2018

Staff and family attitudes to fences as a means of detaining people with dementia in residential aged care settings: The tension between physical and emotional safety

Shoshana J. Dreyfus  
*University of Wollongong, shooshi@uow.edu.au*

Lyn Phillipson  
*University of Wollongong, lphillip@uow.edu.au*

Richard Fleming  
*University of Wollongong, rфleming@uow.edu.au*

Publication Details  
Staff and family attitudes to fences as a means of detaining people with dementia in residential aged care settings: The tension between physical and emotional safety

Abstract
This study investigates staff and family attitudes toward the use of the fences that surround many aged care facilities in Australia, in the context of indefinite detention of people with dementia. This indefinite detention has been described in a report from an Australian Senate Inquiry as “a significant problem within the aged care context”, which “is often informal, unregulated and unlawful”. Five focus groups comprising direct care workers, family members, nurse unit managers and facility managers discussed the reasons for and their attitudes towards fences. The results show a tension between the provision of physical and emotional safety. This is to say that even while it is illegal to detain people with dementia against their will, and even while participants understood the negative impact of fences on the well-being and emotional safety of people with dementia, they accepted and supported the presence of perimeter fences because they provided the perception that fences kept people with dementia physically safe. This has implications for redressing the balance between physical and emotional safety in policy and practice.

Keywords
emotional, means, fences, attitudes, family, staff, people, dementia, residential, safety, settings; tension, between, physical, detaining, aged, care

Disciplines
Arts and Humanities | Law

Publication Details

This journal article is available at Research Online: http://ro.uow.edu.au/lhapers/3494
Staff and family attitudes to fences as a means of detaining people with dementia in residential aged care settings: The tension between physical and emotional safety

Shoshana Dreyfus1, Lyn Phillipson2,3, Richard Fleming4

1School of Humanities and Social Inquiry, Faculty of Law, Humanities and the Arts, University of Wollongong, Wollongong, NSW, Australia
2Faculty of Social Sciences, School of Health and Society, University of Wollongong, Wollongong, NSW, Australia
3Australian Health Services Research Institute, University of Wollongong, Wollongong, NSW, Australia
4Dementia Training Australia, Faculty of Science, Medicine and Health, University of Wollongong, Wollongong, NSW, Australia

Correspondence
Dr Shoshana Dreyfus, School of Humanities and Social Inquiry, Faculty of Law, Humanities and the Arts, University of Wollongong, Wollongong, NSW, Australia.
Email: shooshi@uow.edu.au

Received 10 May 2017. Accepted 7 March 2018

Funding information
masonicare NSWHMRC ARC Dementia Research Development Grant (APP1107401); ACT Freemasons

Abstract
This study investigates staff and family attitudes towards the use of the fences that surround many aged care facilities in Australia, in the context of indefinite detention of people with dementia. This indefinite detention has been described in a report from an Australian Senate Inquiry as “a significant problem within the aged care context”, which “is often informal, unregulated and unlawful”. Five focus groups comprising direct care workers, family members, nurse unit managers and facility managers discussed the reasons for and their attitudes towards fences. The results show a tension between the provision of physical and emotional safety. This is to say that even while it is illegal to detain people with dementia against their will, and even while participants understood the negative impact of fences on the well-being and emotional safety of people with dementia, they accepted and supported the presence of perimeter fences because they provided the perception that fences kept people with dementia physically safe. This has implications for redressing the balance between physical and emotional safety in policy and practice.

KEYWORDS
dementia, detention of people with dementia, fences, human rights, residential aged care for people with dementia
INTRODUCTION

Over the next 40 years the number of Australians living with dementia is projected to increase from 413,000 people in 2017, to more than 1.1 million by 2056 (Brown et al. 2017). Dementia is one of the leading causes of institutionalisation of older adults and more than half of the care recipients in Australian nursing homes, approximately 95,000 residents, have a form of dementia (Brown et al. 2017).

Most nursing homes in Australia can be recognised by the 1.8-metre-high fence around them. While it is possible that these fences are intended to make available a safe outdoor environment for residents, there is strong evidence that fences do not achieve this aim: residents are restricted to being inside and their safety, as against their security, is threatened by a decline in their quality of life as a result (Torrington 2007; Evans 2016). Nevertheless, perimeter fences are so taken for granted that even designers of outdoor spaces for nursing homes specify them as a necessity without qualification (Cochrane 2010).

