leave the facility. However, a recent English court decision clarified the definition of what constitutes deprivation of liberty. The court, in the Cheshire West case found that a person could be seen as having been deprived of their liberty if they:

1. Lack the capacity to consent to their care/treatment arrangements, and
2. Are under continuous supervision and control, and
3. Are not free to leave.

The impact of the decision was to highlight that people without legal capacity are deemed to be detained in a much wider range of facilities, across both public and private provider sectors. It also revealed that the presence of locked doors was not integral to the definition of deprivation of liberty. It also suggests that we should be thinking about the issue in terms of the presence or otherwise of a person’s liberty rather than detention per se.

**Protection of vulnerable adults**
Not only does the New Zealand legal and ethical context make it clear that a person is to be accorded with the discussed rights and autonomy, it also makes it clear that vulnerable adults should be protected from neglect, ill-treatment and unlawful detention. The Crimes Act 1961 lists charges that can be brought against those caring or responsible for vulnerable adults, who do not discharge these responsibilities in the manner expected, whether by ill-treatment or through neglect. These charges can be laid against both individual informal carers, as well as those working for residential care providers.

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18 Crimes Act 1961. Sections 151, 195 and 195A.
Furthermore, section 209 of the Crimes Act defines the crime of Kidnapping\(^\text{19}\) as follows:

“...unlawfully takes away or detains a person without his or her consent...,—
(a) with intent to hold him or her for ransom or to service; or
(b) with intent to cause him or her to be confined or imprisoned..."

This suggests that the detention of someone in residential care without legal authority risks criminal proceedings against those holding the confined person. This is highlighted, not because it is a likely legal outcome, but to show the seriousness of such an act against another person. (I have personally had a complaint of kidnapping made to the local police, by a family member of a patient.)

5. THE SPECIFIC LEGISLATION AUTHORIZING CARE AND DETENTION

The Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA)

The MHA allows for the compulsory assessment and treatment of those who meet the criteria for Mental Disorder, as defined below:\(^\text{20}\)

**Mental disorder**, in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it—

(a) poses a serious danger to the health or safety of that person or of others; or
(b) seriously diminishes the capacity of that person to take care of himself or herself; —

Where a person meets the criteria for Mental Disorder, and a Responsible Clinician decides that they need to be treated under its authority, a person can be detained and treated against their wishes. A person detained under the MHA may be either ‘under assessment’, or subject to a ‘Compulsory Treatment Order’ (sections 29 and 30).

Under the MHA, compulsory assessment and treatment may be directed only to the management of a person’s Mental Disorder (s58, 59). In practical terms this means that investigations can be undertaken and medications provided for the disorder, if needed without the person’s consent. It also legitimises the various forms of restraint, including detention, in order to keep the person safe and to ensure that they are receiving the assessment and treatment deemed necessary by the Responsible Clinician. It also allows for the provision of fundamental care needs – the necessities of life – while a person is under care, and not able to consent to these.

A person under the MHA, whether undergoing assessment or under a Compulsory Treatment Order (CTO) has recourse to a number of legal protections, as follows. Specific rights are listed (sections 63A – 75). The person can appeal against their detention while undergoing assessment (s16), and can appeal against a CTO, to the Mental Health Review Tribunal. The person can only be placed under a CTO by the Court, and they are provided with legal representation for the hearings in relation to this. Their legal status and detention is reviewed by District Inspectors, who are independent of the care provider. Furthermore, a person who is under the MHA is required to undergo regular reviews by their Responsible Clinician, to make sure that they still need to be detained under the MHA. As such, there is a clear documentation trail and the use of legally approved forms.

\(^{19}\) Crimes Act 1961. Section 209.

\(^{20}\) Mental Health (Compulsory Assessment and Treatment) Act (1992) s2.
It needs to be noted that the criteria and threshold for detention under the MHA is defined in terms of having symptoms and clinical risk. The Act does not mention legal capacity to consent to treatment, and there is a risk in the legislation that a person could be detained and treated under the Act, and yet have retained their legal capacity to make decisions about their care. There is discussion about changing the Act, such that treatment and detention against a person’s wishes would be contingent on them lacking legal capacity in respect of this decision. There are examples of this sort of legislation operating internationally. However, it does not seem likely that this change will occur in the near future in New Zealand.

A person may be released at any time from the MHA, if they no longer meet the criteria for Mental Disorder, and are therefore deemed to be fit to be released from the MHA. And once a person with dementia is settled in care, there is often no need for Mental Health services to provide on-going care. However, if the MHA has been employed to effect the placement, then Mental Health services will not be able to discharge the person from care. This can be seen as either a layer of protection for the person, or as an unnecessary drain on DHB resources.

The MHA does provide for a greater level of protection for clinical staff who are detaining the person in a facility, who may be using some degree of restraint to provide personal cares or administer medication for mental disorder, as these authorities are described in the legislation. This protection is blurred when the care is being provided by clinical staff who are not employees of the DHB, such as those in ARRC facilities.

The MHA does not allow for the enforced treatment of physical health disorders, if these are not meaningfully linked to their Mental Disorder. Neither does it allow for supported decision-making of the person’s property or financial affairs, even if the person cannot manage these alone while unwell. Consequently, authority for the management of either or both of these will need to come through from another source.

There are also questions about the utility of the MHA in enforcing detention and management of a person with dementia in a residential facility. If the person is currently in a psychiatric hospital or ward, and is under an Inpatient Order, then the Responsible Clinician may place them on leave under Section 31, specifying as a condition of their leave that they reside in the residential home and comply with their mental health treatments. However, after a period of under six months of such leave under section 31, the person with dementia would, if they needed to remain on a CTO, need to be converted to a section 29 Community Treatment Order.

