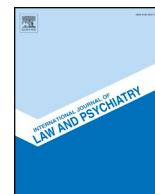




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# The COVID-19 pandemic and the human rights of persons with mental and cognitive impairments subject to coercive powers in Australia



Kay Wilson

Melbourne Social Equity Institute, University of Melbourne, Carlton, Australia

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## ABSTRACT

The purpose of this paper is to explore the effect of the COVID-19 pandemic on the human rights of persons with mental and cognitive impairments subject to coercive powers in Australia. It sets out the relevant human rights in the Convention on the Rights of Persons with Disabilities which have been engaged by the COVID-19 pandemic and the government's response to it. It examines the effect of emergency legislation on the relaxation of human rights safeguards in mental health laws, with a focus on mental health tribunals (although it is limited by a lack of published decisions and gaps in publicly available information). However, some of the issues created for persons with disabilities during the COVID-19 pandemic are evident in some decisions published by the New South Wales Guardianship Tribunal. The paper critically analyses two guardianship decisions UZX [2020] NSWCATGD 3 (3 April, 2020) and GZK [2020] NSWCATGD 5 (23 April, 2020) and some emergency South Australian legislation COVID-19 Emergency Response Act, 2020 (SA) Schedule 1 to demonstrate the ways in which the human rights of persons with mental and cognitive impairments can be more at risk than those of the general population, even when the general population is itself in "lockdown."

## 1. Introduction

The COVID-19 pandemic and the emergency public health measures implemented by governments in response to it have resulted in unprecedented restrictions on the civil liberties of the general population, especially freedom of movement and close physical contact with others. As a consequence, the complex public health "trade-offs" (Gostin, 2007) which usually sit in the background to the provision of individualised healthcare for most people, have suddenly been brought to the fore. By contrast, legal coercion for the purposes of the prevention of harm to self and others is more familiar in the mental health and disability context. Indeed, the use of involuntary detention and psychiatric treatment authorised by mental health law has long been justified as being akin to the coercive public health powers contained in infectious disease laws (Bonnie & Zelle, 2019; Szmukler & Kelly, 2016). While the COVID-19 pandemic in Australia has been largely contained so far, it nonetheless raises issues about how it has impacted the human rights of persons with mental and cognitive impairments,<sup>1</sup> especially those already detained in hospital or under guardianship orders. How should

the physical health of persons with mental and cognitive impairments be balanced against their mental health needs? How should their physical and mental health be balanced against the loss of their legal rights? While Australia has undoubtedly fared better than the United States and Europe, COVID-19 has also exposed gaps in its pandemic preparedness (Itzwerth, Moa, & MacIntyre, 2018; Rubinsztein-Dunlop, 2020), as well as the existing fault lines in its health, aged care, disability and social support systems. Thus, understanding the impact of COVID-19 on the human rights of persons with mental and cognitive impairments has relevance well beyond the immediate crisis.

In this paper, I explore the effect of the COVID-19 pandemic on the human rights of persons subject to compulsory powers under mental health and guardianship laws in Australia. The paper is divided into three parts. First, I set out the international human rights framework with a focus on the Convention on the Rights of Persons with Disabilities ('CRPD') and consider which rights of persons with mental and cognitive impairments in Australia are relevant to the COVID-19 pandemic. Second, I examine the changes to the rights of persons with mental impairments in emergency COVID-19 legislation throughout

E-mail address: [wilsonk1@student.unimelb.edu.au](mailto:wilsonk1@student.unimelb.edu.au).

<sup>1</sup> The terminology which refers to persons with mental and cognitive impairments has always been problematic and contentious. By persons with mental impairment I mean persons with psychiatric conditions including schizophrenia, bipolar disorder, depression, anxiety disorders, eating disorders, obsessive-compulsive disorder and post-traumatic stress disorder which may be treatable by psychiatric intervention. By cognitive impairments I mean persons with intellectual disability, autism and dementia. Mental and cognitive impairments are terms used in the *Convention on the Rights of Persons with Disabilities, open for signature 30 March, 2007*, (entered into force 3 May 2008), Art 1 ('CRPD').

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Australia, particularly alteration in the functioning of the various mental health tribunals. Finally, I critically analyse the way guardianship law has been used in two guardianship cases, [UZX \[2020\] NSW-CATGD 3](#) (3 April, 2020) ('[UZX](#)') and [GZK \[2020\] NSW-CATGD 5](#) (23 April, 2020) ('[GZK](#)'), in New South Wales and emergency legislation in South Australia, [COVID-19 Emergency Response Act, 2020](#) (SA) Schedule 1, to enforce the general prohibitions on movement and gathering under COVID-19 public health orders with respect to persons with mental and cognitive impairments. I argue that while some restrictions may be necessary to protect the lives and health of persons with mental and cognitive impairments, just as they are for the general population, it is important to ensure that the loss of civil and political rights is as narrow and limited as possible and only for the purposes of responding to the COVID-19 pandemic. Further, any restrictions which are imposed ought to be ones which actually do make persons with mental and cognitive impairments safer and be flexible enough to reasonably accommodate aspects of their disability which make it more difficult for them to comply with those rules than others.

The use of public health powers in Australia has been criticised for lacking openness and transparency pre-pandemic ([Carter, 2020](#)) and information about the operation of mental health and guardianship law during the pressure of the state of emergency caused by the COVID-19 pandemic is no different. Therefore, this paper reflects an environment where the COVID-19 pandemic is rapidly evolving and information about government decisions and policies and practices varies from place to place and is not always publicly available. It will, however, identify where those gaps in knowledge are and indicate where inferences have been drawn based on pre-COVID-19 research.