Life for the residents of nursing homes is governed by the Australian Commonwealth’s Charter of Residents’ Rights and Responsibilities, as set out in the Aged Care Act (1997). The Act sets out the parameters for the attainment of the high quality of life that residents can expect to be delivered. Whilst general quality of life measures refer to dimensions such as the quality of social relationships, physical health and emotional well-being (Brod et al. 1999; Banerjee et al. 2006), additional dimensions within dementia-specific models include domains related to having a sense of agency (Kitwood & Bredin 1992), a sense of freedom versus restriction and of togetherness versus aloneness (Parse 1996). Central to this quality of life is autonomy, a basic human right (United Nations 2006). The expression of this autonomy is captured in the statement that:

> each resident of a residential care service has the right to maintain his or her personal independence, which includes a recognition of personal responsibility for his or her own actions and choices, even though some actions may involve an element of risk which the resident has the right to accept, and that should then not be used to prevent or restrict those actions. (Aged Care Act, 1997)

However, there are grave concerns that in the Australian context, the autonomy of people with dementia in residential aged care is not being adequately supported. In fact, it is being severely restricted by their detention within residential facilities. A recent Senate Inquiry into the indefinite detention of people with cognitive impairment concluded that:

> It is clear from the evidence provided that indefinite detention of people with cognitive or psychiatric impairment is a significant problem within the aged care context, occurring both within external facilities and private homes. It is also clear this detention is often informal, unregulated and unlawful. (The Senate, 2016).

It has also been pointed out by the president of the Guardianship and Administration Board of Tasmania (Smith, 2016) that:

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

This state of affairs has been addressed in other parts of the world, such as the UK, albeit with mixed success. In the UK, the deprivation of liberty was the focus of a 2005 European Court of Human Rights case (HL v UK (2005) 40 EHRR 32 (App No 45508/99)), which resulted in a new Mental Health Act 2007 containing Deprivation of Liberty Safeguards (DoLS). The DoLS provide for the authorisation of deprivations of liberty by an administrative process and also a means to challenge any such deprivation in court. These safeguards apply to hospitals and nursing homes in which people who lack the capacity to consent to their living arrangements are deprived of liberty.

In 2014, a decision of the UK Supreme Court significantly widened the interpretation of deprivation of liberty and this considerably increased the number of people recognised as being deprived of liberty and requiring safeguards. The implications for the public sector have been significant, with 1,95,840 applications made for a DoLS in 2015–2016 (Law Commission 2017). This level of demand cannot be met by the services available and a strong case has been made for a review of the DoLS, which will streamline their application (Law Commission 2017).

The point to be made here is that the issue is of sufficient importance for it to be brought before the European Court of Human Rights and to be addressed in legislation that impacts many tens of thousands of individuals. The fact that a satisfactory solution is still being sought does not detract from its importance; rather, it highlights the need to grapple with this fundamental problem.

In Australia, the response to this issue has been very weak. The Senate Inquiry report mentioned above concluded that:

> It is also clear to the committee that evidence for this problem has been well known to states and territories, and the Commonwealth, for some time. Although there have been some moves to address this form of indefinite detention, they have been patchy at best, and significantly underfunded 

(The Senate, 2016).

## 2 | LITERATURE REVIEW

While there is a considerable body of literature that investigates attitudes to the restriction of movement of people with dementia in institutional settings, a review of the literature from seven data bases using the following search terms Alzheimer* OR dementia OR Cognitive with residential OR nursing* OR assisted living AND fence OR contain* OR perimeter OR secur* OR confin* OR enclos* OR barrier, within a time frame of 2006–2015 resulted in the identification of only one study by Wigg (2010), who mentions the most common form of restriction, the fence. Nevertheless, Wigg’s (2010) article, and others that focus on the restriction of movement of people with dementia, has something relevant to say about why the movement of people with dementia is restricted. The most common reason provided for this restriction of movement is the danger posed by “wandering” behaviour (e.g. Ballard et al. 1991; Hope et al. 1994; McShane & Hope 1994; Dickinson & McLain-Kark 1998; Hughes & Louw 2002; Lucerno 2002 & Robinson et al. 2007). Wandering is not a new issue. It was summed up in the editorial of a special edition of The Lancet in 1994:
wandering is a distinctive and difficult feature of dementia. The patient sets off to tour the house, the neighbourhood, or the city, without apparent purpose. Unlike stray pets, they do not usually return home. Every geriatric specialist can tell horror stories of patients crossing highways and walking along railway tracks. Patients often come to grief in road traffic accidents; some continue to drive a car and run someone else over. They often get hopelessly lost. Caregivers are led a merry dance, often getting no sleep, or being driven to distraction wondering where on earth the patient has got to. This is a central component of the so-called “caregiver burden” (Anon 1994, p.1274).