A section 29 Community Treatment Order requires that “the patient attend at the patient’s place of residence, or at some other place specified in the order, for treatment by employees of the specified service, and to accept that treatment.” It is couched in terms of a person coming to a clinic to receive follow-up and treatment, or allowing such to occur in their own home, rather than being a directive for the person to reside in some form of residential care. It has been argued that being in secure residential care, receiving medications and personal cares as needed, are all part of the treatment for the person’s Mental Disorder, and that a Community Treatment Order would be useful in achieving placement for a person. However, the MHA Guidelines make it clear that section 29 orders are not to be used for justifying detention. The guidelines state that “under a Community

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Treatment Order, patients are not detained in a hospital or other place as an inpatient unless section 29(3)(a) has been invoked, and patients cannot be required to live at any particular address.24 Furthermore, a judgement in the Family Court in respect of an application for a CTO, made it clear that detention could not be seen, in of itself, as a treatment for Mental Disorder, unless it was a means to provide some other meaningful treatment for the Mental Disorder such as medication.25

It is also clear that the Community Treatment Order will not provide for supported decision-making for the person, in respect of their physical health needs, or any medical issues that might exist or arise. Additionally, it does not provide a mechanism for making funds available to pay for care; it does not provide for supported decision-making in respect of the person’s financial or property affairs.

The Protection of Personal and Property Rights Act 1988 (PPPR)
The PPPR Act allows for supported or substituted decision-making on behalf of those who no longer have legal capacity, whether from dementia or some other disorder. It therefore offers a means by which a person’s interests can be advanced, through some other person or agency helping to make decisions that reflect the person’s preferences or their best interests. The Act recommends that this assistance allows participation of the person to the extent that they are able to contribute. Therefore, the Act allows for supported decision-making, but in practice the reality is that both Attorneys and Welfare Guardians usually provide substituted decision-making on behalf of the person. The authorities under the Act cover two broad areas, that of Property (the person’s belonging, houses, chattels and finances, including income), and Personal Care and Welfare (referred to as Welfare).

Underpinning the operation of the PPPR Act are the following principles:

- Presumption of competence;
- Least restrictive intervention preferred; and
- Obligation to encourage those subject to an order to develop their capacity to the greatest extent possible.26

The PPPR Act provides two related but separate legal frameworks:

- **Guardianship of adults** through Family Court personal orders such as:
  - Appointment of a Welfare Guardian (WG)
  - Appointment of a Property Manager
  - Section 10 Personal Orders (for example directing that a person live in a particular facility)

- **Enduring powers of attorney**
  - Property (EPOA-P)
  - Personal Care and Welfare (EPOA-CW)

The Enduring Powers of Attorney require that the person (the Donor) has nominated and legally donated this responsibility to another person (the Attorney) at a time when they had capacity to do so. When the donor later becomes legally impaired in respect of their decision-making in either

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24 Ministry of Health (2012) Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992
26 Protection of Personal and Property Rights Act, 1988, ss5 and 8.
Property or Welfare, or both, the EPOAs can be activated by this fact being certified by a Health Practitioner. However, the activation is precipitated by a specific decision to be made or a “significant matter.” The Attorney then takes responsibility for making decisions on behalf of the donor in regard to this matter, in accordance with their (likely) wishes or based upon the principles of what would be in the best interests of the donor. The Attorney must as far as practicable consult with the Donor and support their participation in the decision-making. A deficiency in the Act, is that, where the activation of the EPOA has occurred because of one significant matter, it is not clear that the Attorney has authority in respect of another but different matter. However, it does seem that they do have authority for decisions that need to be made in respect of ordinary day-to-day matters, which are not “significant.”

Where a person with dementia has not made an EPOA for either property or for Welfare, and no longer has the mental capacity to make such an appointment, then a court order needs to be obtained to establish equivalent forms of supported decision-making, usually a Property Manager and a Welfare Guardian. Another situation is where there may have been an EPOA nominated, but that person is unwilling, unable or totally unsuited to this role. Again, in this situation, it is necessary to make an application for court orders (and it often falls to the health provider to do this). Because of the presumption of competence for all people, evidence needs to be produced for the Court, in order to prove the lack. Unfortunately, obtaining these orders can be time consuming and the legal costs can be high. There is often a wait while clinical staff, unfamiliar with the process, provide the medical certificate or submissions to the Court. It is common for the process to take around three months or more, depending on the caseload of the Family Court. This is further compounded by the cutbacks to Legal Aid funding for such applications. Furthermore, for many people with dementia there is not a family member or friend who is either suitable and/or willing to make the application to the court, or to assume the responsibilities of being the Welfare Guardian.

Where the person without capacity has no family or none suitable, it can be difficult for the Court to identify a person (or agency) to act as the Manager of Property. The Public Trust (or some other trustee corporation) is often approached to take on this role on behalf of the person. However, if the person has little income and few assets or investments, the Trust is often reluctant to take on this role. This frequently proves to be a further obstacle or delay to the process of obtaining suitable orders from the Court. (An alternative property order can be made under s11 of the PPPR Act, but this has a very low threshold in terms of assets and income.)

