Human Rights in 'Private'

Meredith Wilkie

Sobering up centres in WA: is the state contracting human rights away?

In Western Australia the transfer of intoxicated people from police cells to sobering-up centres is promoted as a key reform to prevent Indigenous deaths in custody. Police cell deaths have dropped dramatically, although not all of this success can be attributed to the few sobering-up centres which have been established to date. No deaths have occurred in sobering-up centres. Most centres are run by community-based management committees contracted to provide health services on behalf of the state. This article argues that the state retains its human rights obligations to these detainees and suggests that a partnership model would better secure those rights than the current contractual arrangement.

WA sobering-up centres

Public drunkenness was decriminalised in WA in April 1990. The *Detention of Drunken Persons Act 1989* (WA) authorises police to apprehend a person found intoxicated in public and to detain the person for as long as that person reasonably appears to be intoxicated. The Act further authorises police to detain an intoxicated person in police custody or to 'release' the person into the care of an approved hospital or health service or of a person who applies for their release. Relevant 'health services' include sobering-up centres which were listed as health services under the *Hospitals and Health Services Act 1927* (WA) in February 1995.

There are now nine sobering-up centres in WA: in Highgate in the Perth metropolitan area; South Hedland, Halls Creek, Fitzroy Crossing, Roebourne, Kununurra and Derby in the State's north; and Kalgoorlie and Wiluna in the centre.[1]

Most centres operate two eight-hour shifts (opening at about 4 p.m. and closing at 7 a.m. or 8 a.m.) on five or six nights each week.[2] While they accept self-referrals and referrals from hospitals, family members and legal representatives among others, priority is supposed to be given to people admitted by police.

A fairly standard approach is taken to each client on admission. The client's belongings are removed, recorded and secured separately. The client is then showered, given clean sleepwear, encouraged to drink some water or cordial to counteract the dehydrating effects of alcohol and put to bed. Clothes are laundered overnight and returned in the morning when clients are required to strip their beds before eating breakfast and leaving.

The centres have been purpose-built. They comprise a central reception area from which staff can monitor movement between dormitories and other parts of the centre. Separate toilet, showering and sleeping facilities are provided for males and females. A small bedroom is generally reserved as an observation room for clients who are unrousable on admission or otherwise require special monitoring.

The majority of centres are staffed by two people on each shift with a manager on call. Bed numbers range between 16 and 22.

Meredith Wilkie teaches law at Murdoch University, WA.

Admission as detention by the state

It is uncontroversial that a person apprehended and detained in a police cell under the *Detention of Drunken Persons Act* has been deprived of their liberty within the meaning of international human rights provisions and that, therefore, the protection of those provisions applies. Leaving aside the strong arguments that may be made for the human rights obligation of the state to continue into the private sphere,[3] my contention is that the sobering-up centre client apprehended and admitted by police remains in the custody of the state.

Detention in a sobering-up centre is not consensual. Although the Act refers to centre admission as 'release', there is no requirement to obtain the client's consent to that admission. Of course, an intoxicated person (as defined by the Act to mean 'seriously affected apparently by alcohol') cannot give a valid informed consent. This fact confirms that the disposal of the person by police is not consensual. Moreover, the Act does not authorise police simply to release a person or to take the person home, for example.

Detention in a sobering-up centre is a privatised detention initiated, overseen and enforced by the police. The client is not at liberty, at least for the first four hours following admission to the centre. Police require centre staff to notify them in the event of a person refusing to stay at the centre or leaving within four hours thus re-enforcing the obligatory nature of sobering-up centre detention during that period.[4]

It is privatised detention but not private care. Informed consent is not a factor in admission and there are sanctions for failure to remain. Because they operate as alternatives to police detention, sobering-up centres have an obligation to respect the human rights of clients. Moreover, the state which has deregulated or privatised this detention function has not thereby relieved itself of its own obligations to respect and protect the human rights of the intoxicated people detained in centres. The state is obliged to prevent violations of clients' human rights.

The right to life

The human right on which this article focuses is the right to life and physical safety generally, although all of the rights of detainees are potentially implicated. This focus is explained in large part by the rationale for the establishment of sobering-up centres, namely Recommendation 80 of the Royal Commission into Aboriginal Deaths in Custody. Recommendation 80 proposed 'that the abolition of the offence of drunkenness should be accompanied by adequately funded programs to establish and maintain non-custodial facilities for the care and treatment of intoxicated persons'.