## 2. The COVID-19 pandemic and the Convention on the Rights of Persons with Disabilities

The leading international human rights convention governing the rights of persons with mental and cognitive impairments with 163 signatories and 181 ratifications/accessions ([UN website, 2020](#)) is the Convention on the Rights of Persons with Disabilities ('CRPD') which entered into force in 2008. In Australia, international human rights conventions, like the CRPD, while legally binding on Australia under international law are not legally enforceable unless they are expressly incorporated into domestic law by legislation ([McSherry & Wilson, 2011](#)). However, international conventions still provide guidance for policy-making, law reform and administrative decision-making and can be used by courts as an aid to statutory interpretation where domestic legislation is ambiguous ([Minister for Immigration and Ethnic Affairs v Teoh, 1995 HCA 20](#)). Australia does not have a constitutional bill of rights and is not part of a regional human rights system, such as the European Convention of Human Rights ('ECHR'), although Victoria, the Australian Capital Territory, Queensland and the Commonwealth each have statutory human rights acts which provide limited human rights protections ([Charter of Human Rights and Responsibilities, 2006](#) (Vic), [Human Rights Act, 2004](#) (ACT), [Human Rights Act, 2019](#) (Qld), [Human Rights \(Parliamentary Scrutiny\) Act, 2001](#) (Cth)). Accordingly, in the absence of other sources of human rights law, the CRPD is probably of greater interest to Australian lawyers, scholars, disability advocates, and policy makers than to those in jurisdictions with other more entrenched human rights systems ([McSherry & Wilson, 2011](#)). In Australia, the CRPD has considerable moral force in debates about what the future of disability rights should be. From a political perspective, the CRPD is the primary political tool that is being used to advance the rights of persons with mental impairment in law reform and is being taken seriously by Australian governments who have referred to it in the [National Disability Insurance Scheme Act, 2013](#) (Cth) (s3(a)), [National Disability Strategy \(2010–2020\)](#) ([Council of Australian Governments, 2011](#)), and the [Australian Law Reform Commission enquiry into Equality, Capacity and Disability in Commonwealth Laws in November, 2014](#). For these reasons, the CRPD has formed part of the

disability discourse in Australia during the COVID-19 pandemic and has been used by disability advocates and the Australian Disability Discrimination Commissioner as the relevant human rights framework ([Gauntlett, 2020](#); [OCHR 28 April, 2020a](#)).

While the CRPD does not mention global pandemics specifically, Article 11 provides that:

States Parties shall take... all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters.

During the negotiations of the CRPD Article 11 emerged out of discussions about the right to life of persons with disabilities in Article 10. It reflects concerns that in situations of risk to the general population persons with disabilities are often especially vulnerable if their particular needs are forgotten or ignored and access to services is discriminatory or does not cater to their needs ([Bruno, 2017](#)). As Jasmine Harris has noted 'it does not take much of a pretext to roll back disability rights' which are often regarded as being 'nice to have' rather than essential and in the context of an emergency the loss of disability rights can be startlingly quick ([Harris, 2020, p.1](#)).

The COVID-19 pandemic has revealed how much the CRPD has not been implemented by those countries which have ratified it ([CRPD Committee, 2020](#)). As noted by the CRPD Committee:

People with disabilities are not inherently vulnerable; it is attitudinal, environmental and institutional barriers that result in higher levels of vulnerability. People with disabilities may have underlying health conditions that make them more susceptible to COVID-19, pre-existing discrimination and inequality means that persons with disabilities are one of the most excluded groups in terms of health prevention and response actions and economic and social support measures, and among the hardest hit in terms of transmission risk and actual fatalities ([CRPD Committee, 2020](#)).

When looking at the text of Article 11 it appears that a global pandemic is probably a kind of 'natural disaster.' However, it should be noted that even though infectious diseases are naturally occurring, pandemics differ from most other natural disasters, such as bushfires, floods, volcanic eruptions and earthquakes, in a number of ways. For instance, a pandemic involves time lapse and disease modelling by humans which can influence preparation and planning as it approaches and passes ([Huremovic, 2019](#)). Further, unlike other natural disasters healthcare facilities may transform from points of care to nodes of transmission undermining trust in services and exposing healthcare workers to infection ([Huremovic, 2019](#)). In addition, prolonged self-isolation and separation from families and communities in response to the pandemic can impact on mental health even if a person is not affected by the disease itself ([Huremovic, 2019](#)). But, COVID-19 is certainly not an 'armed conflict' or a 'humanitarian emergency' in Australia, although it may create a 'double emergency' in places which are already experiencing emergencies caused by armed conflict, natural disasters and climate change ([United Nations Office for the Co-ordination of Humanitarian Affairs, 2020](#)).

That said COVID-19 certainly represents a 'situation of risk' for persons with mental and cognitive impairments in Australia. While COVID-19 only results in mild illness for most people, it is much more likely to cause serious illness and death for certain vulnerable groups. Persons with mental impairments already have shorter lifespans than the rest of the population and often have co-occurring physical disorders such as circulatory conditions or diabetes at higher rates than the rest of the population ([AIHW, 2020](#)). It is also thought that mental health conditions can increase the risk of infections including pneumonia ([Reis, 2020](#); [Yao et al., 2020](#)). In addition, persons with mental impairment have higher rates of smoking than the general population to cope with mental health conditions ([CDC, 2020](#)) and systemic reviews indicate that smokers are at higher risk of adverse outcomes from

COVID-19 (Vardavas & Nikitara, 2020). However, the exact numbers of persons with mental impairment and COVID-19 are presently unknown.

While COVID-19 primarily presents as a respiratory illness, a subgroup of patients show neurological symptoms such as confusion, delirium, stroke and seizures (Holmes et al., 2020; Rabin, 2020). Further research on whether these neurological effects have current or long term effects on mental health is urgently required (Holmes et al., 2020). Also, persons who experience respiratory failure from COVID-19 and require ICU support may not be able to consent to medical treatment themselves (GMI [2020] NSWCATGD 6 (29 April, 2020)).

Persons with mental and cognitive impairments are also more likely to experience social disadvantages like poverty, homelessness, and dependence on the care of others that make meeting their daily needs and staying safe during the pandemic more difficult (Ruiz, 2020). In addition, domestic violence and alcohol and substance use have escalated with the imposition of state-mandated stay-at-home orders to counter the pandemic (Gulati & Kelly, 2020). Persons with mental impairments are both perpetrators and victims in this rise of pandemic-related domestic violence, especially where there is concurrent alcohol and substance abuse (Gulati & Kelly, 2020). Of particular concern is the impact on women and girls and the fact that many domestic violence support services are not accessible or equipped to deal with persons with disabilities who may be experiencing domestic violence (UN Policy Brief, 2020).

Further, large outbreaks in hospitals (such as, The Alfred and Sunshine Hospitals in Melbourne), psychiatric institutions (such as, the Albert Road Psychiatric Clinic in Melbourne) and nursing homes (such as Newmarch House in Sydney and Hawthorn Grange and Assisi Centre in Melbourne) in Australia and around the world demonstrate the difficulties of controlling COVID-19 infection in communal and closed environments in which persons with mental and cognitive impairments often live or are temporarily admitted. The old and outdated designs of most psychiatric facilities which are often crumbling, closed and overcrowded environments; mental health staff who are not trained in infection control; and the difficulties involved in helping some persons with mental and cognitive problems to understand and co-operate with social distancing and self-protection; all conspire to increase the spread of infection among persons in living in institutions (Zhu et al., 2020). In South Korea a locked psychiatric ward with a COVID-19 outbreak became a medical disaster (Kim, 2020). Measures designed to prevent suicide and preserve life like closed windows, concerns that patients might drink hand sanitiser if it were readily available, and open spaces to allow observation actually worked against containing the virus and providing much needed ventilation (Kim, 2020). The United Nations estimates that the percentage of COVID-19 deaths in care homes (which contain large numbers of older persons and persons with disabilities) is between 19% to 72% in countries where the official data is available (UN Policy Brief, 2020).