In order for a Welfare Guardian (WG) to be appointed, the subject person must be “wholly lacking in capacity” with respect to their welfare decisions. For many people with mild or moderate dementia, their legal capacity is more in keeping with partially impaired capacity, so they do not meet the criteria for “wholly lacking” in their capacity to make Welfare decisions. (However, “wholly lacking” is not defined in the legislation, and there is no clear description of the difference between “wholly” and “partly”.)

Therefore, in those situations where the person with dementia is not “wholly lacking” capacity, or there is no suitable person to undertake the role of WG, the court needs to make a different sort of

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27 An EPOA for property may have immediate effect if so stipulated by the Donor, or may take effect when the Donor becomes mentally incapable: s97(4) PPPR Act 1998.
31 Protection of Personal and Property Rights Act, 1988, s11.
order to provide for the person’s needs. Where the person needs to go into residential care, the
court will make a Personal Order under section 10(1)(d), directing the person to reside in a (usually
named) facility. There may also be a parallel order made under section 10(1)(f) directing that the
person be provided with medical treatments in that facility as directed by the medical staff
employed by the facility.

When the Court makes a section 10 Personal Order, it is effectively taking on the role of decision-
maker in respect of the place of residence of the person. But the Court does not assume this role in
an ongoing sense; once the order is made, only a significant change to the person’s situation will
require that this order be reviewed by a court. If a section 10(1)(f) order has been made as well, then
the medical staff are given authority (with the person’s participation to the extent that they are
able) to make decisions on behalf of the person in respect of their medical treatments, including
hospital admission. However, once the person is in hospital, there is no longer any authority under
the personal order, for the investigations or treatments provided. These then have to be provided to
the person, either under the common law doctrine of necessity or Right 7(4) of the Code of Health
and Disability Services Consumers’ Rights (1996). The burden therefore falls on the applicant DHB to
carefully consider which orders it requests from the Court so as to ensure they correspond to the
person’s future needs. In summary, a person who is detained under a section 10 Personal Order has
less support than a person who has either an activated EPOA-for care and welfare (EPOA-CW) or a
WG appointed, and so someone who can make the necessary decisions, together with the person
with dementia, in an ongoing manner.

In addition, section 10 Personal Orders are commonly made for the maximum allowable term of
three years, after which a review by the Family Court is required. While this can be regarded as a
form of protection for the person, in reality three years is a long period of time before review. It is
common for orders to lapse or cease to have effect, partly because the secondary care health
services that sought the orders in the first place, are no longer involved in the care of the person
three years later. If it is felt that an order should be reviewed or extended by the Court, it is also an
issue as to who will organise the new application or pay the lawyers’ fees.

The PPPR Act, has been shown in a number of cases, to authorise actions such as detention or
sedation in order to provide for the person’s best interests or needs. As such, the court orders and
authorities vested in Attorneys or Guardians are able to be enforced. 32

There is increasing criticism of the PPPR Act and suggestions that it needs to be reformed to make it
more user-friendly and responsive to needs. There is also concern that the Act, which primarily
provides a legal mechanism for appointing substituted decision-makers for those lacking legal
capacity, is seen as inconsistent with New Zealand’s treaty obligations under the CPRD treaty. There
is similar criticism of the MHA, which is also seen as being at odds with the same treaty. 33 There is
also concern that both Attorneys and the Courts make determinations on behalf of a person lacking
capacity on the basis of that person’s best interests. 34 This principle may be in conflict with the ideal
of least restrictive intervention, and yet this overarching principle is ignored. 35

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34 PPPR Act 1988, s 98 A(2).
35 Jeffrey. (2008) Incapacity and consent to medical treatments: inconsistencies and uncertainties in the application of the
There is also criticism of the PPPR Act, to the effect that it does not offer a vulnerable person lacking legal capacity sufficient levels of protection. Once a placement order is made by the court, there is no oversight of the person’s care and no one who is checking that what is being provided is in the person’s best interests. Nor that what is provided fulfils the criteria for the least restrictive option. The lawyer for subject person ends their role with the making of the order. The orders are frequently not renewed after three years, leaving the person with no legal authority for their care. Where an Attorney exists, there is no checking that their actions on behalf the person without capacity are benign or well-intentioned. Sadly, many Attorneys are guilty of elder abuse, financial abuse or neglect. There is scope to remove Attorneys through application to the Court, but the subject person is generally not capable of initiating any such action. The same applies where there is an appointed Welfare Guardian. There is no register of EPOAs, and frequently health or other agencies cannot find out whether such exists.

In summary, the PPPR Act does provide for clear legal authority regarding the care for the person without capacity, and the financing of this. However, once those authorities are activated or made in the court, there is little monitoring of the situation, in terms of whether the person’s wishes are being respected or their best interests are being served by those into whose care they have been entrusted.

**Code of Health and Disability Services Consumers’ Rights (1996) (the Code)**

The Code applies to all health and disability services in New Zealand and gives rights to consumers of those services, while placing corresponding obligations on the service providers.

Right 7 of the Code states that all consumers have the right to make an informed choice and give informed consent to all forms of health and disability interventions, such as assessments, treatments, procedures, and to services such as placement into care. Right 7(4) also contemplates decision-making by clinical staff where the person is unable to make an informed choice and give informed consent.

**Right 7 Right to make an informed choice and give informed consent**

1. Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

2. Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent.

3. Where a consumer has diminished competence, that consumer retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence.

4. Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where—

   (a) it is in the best interests of the consumer; and

   (b) reasonable steps have been taken to ascertain the views of the consumer; and

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(c) either,—

(i) if the consumer’s views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would make if he or she were competent; or

(ii) if the consumer’s views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider...