A client death in a centre will not necessarily have involved a violation of the client's right to life. However, it has been argued that the prohibition on the arbitrary deprivation of life by the state extends beyond the obvious case of a state-sanctioned execution or murder. It extends into the conditions of detention which are provided by the state.

> [Article 6 of the International Covenant on Civil and Political Rights] extend[s] to the recognition of a duty, not only to refrain from the arbitrary taking of life but also to establish and maintain conditions of custody consistent with the recognition of the right to life as the most fundamental human right. The countenancing by a state party of prison conditions (or conditions of police custody) which induce, encourage or permit suicide or the arbitrary killing of prisoners is as much a breach of Article 6 as is the intentional killing of prisoners.[5]

An even stronger argument can be made that the conditions of detention and the standard of care provided must not be permitted to contribute to deaths from 'natural causes'.

Standard of care required

Intoxication played a key role in the majority of the 99 custodial deaths investigated by the Royal Commission. Public drunkenness was the most frequent offence of all the deceased people;[6] many were chronic abusers of alcohol with resulting detrimental health impacts; and many died while intoxicated.

The police cell risk factors identified by the Royal Commission fell into two major groupings: those brought with them into custody by detainees and those common in the police cell environment.

Detainee characteristics

The first group of risk factors featured the very high levels of ill-health experienced by Aboriginal people, notably high rates of ischaemic heart disease at uncommonly young ages, high rates of diabetes, epilepsy and hypertension, high rates of debilitation, and high rates of mental and emotional distress.[7]

Intoxication itself presents life-threatening risks. Long-term abuse of alcohol increases the risk of liver disease, gastrointestinal bleeding, pancreatitis and brain damage. Epileptiform seizures, cardiomyopathy and other heart conditions can be exacerbated by intoxication. Alcohol withdrawal can be characterised by delirium tremens featuring disorientation, fear, illusions and hallucinations or by depression as blood alcohol levels fall. Intoxicated people are also at risk of sleep apnoea, in which the airway is blocked and the person fails to wake to clear it because intoxication has depressed the central nervous system.[8]

Another significant factor noted was the capacity of intoxication to mask underlying life-threatening conditions; and, alternatively, for untrained people to mistake behaviours attributable to other conditions for intoxication. Among the 99 deaths investigated by the Royal Commission some were caused by conditions so masked by or mimicking intoxication: subdural haematoma or closed head injuries, severe infection, hypoglycaemia and drug overdose.[9]

It is apparent that some of these factors increase the likelihood of self-harm while others could precipitate natural death in custody. These factors will be present in a proportion of intoxicated people admitted to sobering-up centres.

Custodial characteristics

The second group of risk factors identified by the Royal Commission related to the custodial environment. They included what were described then as 'absolutely appalling' accommodation and facilities 'unfit for human habitation' in some cases and 'substandard' in others;[10] 'deplorable' attitudes of police to those in their care;[11] ignorance among officers of the risks associated with intoxication; ignorance of the extent of Aboriginal health problems and the symptoms of major diseases; failure to check on prisoners thoroughly and regularly; failure to communicate prisoner information to custodial officers or incoming shifts; and leaving prisoners unattended for long periods with no means of obtaining emergency assistance.[12]

These risk factors, too, are implicated both in Aboriginal suicides in custody and in deaths from natural causes. Prevention of deaths in custody from either cause must be the

objective of sobering-up centres. To achieve that objective, all risk factors must be addressed.

Securing the right to life in WA sobering-up centres

The underlying assumption of the sobering-up centre model adopted in Western Australia is that a straightforward substitution of the sobering-up centre for the police cell would eliminate the risks identified by the Royal Commission. Unfortunately that is patently not the case.

The WA centres largely eliminate the following factors which often contribute to Aboriginal suicides in custody:

- inappropriate and inadequate facilities;
- hurtful and provocative comments;
- locked custody (a reservation needs to be noted here: some restraint may be used and centre accommodation can be perceived and experienced by the client as a form of detention);
- the fact of police custody with its reminders of past custody possibly leading to charge, court appearance and penalty;
- absence of Indigenous carers and Indigenous support; and
- social isolation.

However, other suicide risk factors are *not* eliminated. They include depression, acute intoxication and perceptions of injustice. Nor is the risk of death from natural causes eliminated, such deaths being due to high rates of ill-health often exacerbated or masked by intoxication.

The following features of care in a sobering-up centre would reduce the opportunities for the remaining risk factors to result in death.[13]

- clear guidelines about the standard of care with appropriate accountability mechanisms to ensure compliance;
- appropriate staff training.