The extra risk from COVID-19 to persons with mental and cognitive impairments is compounded by the anxiety caused by the pandemic and the government's response to it. Fear of catching the virus, panic buying and shortages, job losses, enforced social isolation to stop the spread of the virus, changes in routines, saturation media coverage, and barriers to accessing care like discrimination, stigma, and existing distrust of authority and the health system, are all stressors which can exacerbate mental impairments and in some cases precipitate suicide (Druss, 2020; Reger et al., 2020; Reis, 2020).

The importance of Article 11 of the CRPD can be seen by the fact that in Australia persons with disabilities, despite their heightened risk to an adverse outcome from COVID-19, were initially left out of the emergency response plan for COVID-19 unveiled in mid-February (OCHR 9 June, 2020b). That is, in the words of Article 11, all necessary measures for the protection and safety of persons with disabilities were not taken, putting their lives and health at risk. The government's initial emergency response plan provided that healthcare workers and aged care support workers would have access to personal protective

equipment ('PPE'), but persons with disabilities and disability support workers were not included, causing great anxiety for persons with disability who were less able to take steps to protect themselves, and who had to spend much time trying to source essential supplies like masks and hand sanitiser (OCHR 9 June, 2020b). There was also a lack of targeted accessible information for persons with disabilities about the COVID-19 pandemic (OCHR 9 June, 2020b). It was not until April, two months after the initial plan, and after much lobbying by disability advocates, that the Australian Government established an Advisory Committee on Health Emergency Response to Coronavirus (COVID-19) for People with Disability and a disability-specific COVID-19 plan was developed (OCHR 9 June, 2020b). The Australian Human Rights Commission has also been drafting a national health and human rights framework for persons with disability to ensure that persons with disabilities, especially complex support needs, are properly supported by the health system (Gauntlett, 2020). The COVID-19 pandemic has demonstrated the need for governments to take disability rights into account in future emergency response planning and to be able to "respond rapidly to future public health emergencies and to ensure that 'no-one is left behind.'" (CRPD Committee, 2020). It also illustrates the need for persons with disabilities to be consulted and to participate in the development and implementation of government policies and programmes in accordance with section 33 of the CRPD.

The CRPD also covers a broad range of human rights many of which are engaged by the COVID-19 pandemic beyond Article 11. A holistic approach to the interpretation of the CRPD considers *all* of the rights of persons with cognitive and mental impairments and how they interact with each other. The most relevant rights to the COVID-19 pandemic form two broad groups. The first are those which ensure the protection of the life, health and well-being of persons with mental and cognitive impairments from COVID-19 infection and the government responses to it, while the second relate to the civil and political rights of persons with mental and cognitive impairments which can be more affected than those of the general population, even when the general population is itself in "lockdown."

### 2.1. Rights to life, health and well-being

One of the most fundamental rights engaged by the COVID-19 pandemic is the right to life in Article 10 of the CRPD which requires States Parties to 'take all necessary measures to ensure the effective enjoyment of the right to life by persons with disabilities on an equal basis with others.' Similarly, the right to health in Article 25 guarantees persons with disabilities the right to the highest attainable standard of health without discrimination on the basis of disability, including access to the same range and quality of health services as the rest of the population and the provision of services that are specific to their needs. It also prohibits the discriminatory denial of healthcare, an issue which has been raised by the COVID-19 pandemic in the scenario where health systems may become overwhelmed and ventilators and medical care need to be rationed (Harris, 2020). Triage guidelines developed around the world for the allocation of health resources in such a scenario with exclusion criteria based on certain types of impairment and biased medical assessments of "frailty" and "quality of life" have been particularly alarming and have signalled that (contrary to Articles 10, 11 and 25 of the CRPD) the lives and health of persons with disabilities are often considered less valuable and worthy of protection (OCHR Guidance, 2020a). The action of Australian governments in essentially shutting down society in order to stop the spread of COVID-19 at the expense billions of dollars of emergency funding to support the economy, scaling up intensive care resources, and a likely post-pandemic recession, (rather than a more risky 'herd immunity' strategy in Sweden and in the early stages of the pandemic in the United Kingdom) has demonstrated the commitment of Australian society to protecting the lives and health of the elderly and persons with disabilities who are most at risk of serious illness and death from COVID-19. Fortunately,

the success of the Australian government in ‘flattening the curve’ of infections and its work in increasing hospital capacity to accommodate a large influx of cases has meant that so far the need for healthcare rationing has not eventuated. For this reason, Australia has not seen the same level of public debate about the right to life and access to healthcare of persons with disabilities as in other countries.

However, the safe provision of health and disability support services to persons with mental and cognitive impairments during the pandemic has nonetheless created a number of human rights challenges. As noted above, the needs of persons with disabilities were neglected in the early stages of pandemic planning. Further the right to life is well recognised as including a special responsibility of States Parties to ensure the protection of persons with mental and cognitive impairments who are detained in hospitals, prisons and refugee detention centres from COVID-19 infection, severe illness and death as they have little control over their own safety as well as suicide prevention measures for those in detention and in the community (Wilson, 2018). Protection ‘on an equal basis with others’ should take into account any differences that put persons with mental and cognitive impairments at special risk from the COVID-19 pandemic, without being unnecessarily protective and restrictive compared with the general population (Wilson, 2018). As pointed out by the United Nations High Commissioner, Michelle Bachelet, protection of the right to life for persons in detention in hospitals and nursing homes may involve release into the community to reduce overcrowding, improve hygiene and allow social distancing, as well as ensuring access to medical care (Bachelet, 2020). Where release into the community is not possible, the High Commissioner has recommended measures to prioritise testing and address overcrowding, restricting visiting hours, use of PPE and improved hygiene, increased financial and human resourcing of institutions, and transfer to hospital where necessary (OCHR Guidance, 2020a; UN Policy Brief, 2020).