This is a remarkable description when viewed through the lens of Kitwood’s seminal work on person-centred care, published only 3 years later (Kitwood 1997). Kitwood’s work established a context in which it became much easier to see wandering as a response to biomedical, psychosocial and person–environment interactions (Lai and Arthur, 2003). It provided for a much broader view of wandering, which allows for an appreciation of its benefits to the person with dementia (Marshall & Allan 2006).

Marshall and Allan also provide reasons for the pathologising of wandering (2006), arguing that it has three functions: protecting us from the pain we feel when confining people and providing “less than optimal environments” (p14); relieving us of the guilt we feel about institutionalising people; and in using a shorthand label like “wandering”, allowing for behaviour to be described, quantified, pathologised and thus “treated” and vilified.

Despite these advances in thinking being available in 2013, Cott and Tierney (2013) draw attention to the fact that in public health discussions that include dementia care, there is a prevalence of discourses of risk, often subsumed under a discourse of safety, and that these discourses legitimate the view that wandering requires a medical solution, in the form of physical or pharmacological restraints, because it protects the “wanderers” from danger.

Noyes and Silva (1993) explain the restraint of people with dementia as being the result of a clash between two ethical principles: respect for autonomy on the one hand, and paternalism (“a type of beneficence in which limits on a person’s autonomy can be morally justified to prevent that person’s harm to himself or herself.” p.12), on the other. This clash has been described by several authors, (e.g. Callopy 1990; Robinson et al. 2007; Cott & Tierney 2013), and there seems to be consensus that paternalism usually wins out in practice, on the basis that people with dementia are seen to be unable to assess the risks to their own (and others’) safety.

Robinson et al.’s (2007) two-part study of wandering behaviour of people with dementia in England throws more light on the tensions involved in managing this behaviour and highlights an alternative to paternalism. It involves both a systematic review and a qualitative study that explored the perspectives of health and social care professionals, direct care workers and their managers and family carers. Robinson et al. found that family members were cognisant of the tension between the risks associated with wandering (such as accident, injury and/or death) and the rights of the person/persons to wander, and the need to strike a balance between the two. Family members often felt that when rights outweighed risk, the result was an improved quality of life, particularly emotional well-being, for people with dementia. This perspective was supported by the people with dementia who were also interviewed in this study: while they couldn’t always articulate where they wanted to go, they could certainly articulate the need to go. In contrast, professionals in this study tended to favour safety over freedom, due to fear of litigation.

Wigg (2010) explored the impact of the restriction of freedom of movement on the well-being of people with dementia in institutional settings by comparing two different approaches to managing the “wandering behaviour” of people with dementia. In the first, wandering was framed
and treated as purposeful, and enabled with the use of technologies that monitor rather than confine the residents. In the second, wandering was medicalised as a problem behaviour in need of a medical solution and was treated with either physical or pharmacological restraint. The findings were that people with dementia who were able to get outside when they needed to and move without restraint were less psychologically traumatised than those who were confined.

Although there is growing evidence of the negative effects of the pathologising of wandering, it continues to the present day. Very recent Australian research by MacAndrew (2017) demonstrates that aged care staff responded with tolerance to wandering by people with dementia into spaces that are deemed to be out of bounds for them. Staff thought that the behaviour was not only beyond the control of the person with dementia but that it was part of the dementia. However, the staff’s tolerance decreased as the behaviour became visible to other people or involved the possibility of resulting in consequences that were perceived to be unsafe either for the person with dementia or for others. McAndrew’s study confirms that the pathologising of wandering as being due to dementia itself and the focus on perceptions of safety and risk rather than on autonomy continue to be the standard way in which staff respond to the person with dementia’s wandering.

While the focus on risk reduction continues within the boundaries of residential aged care, an alternative view is taking form in the broader community. In 2012, for example, the UK Prime Minister made his Dementia Challenge, which involved the establishment of dementia-friendly communities, that is, communities that enable people with dementia to feel supported and included. Dementia-friendly communities necessarily involve a different perception of risk management, emphasising the right of people with dementia to the dignity of taking risks (Joseph Rowntree Foundation, 2016). There has been significant progress made in establishing such communities in the UK (Hare & Dean 2015) and other parts of the world (Alzheimer’s Disease International, 2017), and these have been successful in reducing stigma and providing better access to community activities (Heward et al. 2017; Phillipson et al. 2018). While Australia has not been as quick to adopt this initiative as the UK, there is evidence of peak body support and local acceptance (see https://www.dementiafriendly.org.au/) and a new national strategy has recently been funded by the Australian Government (Dementia Australia, 2017).