The contractual arrangements

The WA Drug Abuse Strategy Office (the Purchaser) funds the WA centres which in turn are operated by community-based committees. Pursuant to the funding contract the Office 'purchases' health services from the centre managements (the Providers). The contract establishes principles governing the manner of delivery of the services, including:

1. Recognises the dignity, worth, independence, cultural diversity and basic human rights of the Clients;
2. Ensures that the Services provided are of appropriate agreed quality with respect to relevant professional practice, safety, risk, health outcomes and consumer interests.[14]

The contract lists the 'outcomes' for which the Provider is accountable to the Purchaser:

1. Number of persons sobered up in the centre
2. Percentage of persons detained by police for public drunkenness [who are sobered up] in the centre
3. Cost of service provision per admission.[15]

Performance standards are also stipulated, including the minimum hours of operation, the minimum services to be provided to each client, the obligation to give preference to police referrals, the circumstances in which a person may be refused admission, the obligation to maintain basic statistical information, the categories of staff training and the rule that clients must not be pressured into substance abuse counselling.

Accountability in the sense of regular reporting to the Drug Abuse Strategy Office is limited to financial accounting, half-yearly accounting on the three 'outcomes', the obligation to notify the Office of any event which would materially affect the Provider's ability to implement the contract, and the obligation to notify the Office of any 'recognised threat to the safety of Clients'.[16]

Accountability in the sense of contract compliance is naturally somewhat broader. Each centre's 'prime purpose' is described as being 'to provide a safe, care oriented environment' for sobering-up. The minimum services to be provided include 'regular monitoring of clients while they sober up'. Providers are required to ensure staff receive training in Basic First Aid, recognition of medical conditions requiring hospital referral and management of disruptive incidents.[17]

Deficiencies

This standard contract falls short of what is required to limit the risks to client safety. With respect to the need for clear guidelines, the *only* references to the risks identified by the Royal Commission are the obligation of regular monitoring and the obligation to ensure staff are appropriately trained. With respect to monitoring, the degree of 'regularity' required is not stipulated, nor is the quality or extent of 'monitoring'. During the author's intensive observations at four centres during 1995, the regularity and thoroughness of checks by centre staff was haphazard and medical checks (that is, checking pulse and breathing rates) were not performed at all, even on near-unrousable and injured clients.

Although the Royal Commission's recommendations aimed to protect the (human) right to life, the contract has little to say on the subject of human rights. It imposes only a very limited human rights obligation on individual centres.[18] The contract does not define the term 'human rights', does not include safety, security of the person or other human rights among the service 'outcomes' which are the measures of service provision and does not require reporting on human rights outcomes or breaches, with the exception of the obligation to notify recognised threats to the safety of clients. Further, the state distances itself from its own primary human rights obligation by requiring the centres to indemnify it in the event of injury to any client.[19]

With respect to staff training, the contract imposes this responsibility on individual centre managements. Yet the resources provided are sufficient only to pay wages and for the upkeep of the centres and a high proportion of staff have not had the stipulated training. At one centre during 1995 not one staff member had a first aid certificate.

Protecting rights while enhancing self-determination

The adoption of a model of partnership in the running of sobering-up centres is suggested as the best way to secure detainees' rights including their safety while permitting the greatest scope for community self-determination in the management of the centres. In a partnership, each partner remains responsible while contributing its individual resources and expertise.

The WA centres are established on a 'community development' model described as follows.

The concept is one of encouraging the local community to take control of its own social systems, and in this instance, its sobering up centres. This model is also the one which has been adopted by the other States.

> In line with this philosophy the Alcohol and Drug Authority is setting up centres which are managed by a group from the local community, and once each local service is established, the Drug and Alcohol Authority's involvement will be limited to funding, assisting with staff training, monitoring care standards and evaluating and researching the effects of the programme.
>
> This process is aimed at producing community involvement, providing a service which meets the needs of that community, and encouraging understanding, ownership and control of the drinking problem within that community.[20]

Seemingly implicit in this description of the model are two features necessary to the proposed 'partnership' model: empowerment (and resourcing) of 'the community' and retention of state responsibility for human rights protection. The reality does not match the rhetoric, however. The state, as described above, has delegated what little human rights concern it has articulated and 'the community' is reduced to being an under-funded provider of a service 'purchased' by the state. Moreover, there is no recognition of the special interests, sanctioning authority or rights of the Indigenous community/ies from which most clients and staff are drawn and whose plight the centres were established to address.