As noted above, Australia has implemented the [National Disability Insurance Scheme \(NDIS\)](#) since 2013 which provides funding and support for persons with disabilities who are accepted as participants into the scheme to choose and self-manage their own support services to increase their independence and economic and social participation in the community. The NDIS applies to persons under the age of sixty-five who reside in Australia and who have physical, sensory, psychiatric and intellectual impairments which impact their functioning in certain aspects of life, or who have a condition which requires early intervention (NDIS Act, 2013, s22–25). The Australian government regards the NDIS as one of the key ways in which it implements its CRPD obligations (NDIS Act s 3(1)(a)). In response to COVID-19, the NDIS has increased funding for people living in supported independent living situations which are shared with others for \$1200 of extra support services and will pay for deep cleaning and alternative accommodation where a person has been diagnosed with COVID-19 and needs to self-isolate (NDIS, website). It is also working to ensure continuity of support for persons with disabilities during the pandemic and planning reviews have been conducted remotely (NDIS, website). However, only about 465,000 or 10% of Australians with disabilities qualify as NDIS participants (Cukalevski, 2019), leaving the provision of services to others to fall through the cracks. It also remains to be seen whether the efforts of the NDIS and the funding boost will be sufficient to ensure the pandemic-related needs of persons with disabilities are met.

The CRPD also requires the implementation of measures to prevent exploitation, violence and abuse (Article 16) including that all facilities and programmes are effectively monitored by independent authorities. However, such oversight has diminished during the COVID-19 pandemic due to limited external access by friends, families and official community visitors to facilities in order to control infections, igniting much political debate over access to institutions despite the real risk of causing COVID-19 outbreaks among the most vulnerable (Disability Royal Commission, 2020). In this regard, the United Nations High Commissioner has recommended that where restrictions on visits are put in place in closed institutions it should be done in a transparent

way, communicated clearly, not be implemented without notice to give people a chance to adjust, and with increased access to videoconferencing, telephone calls, and email (Bachelet, 2020). The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability has also stated that despite the reduction in external oversight the handling of the COVID-19 pandemic is within its terms of reference and it has been encouraging submissions (Disability Royal Commission, 2020).

## 2.2. Civil and political rights

In addition, as will be discussed below, the COVID-19 pandemic and the government response to it, has impacted the civil and political rights of persons with mental and cognitive impairments, often to a far greater extent than the general population. There is, of course, ongoing international debate between the CRPD Committee, disability advocates, some scholars and States Parties about whether the CRPD requires the abolition of mental health law, guardianship and substitute decision-making (where a decision is made by a third party which may contradict the will and preferences of persons with disability), especially under Article 12 (legal capacity) and Article 14 (liberty and security of the person) (Wilson, 2018, 2020) which is beyond the scope of this paper. Further, it should be noted that even to the extent that substitute decision-making is permitted by the CRPD, Australia’s interpretative declaration of the CRPD provides that substitute decision-making should be only used where necessary as a last resort, and subject to safeguards (UNTC website, 2020). Nonetheless, leaving those larger issues to one side, the COVID-19 pandemic has highlighted the institutionalised structure of most of the services provided to persons with mental and cognitive impairments which are centred around hospital admission for the most serious and acute cases and in which community-based care and non-medical options are lacking (Victorian Royal Commission into Mental Health, 2019). As will be revealed in discussions of emergency responses below, the COVID-19 pandemic has also encroached on other important civil and political rights of persons with mental and cognitive disabilities, such as, the right to independent living in the community and access to support services (Article 19), personal mobility and independence (Article 20), access to information about COVID-19 especially where people do not have access to the internet or require explanations that are delivered in a way that is understandable to them (Article 21), the need for consultation and participation in decision-making for persons with mental and cognitive impairments (Article 33) and access to justice and involvement in decision-making (Article 13). Persons with disabilities are also entitled to ‘reasonable accommodation’ in complying with compulsory isolation orders and a failure to grant ‘reasonable accommodation’ under the CRPD is a form of disability discrimination (Article 5). In this regard, the Joint Statement: Persons with Disabilities and COVID-19 by the Chair of the United Nations Committee on the Rights of Persons with Disabilities, on behalf of the Committee on the Rights of Persons with Disabilities and the Special Envoy of the United Nations Secretary-General on Disability and Accessibility (Basharu and Reyes, 2020) has reiterated the importance of continuing de-institutionalisation especially in light of the heightened risk of COVID-19 infection in institutions (para 5). It has also pointed out that the:

range of support in the community, including home care and personal assistance support, and rehabilitation services, when necessary must be ensured and not discontinued as they are essential for the exercise of the rights of person with disabilities (para 9).

It can be seen then that a holistic interpretation of the CRPD during the COVID-19 pandemic requires recognition of both types of rights: life, health and wellbeing and other civil and political rights.

### 3. Loss of rights of persons detained under mental health law

Emergency COVID-19 legislation and administrative changes in most states and territories has altered the rights of persons with mental impairments under their respective mental health laws. The mental health tribunals in New South Wales, Victoria, Tasmania and Western Australia are all being conducted by video conference and teleconference ([Mental Health Act, 2007](#) (NSW) s 202; [COVID-19 Omnibus \(Emergency Measures Act, 2020](#) (Vic) s 33D; [COVID-19 Disease Emergency \(Miscellaneous Provisions\) Act, 2020](#) (Tas), s 20; [Mental Health Tribunal Western Australia Website, 2020](#)) in order to implement COVID-19 social distancing. Queensland courts are open and hearing cases but people are advised to stay away for fourteen days if they have been overseas or are feeling unwell ([Queensland, Mental Health Court website, 2020](#)). The change from face to face to remote hearings is greater in some jurisdictions than others. For instance, around half of hearings were already being conducted remotely in New South Wales, while remote hearings were rare in Victoria pre-pandemic ([Carney & Tait, 2011](#)).

Many jurisdictions have also introduced temporary changes designed to streamline tribunal processes to allow easy extensions of time for certain compulsory orders and prioritising the hearing of certain types of cases. For instance, in New South Wales the Mental Health Review Tribunal has extended the time required for a person's first tribunal hearing after admission from 21 to 35 days (instead of 7 to 21 days), suspended automatic reviews every three and six months in the first year of an involuntary order (s37(1)(b) & (c)); has the discretion to extend existing community treatment orders for three months without a hearing "on the papers"; can adjourn mental health inquiries for 28 days instead of 14 days; and has cancelled reviews of voluntary patients ([Mental Health Review Tribunal Practice Direction, 27 March, 2020b](#)). Similarly, the Victorian Mental Health Tribunal is prioritising hearings for electroconvulsive therapy and the first hearing for each current episode of treatment, followed by existing treatment orders ([Victorian Mental Health Tribunal website, 2020](#)).

Similar arrangements can be seen in the United Kingdom where emergency legislation has relaxed the usual rules to make it easier to admit persons with mental impairments to hospital or detain them if they are already in hospital, to continue treatment beyond three months without review, to reduce the size of the panels of mental health tribunals from three to one, to suspend the ability of persons with mental impairments to obtain a second opinion and to make decisions "on the papers" without a hearing ([Coronavirus Act, 2020](#), Schedules 8–11). Local authorities are also relieved of many of the responsibilities to provide care and support to meet the needs of persons with disabilities ([Coronavirus Act, 2020](#), Schedule 12). While the [Mental Capacity Act \(2005\)](#) (UK) has not been directly altered by emergency legislation, the effect of Schedule 12 is to indirectly reduce the options available to make decisions in the best interests of persons who lack mental capacity ([Ruck-Keene, 2020](#)).