There is thus a growing tension between current practices on the one hand and the increasing body of knowledge on the detrimental effects of pathologising wandering and focusing on physical safety, or security, on the other. This tension is contributing to a willingness to explore the much less restrictive environment of the dementia-friendly community. It is the authors’ opinion that the fence, both metaphorically and physically, is the boundary between these approaches. Thus, an exploration of attitudes to the fence will inform the development of more enlightened approaches to the care of people with dementia.

3 | DATA COLLECTION AND ANALYSIS

Participants for this study were recruited from a large not-for-profit organisation that provides aged care services in institutional settings in the state of New South Wales, Australia. Participants included managers of aged care facilities, nurse unit managers, direct care workers and family members. Facility managers came from 12 different aged care facilities in very different locations with a variety of types of residence for people with dementia. These ranged from an inner-city facility with no outdoor areas, to suburban facilities as well as to less suburban facilities located in more spacious bushy surrounds. Some facilities had secured dementia units,
whereas others had a more open environment where residents were free to wander around the grounds and through the buildings. Nurse unit managers also came from a variety of facilities; however, direct care workers came from one urban facility only, as it was harder for the organisation to gather these participants. Family members included spouses and adult children of people with dementia who resided in these aged care facilities.

The type and the number of focus group participants can be seen in Table 1. Table 1 shows that there is nearly double the number of managers than other types of participant, as this is the number of people who were available for the focus groups at that time. Additionally, nurse unit managers had a great deal more to say than other participants; thus, managers’ comments are more frequently reported in this paper.

While we are mindful of the need to include people with dementia in research that is about them or affects them, we argue that it is also important and legitimate to take opportunities to explore the views of staff and family carers, as their views and attitudes have a strong influence on how people with dementia experience their lives in residential care facilities.

Focus groups were chosen as the method of data collection as they are useful for obtaining a broad range of information and opinions on a topic (Sandelowski 2000). The focus groups were conducted with each group of stakeholders separately, and in private rooms, to avoid workers being in a group with their line manager, and family participants being in a group with anyone who worked with their family member. While there are limitations to focus groups (e.g. not all voices are heard equally and some people may feel intimidated by other voices with strong opinions), the facilitators were careful to ensure that everybody who indicated a need to speak was given the opportunity.

The questions asked in the focus groups were designed to provide participants with a structure that would assist them to explore the purpose and effects of fences around residential care facilities for people with dementia. Beginning with a general question on the purpose of dementia-specific units, which was expected to bring up concerns about safety and security, the questions proceeded to focus the attention of participants on the issues of balancing rights and risks (Robinson et al. 2007), and the alternatives to restricting movement (Marshall & Allan 2006). The questions, listed below, were deliberately general and broad in nature to avoid biasing the views expressed:

1. What are the goals of having people in dementia units?
2. Why do we have fences around/in dementia units?
3. What are the meanings and effects of fences?
4. What are the alternatives to fences?

The focus groups were recorded, transcribed and analysed with the qualitative thematic analysis method (Braun & Clarke 2006). Both a deductive “top-down” approach (which was informed

<table>
<thead>
<tr>
<th>Group</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical managers</td>
<td>7</td>
</tr>
<tr>
<td>Facility managers</td>
<td>12</td>
</tr>
<tr>
<td>Direct care workers</td>
<td>6</td>
</tr>
<tr>
<td>Family members</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
</tr>
</tbody>
</table>

© 2018 Australian Social Policy Association
by the research aims and questions, as well as by the ideas from the literature reviewed above), and an inductive “bottom-up” approach, which was informed by the themes arising from the participants’ responses to the questions were used to guide the analysis. The data were transcribed, read and coded using NVivo™ software (version 11), which is useful for classifying the data and clustering the emerging themes. A linguistic concordancer (antconc™) was used to view the frequency of key terms such as safe/safety and secure/security, to ensure none were missed.

4 | **FINDINGS**

This section reports on the themes arising from the analysis, which are organised around fences as a “necessary evil”, the tension between safety and paternalism (Noyes & Silva 1993), or Lang and Edwards’ (2006) articulation of physical versus emotional safety; the positive impacts of fences are then discussed. The section then concludes with an overview of the kinds of solutions participants offered to mitigate the negative effects of fences.