Right 7(4) therefor provides a basis upon which clinicians may approve specific treatments, and even direct admission into residential care, having ascertained that the person is not competent to make decisions on their own behalf, and after appropriate consultation with other suitable persons, most likely family members, about what is in the best interests of the person or what would be consistent with their preferences. Nowhere in the Code does it define competence or best interests. Right 7(4) can be viewed as an exception to the general principle that all health and disability consumers should only receive treatment to which they have given their informed consent. My colleague Dr John Scott also describes Right 7(4) as an exception to Right 7(1). He goes on to say that “to talk of ‘Right 7(4)’ is therefore somewhat Orwellian.”

Initially it seemed that the Code codifies the legal doctrine of necessity, where there is common law approval for action being taken on behalf of a person who is unable to give consent, where the services are necessary to preserve life, health or wellbeing, and doing so is in the best interests of the person. This common law principle derives from English Law but is also held as a doctrine in New Zealand. However, necessity as a doctrine mostly applies to emergency situations, and the defence for providing treatment is often couched in terms of “presumed consent”. (There is some case law which allows the doctrine of necessity as a defence in respect of providing interventions to those with long term incapacity: see Re F (Mental Patient: Sterilisation).) However, as drafted the Code does not specify that the provider can only use Right 7(4) in emergency or life-saving situations, and therefore the derived authority could be used in a much wider range of situations. Nonetheless, there is considerable debate as to the extent of the powers conferred under Right 7(4), in respect of medium to long-term treatment for those who lack legal capacity. There is no formal guidance in the publications of the HDC, or in the legislation itself.

Adams and Ifwersen suggest that Right 7(4) can authorise admission to residential care and ongoing treatment of the person without legal capacity, as long as the clinicians can meet the criteria within the Code. Namely, that the services are in the best interests of the person, and the clinician has either ascertained the likely views of the person or taken into account the views of the person’s family or advocates. They do suggest that, where the admission is contested by family or advocates, or where there is no such support for the person (that is, a “non-agreed admission”), an order should be sought authorising the admission under the PPPR Act. They feel that the need for PPPR Act orders is even more relevant for those people going into secure care or detention. Their view is that the DHBs have no professional or legal requirement to seek those PPPR Act orders, but

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38 John Scott, Geriatrician, personal communication.
acknowledge that they may be forced to do so for practical reasons, where the family or other parties will not make the applications. Furthermore, Skegg comments that in providing treatment for those who lack legal capacity, “there is no need to seek court authorisation if the terms of Right 7(4) are met.” However, he goes on to say that “if there is sufficient time and intervention is a controversial one, it will often be appropriate to seek court authorisation. Unless a common law justification is clearly applicable, court authorisation would often be required to avoid the risk of criminal or tortious liability, even where Right 7(4) ensures that there could be no Code liability.”

However, there is also criticism of using Right 7(4) in this manner. Nightingale and Reuvecamp comment that “it is not clear that right 7(4) encompasses situations in which an incompetent person needs to be forcibly restrained or sedated to provide treatment, or whether it covers transportation of a person from one location to another when they resist or are detained against their will. Certainly such interventions are significant and a clear limitation of human rights. One would usually expect, particularly in less urgent situations, that there would be a clearly established foundation for such actions, such as of the kind provided by the MHA.” They go on to say that “the emphasis on autonomy for the competent has not been matched by sufficient regard for the need for due process for those who lack autonomy.”

While Right 7(4) is usually considered to be most applicable to acute and urgent situations, there is no case law that defines the range of situations in which Right 7(4) may be used, and there appears to be nothing to prevent it being applied to a longer-term solution such as admitting someone into residential care, if that is in the person’s best interests, and the other terms of the Code have been met. The previous Director of Proceedings, HDC, Aaron Martin discussed the issue of how long Right 7(4) might be employed for, saying that it could arguably apply over extended periods of time. He went onto say that:

“one possible route through this uncertainty as to how long a consumer may be treated under Right 7(4) may lie in the NZBORA 1990. Section 22 of that Act provides that everyone has the right not to be arbitrarily arrested or detained. Section 11 provides that everyone has the right to refuse to undergo any medical treatment. Whenever an enactment can be given a meaning that is consistent with the rights and freedoms contained in the Bill of Rights, that meaning shall be preferred to any other meaning (s 6). However, recourse to those provisions only takes us so far. Just as clause 3 of the Code provides for reasonable action in the circumstances, the rights and freedoms contained in the Bill of Rights may be subject to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society (s 5).”

He also stated:

“Against this background [the Bournewood case in the UK and deprivation of liberty safeguards] it would be surprising if Right 7(4) provided a legal basis for the provision of treatment and other services on an indefinite basis or for an extended period of time without explicit consent. Given a meaning consistent with the rights and freedoms contained in the

44 Above, at page 11.
The HDC was critical of the detention of a young woman with alcohol-related dementia in a secure residential care in the absence of a placement order.\textsuperscript{46} The woman regained capacity and expressed numerous times her desire to leave for more suitable accommodation. She was detained for over a year in the absence of legal authority and received care which the HDC described as “woefully inadequate”.\textsuperscript{47} The HDC, in finding that the Code had been breached by the agencies involved, held that there were multiple deficiencies in the care provided to her. No one was legally appointed to represent her interests. No one was available to advocate for her. She was detained when there was no legal requirement and that detention was not in accordance with either her wishes or her needs. However, the HDC did not state anywhere in their decision that a PPPR Act order was the required authority for the situation. The facility providing the care to the woman used the defence that care was being provided under the doctrine of necessity (para 239), but that does not appear to have persuaded the HDC. The HDC stated that “at most, (under the doctrine of necessity) it would have been appropriate to treat her for the first few days of her admission, while clarifying the position with regard to the Court order and/or the existence of an enduring power of attorney.” The facility was found in breach, and was also referred to the Director of Proceedings.