The stated purpose of these temporary changes is to ensure continuity of care and to account for anticipated staff shortages caused by the pandemic such as, doctors and tribunal staff and members becoming ill or needing to quarantine, along with an expected increase in demand for mental health services induced by the stressors produced by the COVID-19 pandemic outlined above. Of course, remote hearings, the prioritisation of certain kinds of cases and delay during the COVID-19 pandemic are consistent with changes to the operations of all courts and proceedings across the legal system, with most hearings being done remotely, more decisions being made "on the papers", jury trials being postponed and so on, so persons with mental impairments have not been singled out. However, persons in the criminal justice system, unlike persons with mental impairments under mental health law, have or are suspected of committing crime, are only detained rather than treated without their consent, and the effects of COVID-19 on creating significant delays in conducting trials are grounds for obtaining bail

(eg. [Re Broes \[2020\]](#) VSC 128 (19 March, 2020)). Consumer advocacy groups like Being in New South Wales have pointed out that the effect of the changes to mental health law, while procedural in nature, is still a significant erosion of the rights of persons with mental impairments as they 'appear to give more powers to detaining people for longer periods of time to suit service provision and the needs of the Tribunal' ([Being, 2020](#)). In the United Kingdom Human Rights Watch is concerned that the removal of the right to obtain a second opinion under the [Mental Health Act \(1983\)](#) (UK) means that an important safeguard - under which 16,000 people apply each year and 29% of treatment plans are changed - has been removed and that many persons with disabilities will be left without appropriate care and support ([Human Rights Watch, 2020](#)).

There is a wide literature on the strengths and weaknesses of the operation of mental health tribunals in Australia and overseas which I am unable to explore fully here. Nevertheless, that literature reveals that the vast majority of discharges are by doctors rather than mental health tribunals and mental health tribunals have often been criticised for being too deferential to medical opinion ([Donnelly, 2010](#)). Mental health tribunals are also torn by a number of competing 'tensions' between individual autonomy and substitute decision-making, process and expediency, and the interests of the individual and the community ([Maylea, 2019](#)). However, most mental health laws use tribunals as a critical oversight mechanism to prevent the abuse of substitute decision-making power and for the protection of liberty. Tribunals can also improve communication between patients and their clinicians and have a modest role in improving treatment planning, health and wellbeing ([Carney, Tait, & Beaupert, 2008](#)). Further, the time periods in mental health legislation have been recognised as being more than technical limits, guidelines or mere aspirations, but as being important human rights safeguards in ensuring that the law is adhered to, that persons with mental impairments have access to justice, and vulnerable persons are not forced to accept treatments with unpleasant side-effects longer than necessary ([Kracke v Mental Health Review Board \[2009\]](#) VCAT 646 (23 April 2009). The oversight provided by mental health tribunals is even more important where other processes such as restrictions on family and friends and community visitors due to COVID-19 (discussed above) make the operation of the mental health system less visible.

What is perhaps even more concerning is that there is no publicly available information about how the COVID-19 pandemic has been impacting the substance of detention, discharge and involuntary treatment decisions. While it could be argued that it is unrealistic to expect mental health tribunals to publish their decisions during a public emergency other courts and tribunals such as the New South Wales Guardianship Tribunal have done so. Many mental health tribunals do not regularly publish their decisions anyway and their general lack of transparency and accountability has been criticised, especially in relation to cases for which publication would be useful as they involve a new or complex issue or when a patient requests reasons to be published ([Smith & Caple, 2014](#)). As at the time of writing, no mental health tribunal decisions had been published during the period of the COVID-19 pandemic in Australia, so it is impossible to know how the pandemic and the needs of persons with mental impairments have effected involuntary detention and psychiatric treatment. For instance, it is possible that persons with mental impairments could use their physical health problems and concerns about being exposed to infection while being detained in hospital if there was a COVID-19 outbreak as an argument for discharge (as recommended by the United Nations High Commissioner, discussed above). Alternatively, the impact of COVID-19 and difficulties in complying with the government's public health orders or receiving adequate mental health care while in self-isolation remotely could be used as arguments supporting involuntary detention and treatment in hospital. We also have no knowledge of any alternatives to hospital admission which might have been arranged to protect a person's physical health by limiting their exposure to COVID-19 while still insuring their access to mental health care. However, two

recent COVID-19 guardianship cases published by the New South Wales Guardianship Tribunal and some South Australian emergency legislation [COVID-19 Emergency Response Act, 2020](#) (SA) Schedule 1 provide *some* insight into the dilemmas and conundrums surrounding the use of substitute decision-making with respect to persons with mental and cognitive impairments during the COVID-19 pandemic.

#### 4. The intersection between COVID-19 public health orders and guardianship

Guardianship law in Australia is different for each state and territory. In New South Wales it is contained in the [Guardianship Act, 1987](#) (NSW) which creates a process for individuals to appoint their own guardian (Part 2) and empowers the Guardianship Tribunal to make guardianship orders where persons are 'in need of a guardian' due to a disability which makes them incapable of managing all or part of their person (s 14). While the Tribunal has the power to grant plenary guardianship, where possible it must grant limited guardianship over particular parts of the person's life or 'functions' (s 15(4), s 16(2)). The legislation does not spell out the 'functions' of limited guardianship, although the Tribunal has created various types of guardianship 'functions' such as, powers over where persons should live (the 'accommodation function'), what services they should receive (the 'service function'), and what healthcare they should receive (the 'healthcare function'), to name a few through the development of case law ([GZK \[2020\]](#) NSWCATGD 5 (23 April, 2020), para 48). In deciding whether to make a guardianship order the Tribunal must give weight to the views of the person, their spouse and carers, the need to preserve family relationships and their cultural and linguistic environment and whether it is possible to provide services without making a guardianship order (s 14). The general principles of the legislation refer to the importance of freedom, self-reliance, living a normal life in the community, taking into account the views of the person and the preservation of family relationships and culture and protecting the person from abuse, neglect and exploitation (s4). However, the legislation is ultimately rather paternalistic in that it is the welfare and interests of the person which must be the paramount consideration (s 4 (a)) The Tribunal can appoint a guardian who is close to the person who needs one and where no one is suitable, the Public Guardian (s 15(3)).