5 | **FENCES AS A “NECESSARY EVIL”**

The participants in this study acknowledged that there are aspects to fences that are detrimental to the emotional safety and well-being of residents with dementia. Family members in particular noticed the decline of their family member with dementia when contained within locked facilities. While the management and direct care workers were at pains to increase the life satisfaction of the residents where possible through programs such as walking activities and other diversional therapies, they were in no doubt that for some residents, this was not enough for their mental and emotional well-being and did not compensate for the distress caused at being locked behind a fence:

*Family member:* The entrapment is like, it causes frustration, frustration causes anxiety; anxiety accelerates everything; you’re stressed. It just, and it magnifies. Then they get sedated because they’re so frustrated. It’s just a vicious circle once you’re on it;

*NU Manager:* They’re closed in and it makes you want to scream. They just want to get out and it makes their behaviours worse because they feel trapped;

*Family member:* . . . needing just the fresh air, the trees, a little bit of, because they feel imprisoned. Dad [would] often come down here . . . level two, and he just needed to get out. He just needed to, and you could see him, and even now he’s on level one and he smashed the windows trying to get out.

Despite these concerns, all participants from all groups privileged the physical safety of residents over their emotional safety. They considered the fence a necessary feature of aged care facilities as they saw it as enabling the provision of physical safety, even if they liked the idea of residents being able to wander around a large outdoor area. Indeed, all participants, regardless of the participant group they came from, stated that safety was the main reason for having and keeping people in dementia units. Keeping a person safe was framed by all participants as being safe from perceived dangers — from wandering and getting lost or run over, from doing dangerous things in the home, such as putting inappropriate items into a microwave oven, and even from endangering others. Thus, the kind of safety articulated by participants corresponded
closely to Lang and Edwards’ (2006) category of physical safety. Numerous comments in the data highlighted the privileging of physical safety over emotional safety. This is evidenced by the following comment from a family member who, whilst also expressing great distress at their father being locked behind a fence against his will, still felt the fence was necessary to contain him:

Family member: You need to contain. I’m sorry, I don’t believe in freedom and all like that. The reason dad is here because we weren’t sleeping. Because we were scared. So we’re, I’m assuming we’re all in agreement that there’s some form of boundary within the area.

Fences were not only seen as necessary, but in some cases, as inevitable, as one group of nurse unit managers commented:

NU Manager 1: I think we will never get rid of fencing, to be honest. Like using fencing in the broad term, I don’t think you could ever get rid of it.

NU Manager 3: There will always be some sort of barrier.

NU Manager 1: It’s a necessary evil, let’s say that, we have to have them.

However, the combination of necessary with evil points to the tension between the two values of physical versus emotional safety (Lang and Edwards 2006); between paternalism and a respect for autonomy (Noyes & Silva 1993); and between right and right (Callopy 1990). Necessary because fences keep people physically safe and evil because they by and large deprive people of autonomy and emotional safety. Thus our data showed that even while there was a tension between protecting physical safety (paternalism) as opposed to emotional safety (respect for autonomy), paternalism was a prevalent attitude amongst many participants from all groups. And as Cott and Tierny (2013) articulate, this attitude was framed as keeping people with dementia safe.

Those in positions of power, such as facility managers, showed more unequivocal support for fences, as did a number of family members. However direct care workers, nurse unit managers and other family members would have preferred that people have less restriction and more freedom, as per the findings in Robinson et al.’s (2007) study.

6 | TENSION BETWEEN PHYSICAL AND EMOTIONAL SAFETY

Despite the recognition of the detrimental effects of keeping people behind fences, many participants, both family members and some workers (particularly clinical managers and direct care workers), keenly expressed the tension between concerns for physical safety (paternalism) and concerns for emotional safety (respect for autonomy).

One point that clearly highlighted this tension was the discomfort many participants expressed with the interviewer’s use of the term “fence”. The following series of quotations come from a part of the discussion that occurred at the beginning of the nurse unit managers’ focus group, when the interviewer asked about the role of the fence:

NU manager 2: “fencing” is a horrible word, hey [laughs] yeah, it’s a horrible word, but if we can secure the maximum perimeter as we possibly can...
NU manager 1: Yeah. I don’t like the word “fencing” because it just conjures to me a prison, and that’s not what we are trying to achieve.

NU manager 2: I’m not quite sure of an alternative, but I’m sure I have if I thought about it, fencing just sounds, it does have that connotation of...

NU manager 1: Of imprisonment.