Yet for most centre managements and staff the most potent form of accountability for client safety is to traditional Law and Indigenous community approbation and patronage. Aboriginal staff at the South Hedland centre advised:

> We say it's a neutral zone — Law stops at the door. But it doesn't always work. We get 'stood over'. We have to run around getting cups of tea for people.[21]

The manager of the Fitzroy Crossing centre stated that there are 'lots of cultural issues to be aware of'. She advised that the centre had twice been smoked after former clients had died, even though their deaths were not connected with the centre.[22]

> The committee and I spend a lot of time and effort protecting ourselves, staff and the shelter from payback . We need to make sure no-one dies in here.[23]

Should a death occur in a centre serving a community with allegiance to traditional Law, the staff and management would be subject to payback punishments and the centre would be avoided for a lengthy period, if not permanently. More generally among the centres serving predominantly Indigenous clients, the majority of both staff and clients are part of the local Indigenous community and rely on the support and patronage of that community. That support and patronage would be withdrawn if unacceptable practices were known to occur in the centres. In other words, the sanctioning power of the local Indigenous community is potentially at least as potent as that of the state, which could withdraw funding, and the centre management, which could discipline and even dismiss staff. It should be appreciated, however, that fear of payback will not prevent deaths in a centre where staff are not equipped to recognise and deal with health risks among their clients.

The contractual model excludes the Indigenous community and positions the state as a purchaser of stipulated services on its own terms. In contrast, the partnership model would position the state in a partnership with the local Indigenous community to provide a safe and culturally appropriate sobering-up facility to clients.

The notion of partnership between the state and the Indigenous community would require parity between them. That is, each party must be an equal participant. This is not to say that they bring identical strengths or that they are concerned to fulfil identical obligations. On the contrary, their roles in the partnership are likely to be quite different. For example, the state has financial resources and expertise in modern health service provision and training. The Indigenous community has potent sanctions, traditional knowledge and knowledge of each individual client's history and current state of mind. The state is obliged to deploy its resources and sanctions to ensure the human rights of clients. The community must be empowered through its partnership to deploy its knowledge and sanctions to the same end. The partnership relationship will require that agreement on all matters affecting the operations of the sobering-up centre will be arrived at by negotiation and thus should ensure that the way in which the state achieves improvements in human rights protections is culturally appropriate.

References

1. Planning for centres at Broome, Wyndham, Midland, Carnarvon and Geraldton has commenced.
2. Bridge House in North Perth is an exception, operating 24 hours every day, seven days a week.
3. See, for example, Clapham, Andrew, 'The Privatisation of Human Rights' [1995] *European Human Rights Law Review* 20–32.
4. The contract manager advises these are local arrangements not authorised by the Purchaser.
5. Dr John Hookey in a commissioned research paper, quoted in Royal Commission into Aboriginal Deaths in Custody *National Report*, Vol. 5, para. 36.2.51.
6. *National Report*, Vol. 3, para. 21.1.9.
7. *National Report*, Vol. 3, paras 23.5.12, 13 and 18.
8. *National Report*, Vol. 3, paras 23.4.7 and 11; paras 23.5.2, 3 and 6.
9. *National Report*, Vol. 3, para. 23.5.5.
10. *National Report*, Vol. 3, para. 24.3.123.
11. *National Report*, Vol. 3, para. 24.3.51.
12. *National Report*, Vol. 3, paras 24.3.40, 44, 45, 56, 68 and 77.
13. Reforms already introduced into the WA Police Service.
14. Standard contract, clause 3.
15. Standard contract, Schedule One, clause 3.
16. Schedule Two, clause 2; Schedule Five, clause 4.2; and Schedule Six, clause 10 (in the event of such a threat the *Provider* must implement adequate safety measures and security procedures in response)..
17. Schedule One, clauses 1, 4.2.1 and 4.5.1.
18. Standard contract, clause 3.1 requires the Provider to provide the Services in a manner which 'Recognises the dignity, worth, independence, cultural diversity and basic human rights of the Clients'. Schedule Five, clauses 4.1, 4.13 and 4.14 prohibit discrimination on grounds established by the *Equal Opportunity Act 1984* (WA) and require the provision of an interpreter if needed by a client.
19. Schedule Five, clause 5.1.
20. Daly, A., Midford, R. and Wilkinson, C., 'A Survey of Twenty-Seven Sobering Up Centres in Australia', Alcohol and Drug Authority, Perth, 1991, pp.2-3.
21. Notes of interview conducted 10 June 1995; staff remain anonymous.
22. Smoking is a cleansing ceremony.
23. Notes of interview with Emily Carter, Fitzroy Crossing, 6 July 1995.