As with the various mental health tribunals, discussed above, emergency COVID-19 legislation in New South Wales has altered the functioning of the Guardianship Tribunal during the pandemic ([COVID-19 Legislation Amendment \(Emergency Measures\) Act, 2020](#) No 1 (NSW) Schedule 2). Such alterations include the reduction of the number of Tribunal members from three to two where one is an Australian lawyer (cl 23), providing a statement of oral or written reasons thirty days after the decision (cl 24), and the ability for regulations and for the Tribunal on its own motion to alter the periods of time in which things must be done (cl 26). Of course, these procedural changes to the composition and powers of Guardianship Tribunal raise similar issues discussed in relation to the mental health tribunals in section 3 above.

The cases of *UZK* and *GZK* both involve applications to expand the powers of the Public Guardian over indigenous persons with mental and cognitive impairments in regional New South Wales due to concerns that they were breaking the [Public Health \(COVID-19\) Restrictions on Gathering and Movement Order, 2020](#) made under s 7 of the [Public Health Act, 2010](#) (NSW) ("the Order"). The Order prohibits everyone in New South Wales, other than a person who is homeless, from leaving their place of residence without reasonable excuse (clause 5). It also prohibits gatherings of more than two people, subject to certain exceptions (clause 6) until 29 June, 2020. There was no evidence that either *UZK* or *GZK* were actually infected with COVID-19 and were spreading it in the community, but there was concern that both were of an age and had health conditions which would put *them* at risk of serious illness or death if they were infected with COVID-19 which was why the cases were brought in the guardianship jurisdiction of *parens*

*patriae*. While it was unlikely that *UZK* or *GZK* had breached the [Public Health Act, 2010](#) (NSW) as there was no evidence that they were infected with COVID-19 or had been exposed to it, the Guardianship Tribunal declined to rule on the issue, deliberately leaving the question opened (*UZK*, para 43, *GZK*, para 36).

To be fair, it should be noted that throughout the pandemic the Australian government has feared a COVID-19 outbreak within the indigenous community and has regarded the safety and protection of indigenous persons as a high priority ([National Indigenous Australians Agency, 2020](#)). No government would want to be accused of failing to intervene and allowing indigenous persons to die of COVID-19. The rather severe restrictions imposed by the New South Wales Guardianship Tribunal in *UZK* and *GZK* can perhaps be partly explained in light of that overriding concern, even if, as I argue, they were not particularly well thought out or consistent with the CRPD. To this extent, *UZK* and *GZK* also demonstrate the importance of intersectionality and the combined impact of disability, race and gender on discrimination.

The cases of *UZK* and *GZK* in New South Wales can be contrasted with an alternative approach to using guardianship law to address the public health restrictions on persons with cognitive impairments in the South Australian [COVID-19 Emergency Response Act, 2020](#) (SA) Schedule 1. I discuss each in turn.

##### 4.1. *UZK [2020]* NSWCATGD 3 (3 April, 2020)

The case of *UZK* involved a 69 year old Aboriginal woman whom the Guardianship Tribunal regarded as a "vulnerable person." *UZK* had a history of paranoid schizophrenia which was well controlled by medication as well as being a heavy smoker and having a history of respiratory problems which would put her in the high risk group for COVID-19 if she were to contract it. The reason *UZK's* behaviour was problematic was that she was:

...said to be at high risk of contracting and potentially spreading COVID-19 as she is said to spend her days walking the streets, can sometimes be found wandering the street in urine soaked clothes begging for money, allows strangers into her home and does not understand the need to self-isolate due to her cognitive impairment (para 7).

In the judgment there was no evidence of what exactly *UZK's* cognitive impairment was other than that she "struggles with self-care, food preparation and cleaning of herself and her unit" (para 7), nor was there any assessment of her mental capacity. There was also no evidence that anyone had explained to her that there was a COVID-19 pandemic, the likely risks to her, or the need for her to self-isolate, although the orders made by the Tribunal required the Public Guardian to do so before acting on the orders. There were also concerns that *UZK* may in her wandering come to the attention of police for breaking the Order and risk a significant fine. But, most importantly, her in-home disability support services decided that *UZK* was too great a risk to continue to assist given her wandering and risk of contracting and spreading COVID-19 to them and the risk that they would then spread it to other frail clients with disabilities. Therefore, the Public Guardian made the application to have the power to exercise an "accommodation function" and make *UZK* temporarily reside in a nursing home. *UZK* did not attend or even know about the hearing as she was regarded as being too difficult to locate due to her daily wandering, although legal counsel was appointed to represent her interests. The Tribunal was told that the possibility of moving *UZK* out of her unit into an aged care facility had been discussed with *UZK* in the past and that she was strongly against it. In considering the evidence the Tribunal granted the Public Guardian the power to force *UZK* to live in an aged care facility against her will for a period of twelve months. The Tribunal was particularly concerned by *UZK's* failure to self-isolate and her ability to live in the community when her in-home support had been withdrawn. The Tribunal considered that *UZK's* safety and self-neglect outweighed her

wish to live independently and her freedom of movement and decision-making.

Obviously, the case of *UZK* raises a number of human rights issues about the use of compulsory powers to detain persons with mental and cognitive impairments during the COVID-19 pandemic. The first is the lack of effort to explain to *UZK* the nature and consequences of the COVID-19 pandemic and her need to self-isolate (Article 21, right to accessible information) or to even locate her and notify her of the guardianship hearing (Article 13, right to access justice). It is difficult to believe that a disability support professional, such as a speech or occupational therapist, would not be able to present information about the COVID-19 pandemic to *UZK* in an accessible form. There is also information for persons with disabilities explaining the COVID-19 on the internet by various self-advocacy groups, the NDIS, and Mencap (although they may not have been available at the time of the judgment). The judgment creates the impression of being incomplete without *UZK*'s involvement as there is a significant gap without her input, although in light of *GZK*'s case discussed below, *UZK*'s participation may not have made much difference to the outcome. While the Tribunal was correct to be concerned about the danger to *UZK*'s health if she were to contract COVID-19 and the protection of her rights to life (Article 10) and health (Article 25), the judgment contained no assessment of how risky *UZK*'s habit of walking the streets actually was in terms of her contracting COVID-19. One of the features of the spread of COVID-19 in Australia is that cases have been concentrated in the major cities, particularly Sydney, Melbourne and Brisbane ([COVID-19 tracker, 2020](#)), with few and often no cases in the regions ([NSW Health, 2020](#)).