In summary, the limits or extent of the authority provided by Right 7(4) remain uncertain, and there is little agreement or clear articulation on those clinical situations in which a PPPR Act order should be preferred. Nonetheless, the previous Director of Proceedings at the HDC did suggest that Right 7(4) should not be used in the medium- to long-term, without explicit consent. By “explicit consent” he meant that the consumer’s wishes had been ascertained. (Clinical experience tells us that very few people lacking capacity, have previously provided explicit consent or an informal advance directive consenting to residential care. Most people dread the prospect of residential care. Consequently, no explicit consent in this regard is likely to be obtained.)

There are obvious deficiencies in using Right 7(4) as legal justification for admission, ongoing care and even detention for someone who lacks legal capacity. Right 7(4) does not require any specific documentation or ongoing reviews of the person. There is no definition of “competence” and there is no evidential process required to demonstrate that the person is lacking in this respect. There is no “due process” or paperwork required when it is relied upon, although there may be some documentation, contained in the Policies and Procedures within each DHB, relating to treatments provided to those who are unable to consent. There is no specific protection for the person with dementia, in the form of an appeal process, representation or independent oversight. There is scope for the person with dementia to make a complaint against the placement, either to the provider or to the HDC, but it needs to be remembered that people with dementia are a particularly vulnerable group and unlikely to have the wherewithal to make any such complaint without support. Right 7(4) also confers decision making authority for the person onto the clinicians or facility providing care, and it is far from clear that this is either desirable or satisfactory. Lastly, any placement under Right 7(4) will not address issues around the person’s financial affairs and how funds will be made available to pay for the care they will be receiving, when it is most likely that they will no longer have capacity to manage these effectively.

\textsuperscript{45} Above, at p 13.
\textsuperscript{46} Opinion 08HDC20957. The DHB had intended to apply for a placement order but due to an internal miscommunication the application was never made.
\textsuperscript{47} Opinion 08HDC20957, at para 220.
6. WHOSE RESPONSIBILITY IS IT TO OBTAIN THE LEGAL AUTHORITY?

Where a person lacks legal capacity, is under the care of the hospital and PPPR orders are being sought from the Court to facilitate admission into residential care, who should take responsibility for obtaining the necessary legal authority for care? The hospital has assessed the person’s capacity and been responsible for leading the discussions and plans for on-going residential care. The person’s family (may) have agreed to the plan for residential care. The care facility will be the provider that will be offering long-term care (and detention.)

In most circumstances it is hoped that the person’s family will take responsibility for arranging any legal orders but it is not clear that they have any legal responsibility to do so. (If the costs of obtaining court orders were to be charged to any party, it would be back to the person themselves. It could be said that the person themselves is the only party who has legal responsibility to arrange the authority, but this is clearly a futile stance in respect of a person without legal capacity.)

It is common enough for the family to be either not helpful (as in the first scenario) or not available (as in the second scenario). Responsibility for seeking orders then sheets back to either the clinical teams in the DHBs or to the care provider themselves. Both share clinical responsibility for obtaining the orders, in that once a clinical (in the broadest sense) problem is identified (the cognitive impairment leading to a lack of capacity), safe solutions need to be found.

The care provider needs to be certain that, if they are providing care and detention for a person without legal capacity, this is going to be authorised under the law. Otherwise they may be found liable if challenged. In the first scenario, this really means that they will decline to accept anyone for admission into their care, until such orders are obtained (or the process is underway.) In the second scenario, where Mr B is being moved from one facility to another, is it therefore going to fall to the Rest Home to organise the authority, because the Private Hospital will otherwise decline the transfer? Or will it inevitably fall to the DHB community staff to organise, as they are more familiar with the process. In practical terms, it is very unlikely that the smaller providers of residential care will have the capacity to make applications to the court for authorities. There is a risk that the provider will solve the problem by sending the person to the hospital for it to be sorted there.

There is also the practical issue for the hospital in the first scenario, where they wish to discharge the person into residential care, and thereby make a bed available in the hospital for another admission. With no other party willing to apply to the court for authorisation, it will fall to the hospital to do this, in order to facilitate discharge and help with overall bed management.

In summary, if families are not able or willing to apply for a court order for the admission of a person into care, it will largely fall to the DHB to do this on behalf of the person. This is frequently done for practical reasons, but it also needs to be acknowledged that the DHBs are much better equipped in terms of staffing and skills to file the application in a timely manner. The residential care providers are, at the present time, ill-prepared to undertake this task. Furthermore, the high costs of seeking Court orders will deter care providers from taking on this responsibility.

7. REFLECTIONS ON THE AVAILABLE LEGISLATION

None of the existing laws are completely suitable for purpose, and none meet all the criteria proposed at the start of this paper.

The MHA and the Code both authorise clinical staff to become the decision-makers on behalf of the person with dementia, but it is unclear that this is an ideal situation for the person or their families.
It could be argued that clinical staff are not suitable decision-makers for a person with dementia, as they have often only had brief contact with the person, and are often conflicted by the pressures such as needing to discharge a person quickly from hospital. Similarly, residential facilities are businesses, and there is the attendant pressure of keeping residential beds occupied, which may influence decision-making by this group of clinical staff.