NU manager 2: It’s linked to the prisons. It’s sort of linked to animals as well, I think, fencing, when I think of fencing a dog in, or fence, yeah. I don’t think we actually...I can’t remember using the word “fencing” except for in here, you know, this talk here. I don’t think I’ve ever used it as fencing...or secure sounds a bit nicer.

This discomfort around using the term fence could be an indicator of the denial of the role of the fence in enabling the subjugation of residents’ emotional safety in service of their physical safety. Not using the term fence allows people to not consider its role in detaining some residents against their will, that is, it enables a rationalisation of the privileging of physical safety over emotional safety. This is similar to Lang and Edwards (2006) findings, which include that physical care is given highest priority within acute care.

In juxtaposition to this reticence by nurse unit managers for using the term fence was the use of the term “prisoner” by family members, who in situations where their family member did not like being contained, acutely felt their family member was a prisoner:

Family member: I have had my mother-in-law in another dementia facility with severe dementia, and it was very difficult for her because you did have to get through a door, you did have to push the numbers, and it was quite heartbreaking because she did feel a prisoner, very, very much so. They did take her out to a very nice garden, but she had to be taken out. She was no longer free and that was an entirely different situation to my father and mother. So I can see it from both sides. But for safety I see no alternative.

However, as the end of the above quote testifies, while many family members felt their family member was a prisoner and did not like this, they still thought the fence and restraining people behind it was equal to (physical) safety, and this it seems was the highest priority of all. Additionally, they often finished their comments reiterating their support for the fence.

This tension between protecting the physical safety of residents and allowing them autonomy and freedom was also expressed as a contradiction in some cases. This becomes evident in the following manager’s quote, where there is denial of the practice of locking people behind fences:

NU manager 2: Yeah, I think I agree with you with the duty of care and the prevention of foreseeable harm, you know, which is the definition of it. So as people who are setting up units and we see that foreseeable harm, like the water across there, we’d have to prevent that as much as we can. I agree with D, I don’t think you’d find anyone around the table that wants to lock residents up or keep them restricted in any way. I mean, that’s just archaic; we don’t do that anymore.

An intercultural comparison from the direct care workers’ experiences is illuminating here: one direct care worker, whose country of origin was on the African continent, stated that in his country they called dementia “second childhood”, and that in this context, the family and community shared the role of looking out for a person who was experiencing their second childhood. However, it is
clear from the literature (e.g. Aminzadeh et al. 2010) that in developed countries such as Australia, if the person is in the family home, this can become too much of a burden on their co-habiting family member (often a spouse), or their wider family (if the person with dementia lives alone). Thus, the tension arises between taking care of the person’s emotional safety, their physical safety and the family and society’s emotional safety. The only mechanism our broader society has to offer for the solution of this problem is accommodating people within aged care facilities, which involves privileging the person with dementia’s physical safety over their emotional safety and privileging the family’s emotional safety over the person with dementia’s emotional safety.

7 | PRESSURE ON STAFF TO KEEP RESIDENTS “SAFE”

The data showed that workers also felt an external pressure to keep residents (physically) safe.

**NU manager 3:** ... if you know that it’s put down to somebody suffering from dementia floating . . . ;

**NU manager 2:** Yeah, floating in the river;

**NU manager 3:** ... in the river out there, in the lake, yeah, be all over the news, and major investigation;

**NU manager 1:** Yep. So that’s a major dilemma in my job. And quite often I don’t sleep well over that, depending on the decisions that are made. That’s a part of my job I really don’t like.

Facility managers said that fences gave them peace of mind in knowing their residents could not wander:

**Facility manager 5:** If you’ve got the doors open to the garden and there’s another boundary out there and all your staff are with a resident on the toilet or doing something else, then you’ve got peace of mind knowing that they’re going to be secure and safe, not secure, but more safe.

Managers also felt that the wider society, both the public and the government, expected them to keep people (physically) safe, which again meant keeping residents behind a fence, so they can’t wander:

**Manager:** And I think the community want that, and I think society expect that degree of safety. So how we do it is how we do it. Some people choose to do it differently but, you know, if we said, “Oh okay, well, I’m not that risk-averse, so hey, I’m happy to let you wander wherever you go”, and someone else says, “Well, no, how could you possibly do that?” You know, and then we’re accountable to the government.