The order was also justified by the concern that *UZK* might incur a substantial fine if she was found wandering and could not adequately explain the purpose of her walking. However, as pointed out by Alex Ruck-Keene it is difficult to see how a person can be guilty of an offence if by reason of their mental or cognitive impairment (and lack of explanation to them about the pandemic) they do not understand that they are breaking the law ([Ruck-Keene, 2020](#)). Further, the Order does not prevent people from leaving their homes to walk the streets for exercise and does not place any time limits on how long a person is away from home. There was also no evidence of whether *UZK* actually had contact with other people on her walks and, in any event, meeting one other person was not illegal under the Order. Finally, given that it may be more difficult for some persons with disability, especially those with mental and cognitive impairments, to stay inside and comply with the Order than for others, there is a strong argument in favour of applying the lockdown rules with a measure of flexibility and reasonable accommodation for individual needs, in consultation with police to avoid any misunderstandings ([UN Policy Brief, 2020](#)).

What is even more startling is that for a judgment that was purportedly made to increase *UZK*'s safety, there was no consideration of whether *UZK* might actually be *more* at risk of contracting COVID-19 being by confined to an aged care facility (given the danger of outbreaks in residential care outlined above) than in living in her own unit and walking the streets in the open air of a regional Australian town. The Australian Department of Health has reported 68 cases and 27 deaths of persons living in government subsidised residential aged care facilities, whereas there have only been 31 cases and 3 deaths throughout Australia, and only 13 cases and no deaths in New South Wales, for people receiving government subsidised care in their own home ([Australian Government, 2020a, 2020b](#)).

The unilateral decision of *UZK*'s service disability providers to withdraw services because she was "too risky" was undoubtedly pivotal to the decision to deprive *UZK* of her rights to liberty and ability to live independently in the community. The perception of *UZK*'s disability service providers may have reflected the fears of many disability service workers about a lack of PPE, unsafe practices in the sector and as noted above a result of the disability sector being overlooked in the early response to the COVID-19 pandemic ([Cortis & van Toorn, 2020](#)). As is noted in the *UZK* judgment, in many respects guardianship for the

protection of the person with mental and cognitive impairment, is more restrictive than a public health order because it is of longer duration and applies to many more aspects of a person's life. Further, a public health order can only be made if the restriction of a person's liberty is the most effective way to prevent any risk to public health (s62(6)). There seems to be no equivalent requirement of ensuring that any restrictions to a person's liberty under a guardianship order is the most effective way to ensure his or her safety. As set out in the Joint Statement above, support services should not be withdrawn to persons with disabilities during the COVID-19 pandemic. The right to live independently in the community in Article 19 of the CRPD reflects the historical horrors of institutionalisation and is regarded as being a unique and fundamental right of persons with disabilities, the absence of which makes it difficult for persons with disabilities to exercise their other CRPD rights ([Lewis and Richardson, 2020](#)). The right to live independently in the community is a good example of a hybrid right which guarantees civil rights such as freedom and independence, but which can only be ensured by the socio-economic right to resources and social support to make it a reality ([Lewis and Richardson, 2020](#)). Yet, there was no consideration by the Public Guardian of engaging another provider or trying some alternative arrangements just for *UZK*, to prevent infection to other clients as a form of reasonable accommodation. Nor is there any consideration of or sensitivity to the cultural and historical reasons that *UZK*, as an older Aboriginal woman, might particularly wish to avoid institutional care ([Victorian Royal Commission, 2019](#)).

It is stated at the end of the judgment that 'in *UZK*'s case the prospect of needing residential care has been on the horizon before this application' (para 35). It is hard not to read the decision without thinking that the COVID-19 pandemic was being used as an excuse to move *UZK* into residential care whether she wanted it or not because her service providers did not like her and had decided that she required too much support to live independently. That is, despite the mention of emergency respite accommodation in the judgment, the move to a nursing home in the guardianship order was going to be permanent rather than temporary for *UZK*. Such an impression is reinforced by the length of the order being for twelve months, rather than being limited to the duration of the COVID-19 pandemic.

#### 4.2. *GZK [2020] NSWCATGD 5 (23 April, 2020)*

The case of *UZK* became a precedent for the development of a new COVID-19 guardianship 'function' in the case of *GZK*. While the case of *GZK* did not involve transferring *GZK* to an aged care facility, it did involve orders approving detaining *GZK* to his own home by authorising the use of physical restraint, environmental restraint or seclusion if required to ensure *GZK* abided by the Order. *GZK* is a 76 year old Aboriginal man who lives with his wife in regional New South Wales. He has a history of persecutory type delusional disorder, is a bilateral below-knee amputee, and has chronic brittle diabetes which would make him at risk of serious illness or death if he contracted COVID-19. Of particular concern was that *GZK* insisted on travelling in his electric wheelchair at least once, but often several times a day, to the local shopping centre for the purposes of gathering with others. *GZK* attended the hearing by telephone and explained that he understood the risks of "this flu" and that he would like to be in control of his own affairs. He also explained that going to the shopping centre was of cultural importance to him, being his "walkabout." *GZK* also denied leaving the house for fifteen days. He was, however, contradicted by his wife and service provider (who also attended the hearing by telephone) and it is clear that his wife who also had a number of health problems was worried about *GZK* bringing back COVID-19 infection with him and infecting her. Apparently *GZK* would agree to stay home for a while, but then forget his promise and revert back to his old ways. Unlike *UZK*, the Tribunal had a comprehensive capacity assessment of *GZK*, a report which revealed that *GZK* had relative weaknesses in the encoding of



information into memory, retention, reasoning and language skills which were thought to reflect likely cerebrovascular burden against a background of low cognitive reserve. GZK's service provider conveyed her opinion that GZK's cognitive abilities had "slightly declined" since the report, evidence which the Tribunal readily accepted and emphasised. Like UZK, GZK's service providers were threatening to withdraw services if GZK did not stay at home. In order to contain GZK it was proposed that the Public Guardian would have the power to remove his electric wheelchair and he would instead need to rely on a manual wheelchair to move about his home. The Tribunal granted the guardianship application, but limited the power to restrain GZK's movement to the duration of the Order, without the need for a behaviour support plan. Like UZK, the Tribunal concluded that GZK's self-neglect outweighed his liberty and self-reliance. The Tribunal stated that 'we took into account GZK's views but could give them little weight due to his cognitive impairment' (para 54).

While in many respects the case of GZK is an improvement on UZK, it also raises a number of human rights issues, specifically related to the deprivation GZK's liberty and freedom of movement and the discriminatory dismissal of his views because of his cognitive impairment. While the Tribunal admits that 'the function we proposed could, on one view, be seen as broad and draconian'(para 43), it defends the new COVID-19 function as being flexible, limited to the duration of the pandemic, and necessary to prevent GZK from catching COVID-19 or incurring a substantial fine or imprisonment under the Order. Hence, it uses the *parens patriae* jurisdiction of guardianship to ensure the compliance of a person with mental and cognitive impairment with the police powers in the Order and section 10 of the [Public Health Act, 2010](#) (NSW). However, it is clear from the judgment that the justifications for using guardianship law ostensibly for the protection of GZK's life and health was muddled with the Tribunal's concerns about GZK's wife, his disability support workers and general community transmission.