The authorities conferred under the MHA are largely restricted to the interventions directed at managing the person’s Mental Disorder (which includes dementia), but exclude unrelated but important physical health concerns, the treatment of which must be ancillary to the treatment of the mental health issue for the patient to be detained under the MHA. However, the MHA does not authorise detention unless there is being provided some specific treatment for the mental disorder. Furthermore, the MHA only can justify detention in a specified community facility for a maximum period of six months, under section 31. Following this time, the MHA cannot legitimise detention of a person. The advantages of the MHA are that it provides the greatest protection for the person, in terms of oversight, documentation, opportunities of appeal and regular reviews by both clinicians and judicial bodies. It also specifically allows for the various forms of detention and restraint, and there are clear authorities and protections for clinical staff attempting to provide cares for a person who is resistive. These staff are thereby offered some protection from liability relating to their actions.

The Code, and specifically Right 7(4), provides very little protection for the person, their families or the clinical staff. There are no formal reviews of progress, no documentation required, nor any independent oversight of its use. People being detained are not provided with any legal representation or advocacy, in spite of the removal of their liberty and autonomy. The use of Right 7(4) of the Code for medium-to-long term care solutions, such as secure placement is untested. However, it is not clear that this use of the Code is consistent with NZBORA, when used for long-term secure placements. Relying on the Code is also viewed as unsafe when the person has no family or where the family are in dispute about what is in the person’s best interests. Furthermore, because of the lack of formal process and documentation, it is not clear that detention of a person under the Code would withstand an application to the High Court for a writ under the Habeas Corpus Act. In my view, using Right 7(4) of the Code to deprive people without capacity of their liberty in the medium- to long-term will perpetuate the “Bournewood gap” that already exists in New Zealand.

It is my view, that the use of the Code should be restricted to those situations covered by the doctrine of necessity; that is primarily emergency situations or those where it is not practicable to seek a court-issued formal authority. It is legitimate to use the Code to cover the period while waiting for such orders to be granted, as there is little other source of authority.

In my view, Right 7(4) of the Code seems to have been provided as a defence for clinicians acting in the best interests of a person lacking legal authority, in those situations in which the doctrine of Necessity would apply. This is normally where a person lacking capacity requires urgent treatment, or where some intervention is needed despite no existing authority (and the latter cannot be arranged in a timely manner). It appears (to me) that the use of the Code to authorise longer-term forms of detention and management such as residential care, in lieu of formal court orders, is an unintended consequence of a relatively broadly-worded Right. Simply put, as a piece of legislation, the Code is not fit for the purpose of depriving people of their liberty and rights. At best, it should be employed as a stop-gap measure, while waiting for formal orders to be made by the court, and that

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use would be consistent with the doctrine of Necessity. Its use should be restricted to these situations.

Neither the MHA nor the Code allows for the management of a person’s finances, such that their care might be funded from their savings, property or by diversion of their National Superannuation.

The PPPR Act comes closest to being fit for purpose, especially where there are responsible parties who can support decision-making by the person with dementia, whether through activated EPOAs or appointed by the court (Managers of Property and WGs). All aspects of a person’s care can be supported or consented to by these authorities, and their finances made available to fund care. Furthermore, because such decision-making support is present, the arrangement is responsive to changes in the person’s needs, such as moving to a different level of care or alterations in treatment. However, the actions of the parties supporting the person with dementia, once appointed by order of the court or by activated EPOA, are relatively free from scrutiny, with the possibility of elder abuse occurring without check. (There is scope for removal of an Attorney or Welfare Guardian, if they can be shown to be not capable of filling those responsibilities or have abused that position. However, that requires an application to the Court, with the attendant delays and costs.)

More problematic is the situation where a person is placed into care under a section 10(1)(d) Personal Order, which may specify the facility but without a parallel section 10(1)(f) order providing authority for the management of their medical issues. Furthermore, these orders are inflexible and new orders may be required, if the person’s needs change significantly.

The PPPR Act offers some protections for the person, in terms of receiving legal representation for the making of the orders, and also because the Act specifies the legal obligations of the party to support decision-making by the person. There is also the ability to go back to the court in situations of dispute or concern.

The main disadvantage of the PPPR Act is that it is complex, expensive for families, and the processes are difficult. (Hence, the low rates of people who have nominated their EPOAs in advance of becoming unwell.) It is also time-consuming for clinical staff and expensive for DHBs. When hearings in Court are delayed, patients’ hospital stays are prolonged until orders are made. As such, hospital stays may be hostage to disorganisation in the courts. There are also the mentioned concerns that the PPPR Act does not truly promote supported decision-making. Furthermore, as there is no National register of EPOAs, it can be difficult for clinical teams or residential care facilities to find out whether a person has donated an EPOA.

These reflections on the advantages or flaws of the legislation options have to be seen in the context of the pressures on hospitals to effect discharges efficiently, the inability or reluctance of many families to pay for the legal costs involved, the increasing reluctance of care facilities to accept people who lack capacity for whom there are no legal orders, and the reluctance of health services to commit to long-term follow-up care for people when this is required legally but not clinically.