Thus, the fence could also be viewed as a symbol of other people’s peace of mind and emotional safety whilst simultaneously being a symbol of the deprivation of emotional safety for the person with dementia. In this sense, we can expand Lang and Edwards’ (2006) classification of types of safety to factor into the tension between the emotional safety of others (family, staff and management) versus the emotional safety of residents. The question then needs to be asked: Whose emotional safety are we looking out for in fencing aged care facilities?
FENCES AS A THREAT TO PHYSICAL SAFETY

While for the most part, worker participants, both nurse unit and facility managers and direct care workers, reported that fences kept residents physically safe, they also reported that fences sometimes cause physical harm, as residents have tried to climb them to escape their confinement. This, they said, presented serious risks of injury:

Manager 5: 

...we’ve got a four or five foot retaining wall in our DSU which has been there forever and we thought that was going to, when we opened the unit, that would form the natural boundary for the outside garden area, and I thought it was good because it’s been there forever, it’s aged, it’s interlocked bricks and it’s got a garden above it. But we have had two residents who’ve climbed it and got up on top of the garden, and one lady fell over. . . .

Managers’ concern for residents’ safety sometimes obstructed their ability to provide a nicer fence than they would have otherwise liked:

Facility Manager: I don’t want to put a fence up in front of this retaining wall, because the retaining wall has got this natural bush above it, but I have a duty of care for the safety of the residents.

Thus while, by and large, participants spoke of the role of fences in protecting residents’ physical safety, there were examples where they did the opposite.

THE POSITIVE IMPACT OF FENCES ON EMOTIONAL SAFETY AND WELL-BEING

It is clear from the data that fences often have a negative effect on the emotional safety and well-being of residents; however, participants also identified a number of positive features of fences. These included the provision of feelings of security and homeliness for residents with dementia and, depending on the style of fence, the ability to encourage socialisation.

According to some staff, fences can help anxious residents feel safe and secure, and provide a sense of ownership over a space, similar to the ownership felt about a front and back garden at home:

Manager 1: It becomes their home; it’s ownership people have in, people of that generation have, all have little fences in their homes, so that’s good. . . ;
Manager 2: Safety, boundary, ownership;
Manager 1: . . . it makes them feel like it’s their area and. . . . I could say, “And I can sit here because this is my home.”

In one facility, staff commented how some fences, such as metal swimming pool ones that can be seen through, reduced their detrimental impact on emotional well-being because they enabled residents to socialise with the outside world:

Manager: We have a very small courtyard and there’s a fence just like that which goes to the road, and the ressies sit out there during the day and talk to every passer-by that goes past, and
it’s the talking over the fence, and quite honestly I’ve had people come in some days and I’ve asked, “Hello, who are you?” “Oh, Tom outside said I could come in and get a coffee,” [laughter] which is kind of nice, and so there’s this really nice social aspect to our fence which is kind of weird but really lovely, so they don’t see it as that fence.

Some managers also pointed out that part of their job in keeping residents with dementia safe is to protect them from unwanted outsiders wandering in, and the fence helped them do that.

Managers also articulated that fences helped to protect other frailer, elderly people in different sections of the aged care facility from the actions and behaviour of people with dementia:

Facility Manager: Because we’ve got people here who are aggressive, because that’s part of their dementia process, and we could not have these people out in the community because of the dementia, that they would do potential damage to other people who are very frail.

Other managers said that the fence helped them protect the general population from the risks posed by people with dementia being free to wander outside the facility:

Manager: ...but they [the families] are under no illusions that these people will get hit by a truck because they do not stop and look for the traffic, they do not wait for a light; they do not have any idea of their safety. And I have an issue with that because the poor bus driver or truck driver ...that’s the one that’s going to hit them, so that’s a major dilemma in my job.

These concerns, however, are more about protecting the well-being of others, rather than that of the person with dementia.

# Ideas for Mitigating the Negative Effects of Fences on Residents’ Well-being

Participants from all focus groups had ideas of how to mitigate the negative effects of fences. The greatest diversity of ideas came from facility managers, possibly because they are in positions of decision-making power and responsibility over a facility, and family members, who wanted to see changes that would improve the lives of their family members. Managers reported that many facilities have experimented with different types of fences to obscure the fact that there is a fence. For example, some places have hedges instead of fences, or gardens in front of fences. All workers reported that in most cases this improved the well-being of people with dementia and distracted them from the idea that there was a fence keeping them in at all:

Manager: So it’s what the fences look like, because when they’re just like that out there they represent “you’re locking me in”. But when they’re a garden or a hedge, “Oh, that’s pretty.”