However, it is arguable that GZK, like UZK above, actually has more rights under section 10 of the [Public Health Act, 2010](#) (NSW), than under the amended guardianship order. It should also be noted that there are many people without disabilities who have breached COVID-19 restrictions, some repeatedly. While it is hard to obtain up to date statistics, it has been reported on 27 May, 2020 that almost 6000 people from Victoria, 2069 from Queensland, 1290 from New South Wales, 271 from South Australia, 104 from Western Australia and 50 from Northern Territory had been fined thousands of dollars for breaching social distancing rules ([Mills, 2020](#)). Even the case of Matthew Stephens who arrived from Jordan and repeatedly breached compulsory self-isolation for returned travellers was given a twelve month community corrections order by the Sydney Central Local Court and still escaped significant fines and prison time ([Wootton, 2020](#)). At the time of writing, no one without a disability has been restrained, secluded or forcibly kept in their homes for breaching the Order.

Further, while GZK's legal advocate did suggest other less restrictive ways of containing GZK's movement other than taking away his electric wheelchair, these were not listed or explored at all in the text of the judgment. Nor was the possibility of allowing GZK to leave the house from time to time and to go to the shops for "exercise" and fresh air, or to buy essential items as permitted by the Order, possibly with an escort if they were concerned that he was not appropriately social distancing from others. Alternatively, as for UZK, some other form of reasonable accommodation, in consultation with police, may have been appropriate. While the Tribunal stressed that GZK's movements would ordinarily not be illegal and were only problematic because of the COVID-19 pandemic, it is not clear why this meant that a behaviour support plan should not be developed for the duration of the order, other than the need for the professionals making the plan to be able to engage in social distancing. The authorisation of environmental and physical restraint and seclusion are among the most serious restrictions on an individual's freedom of movement, which are usually strictly regulated

and are widely reported as being overwhelmingly negative and traumatising by persons with disabilities ([Melbourne Social Equity Institute, 2014](#)). The authorisation of seclusion and restraint should never be given lightly and always as a last resort.

### 4.3. South Australian legislative approach

The approach of the New South Wales Guardianship Tribunal can be compared with the provisions in the South Australian [COVID-19 Emergency Response Act, 2020](#) (SA) Schedule 1 which permits the detention of certain 'protected persons' during COVID-19 pandemic including a person under guardianship, or an incapacitated person resident in a supported residential facility, or other kind of supported accommodation (cl.1(1)). Unfortunately, the structure of the regulatory regime is complicated and confusing and can be found in a combination of legislation, regulations and guidelines. It gives powers to guardians to apprehend and detain protected persons, but it also sets up an Authorising Officer, a public servant appointed by the Minister who is responsible for monitoring the operation of the Schedule and protecting the rights of protected persons. The exercise of powers by guardians and the Authorising Officer is overseen by the Guardianship Tribunal. A Community Visitor has access to visit protected persons.

While Schedule 1 has a number of similarities to the NSW Guardianship Tribunal's 'COVID-19 guardianship function' in that it gives power to detain protected persons at home or at a facility for as long as the emergency response lasts, it also contains a number of additional protections. For instance, the actual spread of the COVID-19 pandemic in the state at the time the order is made must be taken into account by the Authorised Officer (presumably to prevent detentions where there are few cases in that area and the risk of infection is low), the maximum period of detention is 28 days unless extended by the Tribunal, and the decision-maker must also take into account the guidelines.

While guidelines are often regarded as being merely directory ([Broadbridge v Stammers, Federal Court of Australia, unreported, 4 November, 1987](#)), the Act and regulations state that compliance with them is mandatory. The guidelines contain a number of safeguards, such as, ensuring the nature and means of any detention of a protected person must be the least restrictive of the protected person's rights and personal autonomy as is consistent with his or her proper care and protection to protect their own and public safety. Detention must not comprise seclusion except as a last resort and the nature and means of any detention must not be determined based upon the convenience of others (including the person exercising the power of detention). If a person is detained it needs to be recorded in a register and reported to the Authorising Officer.

It can be seen then that the South Australian approach contains more human rights protections for the liberty of persons with mental and cognitive impairments than the Guardianship Tribunal in New South Wales. However, as at the time of writing there have been no published tribunal cases implementing the provisions in Schedule 1 in South Australia. Given the low number of COVID-19 cases in South Australia and the lifting of some restrictions, Schedule 1 may never be used. I am also not aware of any other Australian jurisdictions which have used guardianship to detain persons with mental and cognitive impairments who may be breaching COVID-19 stay-at-home orders. The lack of specific COVID-19 regulation of persons with mental and cognitive impairments under guardianship or emergency legislation in other states and territories raises the question of whether it is really necessary at all.

## 5. Conclusion

The COVID-19 pandemic has seen the introduction of restrictions on the civil liberties of the general population in Australia and much of the world that were previously unthinkable. In order to stop the spread of

the virus and implement social distancing, emergency legislation and operational changes have relaxed many of the previously rigorous safeguards and oversight mechanisms that regulated the use of coercive powers in relation to persons with mental and cognitive impairments under mental health and guardianship laws. This has resulted in a number of human rights challenges with respect to the rights of persons with mental and cognitive impairments under the CRPD. The protection of the life, health and well-being of persons with mental and cognitive impairments who are at high risk of serious illness and death during the COVID-19 pandemic are undoubtedly important rights. The COVID-19 pandemic has demonstrated how embedded medical bias and discrimination against persons with disabilities can threaten their very lives and health. It is pleasing that, unlike other countries, in Australia every death from COVID-19 is counted and is regretted as a terrible loss. But, the exclusion of the needs of persons with disability from the government's initial emergency planning in breach of Article 11 of the CRPD is concerning and caused persons with disabilities undue anxiety, confusion and personal risk. This paper has also demonstrated that the disproportionate impact on the loss of the civil and political rights of persons with mental and cognitive impairments also needs to be taken into account to ensure that *all* of the person's human rights are respected. This is especially the case where a person may be institutionalised against their will for a long period of time, like a year, or may become subject to restrictive practices like seclusion and restraint and being forced to remain at home well beyond the restrictions placed on the general population. The COVID-19 pandemic demonstrates that States Parties, including Australia, still have a long way to go with CRPD implementation. Moving forward States Parties need to continue realising their CRPD obligations, especially deinstitutionalisation, ensuring that persons with disabilities are included in emergency planning, and in developing more equal, inclusive and sustainable economies and societies (UN Policy Brief, 2020).

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