8. DISCUSSION POINTS
I have divided the points for discussion into those for the two main clinical groups of patients, this division being to some extent artificial. (Particularly since the Cheshire West court case, which highlighted that people who lack legal capacity are deprived of their liberty in ordinary “non-locked” residential care.) However, I hope that these suggestions can be adapted clinically for those patients whose needs may vary in some way.
People with dementia being admitted to secure facilities (the first scenario)

This group, usually those with significant behavioural or psychiatric complications of their dementia, are admitted to secure facilities because of risks such as them absconding from open facilities, or because they need higher levels of nursing input. This nursing input may require physical restraint either to manage periods of agitation or to make sure personal cares can be completed in the face of resistance. Mrs A in the first scenario is an example of this group. Depending on the level of agitation, aggression or resistiveness, patients may have been in a mental health hospital ward prior to their placement, and may have been under the MHA prior to discharge.

This group of patients should all have either activated EPOAs for both property and welfare, or equivalent orders sought from the Court under the PPPR Act. Ideally, these orders would include the appointment of both a Property Manager and a Welfare Guardian; that is there would be identified people providing supported decision-making for the person. However, on occasion it is not possible for the court to appoint a Welfare Guardian, and therefore section 10 Personal Orders directing placement into a facility is made. It is the view of this paper that all patients admitted to secure facilities should have PPPR Act orders or authorities sought and obtained.

The authority for the admission, on-going treatment and detention in the residential facility, while waiting for the Court to make the above orders, can occur through either a MHA section 31 order (if the person is under a section 30 CTO) or by reference to Right 7(4). Most will occur under Right 7(4) of the Code. However, for those patients who require higher levels of physical restraint, or where the placement may be proceeding on a hopeful basis (i.e. there is a risk of failure) it will be best if the intervening period is covered by the MHA. This is so that re-admission can be organised promptly if the placement fails, and also requires that the mental health services are still involved in the person’s care in the early stages of placement. The MHA may also be used in situations where there is significant disagreement within the family, or non-endorsement of the placement by the family. However, neither the MHA nor the Code is ideal in terms of permanent placement, for the reasons described in the previous section and neither of these should be relied on for any extended period.

The MHA, may be continued beyond the making of an order under the PPPR Act, in situations where the patient is receiving IM injections of psychiatric medication or having regular admissions back to hospital. The MHA may also need to be continued where the court makes a Personal Order under section 10(d), which does not include specific treatment approval.

Information provided to the author suggests that the above is the usual practice currently in most DHBs through New Zealand.

In the case of Mrs A, it is my recommendation that orders for a Welfare Guardian and Property Manager under the PPPR Act be sought. (Section 10 personal orders may be required instead of the WG, if there is no one suitable or willing to provide this support.) Mrs A could be discharged into residential care once the applications are filed, under a MHA section 31 leave assuming she is still under the MHA at the point of discharge. However, if she has been released from the MHA, then Right 7(4) of the Code or the doctrine of Necessity can be used as authority for the intervening period until the Court makes the orders sought. In this situation, with the family proving reluctant to apply for the Court order, it is difficult to see who will arrange for the application aside from the DHB.
People with dementia being admitted to non-secure facilities (the second scenario)

This group is able to be cared for in open-door facilities, where there is no risk of them absconding and they do not generally require physical restraint in providing personal cares or medication administration. Mr B in the second scenario is an example of this group. They are often seen as passively consenting to their care. However, many of them lack legal capacity, and, if interviewed, would not be able to say either “what this place is” (where they are living) or why it was no longer possible for them to live in their own homes. Many require daily assistance with personal cares such as toileting, dressing and showering, in a manner that might be regarded as intrusive or intimate. Some will have intermittent periods of agitation and some may develop delirium, which can make them aggressive for a short period. Some will pass through longer periods of agitation and resistiveness as their dementia progresses, and may even ultimately need transfer to a secure facility. Most people with dementia in rest home care will be transferred to a Private Hospital as their illness progresses and they deteriorate mentally and physically.

People with dementia and who lack legal capacity need legal protection of their status and some form of supported decision-making. This is not just because their clinical situation may change at any time, requiring them to be treated, restrained or transferred, but also because passive acceptance of cares by a person lacking decision-making capacity is fundamentally meaningless and legally risky. The person has neither liberty nor autonomy, but without robust legal justification for these rights being removed. Furthermore, the person is potentially without protection and oversight of their care, particularly if they have no family to advocate on their behalf. These legal protections are readily provided, if the person has previously donated EPOAs, which can then be activated. However, for many people, this option is not available and other legal authorities need to be identified.

A lack of formal legal orders also renders the clinical staff the person’ de facto and un-appointed decision-maker, which is unacceptable. This is not to say that many clinical staff will not act in the best interests of the person, but where those clinical staff are employed by a residential care facility, there may be competing business factors influencing decision-making. Where there are family members present, they may not necessarily be in agreement, and may not endorse decisions or plans made by clinical staff. There is no ultimate authority in these situations without the formal appointment of a supporting decision-maker. There is therefore a risk that the care will become arbitrary, unreasonable and unlawful.

As discussed, it is my view that Right 7(4) of the Code is an inappropriate legal basis on which to provide treatment to this group in the medium-to-long term. This is particularly so in view of the uncertain status of this authority in the medium-to-long-term, but also because the Code contains little in way of protection for a group of people who are very vulnerable by virtue of their illness. Therefore, every effort should be made to appoint a Property Manager and a Welfare Guardian for this group if EPOAs do not exist.