Other managers talked about certain kinds of fences having a less negative impact on residents when they looked like house fences rather than institutional fences; for example, wooden palings were seen as a much better option than wire. Managers also commented that the design of outside areas had a significant impact on the way residents felt about the presence of a fence. For example, if the facility had an outdoor area with a garden and a winding path through it...
with gates to go through so that people could feel like they have actually gone somewhere, then this minimised the effects of the fences and being locked behind them. Family members expanded this idea by suggesting coloured footsteps on pathways marking the way to go for residents who needed to wander but needed help finding their way. Participants from more than one focus group also commented on facility design more generally and felt that if there was a secure perimeter fence, then residents should be able to wander within the facility. Family members suggested leaving cars on the outside rather than on the inside, to ensure residents’ safety.

A number of alternatives to fences were offered. These included natural barriers such as vegetation to obscure fences and GPS trackers to allow some degree of freedom. Staff in facilities that used trackers recognised the importance of allowing freedom of movement and felt this was a “dignified” symbolic fence.

11 | DISCUSSION AND CONCLUSION

The findings of this study illustrate the tensions between the protection of people with dementia’s physical safety and their emotional safety, between dignity and risk, and between paternalism and respect for autonomy. The responses to these tensions are played out with limited regard to the legality of the actions, with a great deal of dependence on the belief that they are undertaken in keeping with the duty of care owed to the residents. Both staff and family members’ attitudes towards the use of fences in the context of the indefinite detention of people with dementia largely support the use of the fences and barriers that make this detention possible. Despite the existence of a substantial amount of international experience and literature on the subject, detention was justified on the grounds of keeping people safe, with safety being defined more in terms of physical safety or security than the provision of an environment that affords both emotional/psychological safety and physical safety. Most participants put physical safety before emotional well-being, even when they understood that emotional well-being was vitally important. While accepting the presence of fences, staff in particular found themselves in a bind about meeting the diversity residents’ needs.

Thus, the tensions between risk management and emotional well-being (as an important dimension of quality of life) as articulated by Robinson et al. (2007), between right and right (Callopy 1990), and between physical and emotional safety (Lang and Edwards 2006) are evident in the results of this study. This perhaps points to a hierarchy of safety in the minds of participants. It seems that “physical safety” is given highest priority.

Over recent years there have been a large number of environmental design solutions, technology and assistive devices which provide the potential to address many challenges posed by staff and family members in this study (Lynn et al. 2017). In light of these, the view that fences will always be with us has to be challenged due to both the range of available solutions and the evidence that keeping people behind fences may provide physical safety but threatens emotional safety. The presence of fences around Australian aged care facilities needs to diminish as Australia embraces the idea of dementia-friendly communities and environments. It is anticipated that this movement must also evolve to support freedom of movement for residents living in aged care facilities.

ACKNOWLEDGEMENTS

The authors acknowledge Catherine Kubel for the conduct of the initial literature search that informed the background to the paper and Federico Tartarini for his work in the preparation of the ethics application.

© 2018 Australian Social Policy Association
REFERENCES

Alzheimer’s Australia (2016) Creating a Dementia-Friendly Nation, Canberra, Alzheimer’s Australia.


Brown, L., Hansnata, E. and LA, H.A. (2017) Economic Cost of Dementia in Australia, Canberra, Australia, NATSEM, University of Canberra, Alzheimer’s Australia


© 2018 Australian Social Policy Association


Shoshana Dreyfus is a senior lecturer in English Language and Linguistics at the University of Wollongong. Her research has mostly focused on non-verbal communication and language disorder, and discipline-specific academic literacy, as well as on developments in systemic functional linguistic theory and discourse semantics. In addition to these areas, she is interested in many applications of linguistic theory to a wide range of objects of study including language and power, evaluative language, and media discourse.

Lyn Phillipson is an NHMRC-ARC Dementia Development Fellow from the Australian Health Services Research Institute at the University of Wollongong. She has published in the areas of dementia-friendly communities and environments, stigma and dementia attitudes and respite for carers of people with dementia. She has a strong interest in inclusive and participatory research methodologies.

Richard Fleming is a psychologist who has specialised in the development of services for people with dementia for more than thirty years. He has published papers on environmental design, reminiscence therapy, reality orientation, depression, assessment of the elderly and service evaluation, and is the principal author of books on care planning for people with dementia, environmental design and a comparison between Australian and Japanese dementia care.

How to cite this article: Dreyfus S, Phillipson L, Fleming R. Staff and family attitudes to fences as a means of detaining people with dementia in residential aged care settings: The tension between physical and emotional safety. Aust J Soc Issues. 2018;53:107–122. doi: 10.1002/ajs4.34.