It is therefore my recommendation that Mr B have a Welfare Guardian and Property Manager appointed, and that an application to the court for these should be made around the point of transfer to the Private Hospital. I believe that he can be transferred into the Private Hospital according to his care needs, and that the period prior to the legal authorities being obtained can be covered by appeal to either Necessity or to Right 7(4) of the Code. I do not believe that the MHA has any role in this situation. Who will be responsible for organising the application to the court will be driven by practical considerations.
9. FURTHER RECOMMENDATIONS

There are clear deficiencies in the current system of orders and authorities for people with dementia, who lack legal capacity, to ensure that their needs and met and that they have adequate protection under the law. For this reason, the following recommendations are added to the above.

**Welfare Guardian orders to be preferred**

Currently the PPPR Act requires that a person be *wholly lacking in capacity* in order for a Welfare Guardian to be appointed. This has been interpreted relatively rigorously by the clinical staff in preparing reports and making recommendations, and tends to be interpreted as meaning the person has little ability to deal with decision-making in most areas of their life. This means that for those with “partial capacity” or residual islands of capacity, the clinical recommendation has been to seek a section 10 Personal Order rather than a WG. However, Professor Skegg suggests that “wholly lacking” should be interpreted to mean that the person is markedly impaired only in respect of the particular issue currently being examined.\(^{49}\) There is no definition of “wholly lacking in capacity” in the Act, and selection of the threshold between this and having partial capacity appears to come down to clinical judgement.

Given the limited utility and efficacy of a Personal Order in providing for support around a person’s wider needs and anticipated decline, it is suggested that we seek more WGs in for our patients. This would require a conscious lowering of our clinical threshold, such that we would seek a WG if the person had a reasonable level of impairment in their capacity in regards to the decision under examination.

**Combined Personal Orders**

In those situations, where a section 10(d) Personal order is made directing a person to care in an institution, most often a residential home, the authority for their day-to-day management, medications changes, investigations and admissions to hospital appears to default to either the common law doctrine of necessity or to section 7(4) of the Code mostly without ever being stated as such.

It is worth exploring whether a section 10(d) order should always be supplemented by a section 10(f) order directing a specific medical intervention. It should be investigated whether the sorts of day-to-day management of a person’s needs could be covered by a section 10(f) order, but if so, then perhaps we should be making an application for dual orders, such that there is authority for the clinical team looking after the person to provide treatment and change this as required, in an ongoing fashion. That is, the clinical staff would have been identified formally as the care and welfare proxy decision-makers through the section 10(f) order.

**Public Guardians**

Given that Personal Orders do not offer adequate on-going proxy decision-making, and the fact that many people do not have family members or friends suitable to act as their EPOA-CW or WG, the role of a publicly appointed Guardian who can act in this role should be explored. Public Guardians in other jurisdictions allow for a person without legal capacity to have an advocate and substituted or supported decision-maker, if there is not a suitable person in their family.

There are examples of some people doing this informally, such as lawyers. However, it would be preferable to have an established body of professionals, bound by clear rules of conduct, and that these roles are recognised in the law and overseen by an appropriate agency.

It would be my preference that this group also take on a role of monitoring those that are appointed as EPOAs or Welfare Guardians. They could also check on the care being provided to those under section 10 Personal Orders. In this, their role would be similar to that of the District Inspectors under the MHA.

**Enduring Powers of Attorney**

Most people do not have EPOAs before becoming unwell with dementia, and for many, by the time they have received a diagnosis, it is too late for them to make this donation as their legal capacity is already compromised. It is recommended that more be done in our society to ensure that everyone has an EPOA prepared before they become unwell. In fact, it would be ideal if everyone were to be set up with their basic legal package (Will, EPOA and possibly Advance Directive), and that this would be widely available and promoted as a legal service, either pro bono or subsidised in some manner.

**Right 7(4) of the Code**

When a person lacks legal capacity, care and treatment can be provided under Right 7(4) of the Code or under the doctrine of Necessity, as long as the conditions are met. However, it is rare to see any reference to either of these in the clinical records, leaving it unclear as to whether the clinicians are aware of the issues around treating those who lack legal authority. Where a person requires an intervention that requires signed consent, there are forms that can be completed, including the opinion of a second clinician. However, for interventions that do not require signed consent, including medication changes, investigations or admission into care, there is frequently no documentation of the person’s legal capacity or of the authority being relied upon to provide care.

It is my recommendation that some formal documentation be developed where a person lacks capacity, which both records that fact and the interventions being provided under Necessity or Right 7(4) of the Code. In my view, not only should clinical staff show their awareness of these issues by completing such documentation, it would offer the same clinicians protection from any challenge to their actions.

I also believe that Right 7(4) of the Code either needs amending or specific guidelines need to be produced, with the effect of limiting its range of application.

**10. CONCLUSIONS**

It is hoped that this paper will add to the discussion currently taking place within the health and residential care sectors about the legal justifications for looking after those who lack legal capacity in residential care. It is the main conclusion of this paper that authorities under the PPPR Act, either EPOAs or Court orders, are necessary to protect the legal rights of those without capacity, whether they be in secure residential care facilities or in ones that have open doors. I do not believe that Right 7(4) of the Code justifies either sort of deprivation of liberties, except in the short term while PPPR Act orders are being sought.

This review primarily addresses those authorities which exist in current law, and the legal safety of the options available. I have made some comments about improvements to the legislation that I would like to see. And I hope these comments may contribute to the movement looking to improve the PPPR Act which has been the main source of legal authority for this sort of care. It can only be hoped that this legislation might become more easy to use, and consistent with international laws and conventions. However, we look forward to the publication of the review being undertaken by Alison Douglass, which will provide a much more comprehensive analysis of the deficiencies in the existing legislation.