



## EDITORIAL

# COVID-19: Restrictive practices and the law during a global pandemic – an Australian perspective

### A NEW AGE OF RESTRICTIVE PRACTICES?

The COVID-19 pandemic has created a heightened state of anxiety and fear in many communities (Usher *et al.* 2020), particularly within vulnerable populations (such as the elderly, people with disability, people with mental illness, prisoners, and asylum seekers). These vulnerable populations are already sensitive to the use of restrictive practices, namely, the use of interventions that restrict the rights or freedom of movement of patients via restraint (chemical, mechanical, social, or physical) and seclusion. These concerns are exacerbated in a time of pandemic (World Health Organization 2020). The laws in all Australian jurisdictions require consideration of the principle that the freedom of people in care is restricted as little as possible. It is therefore essential that restrictive practices are undertaken lawfully and with careful consideration (Chandler *et al.* 2016). Two recent decisions of tribunals illustrate these concerns (See Box 1).

### WHAT ARE THE LEGALITIES OF RESTRICTIVE PRACTICES?

Australia lacks a uniform regulatory approach to restrictive practices in mental health, but they usually fall under each jurisdiction's regulation of compulsory treatment orders, with an emphasis on them being seen as 'last resort', subject to the principle of being the least restrictive alternative of caring for the person, and having to be reported and regularly reviewed (Table 1). Guardianship and disability regulation may also play a role in regulating restrictive practices for those with mental illness who are under some form of guardianship arrangement but not subject to a compulsory mental health order (see Box 1; see Table 1).

COVID-19 has added another dimension to this picture via the introduction of public health law. Health authorities in all Australian jurisdictions can invoke public health orders that allow for an extremely broad range of coercive orders including controlling the

#### **BOX 1:** Cases on restrictive practices and COVID-191

##### **UZK [2020] NSWCATGD 3**

UZK was a 69-year-old Aboriginal woman who was described as a vulnerable person with paranoid schizophrenia. The Public Guardian of New South Wales had already been appointed to make decisions concerning her accommodation and access to services. UZK had a tendency to wander. She had no capacity to observe social isolation. Her primary mental health clinician brought an application to place UZK in emergency respite accommodation and keep her there during the pandemic. The Tribunal ordered that the Public Guardian be given this additional power, including the power to request the police to take her into custody and bring her back to respite. However, her particular care needs were considered appropriately the subject of a guardianship order and not a public health order. One reason for this decision was that a public health order could not yet be made against UZK as she had not contracted COVID-19, nor was she reasonably suspected of having done so. The Tribunal determined that a public health order would only be made in extreme circumstances where the person poses a risk to public health. It is not the appropriate order where the concern is protection of the health and well-being of a particular individual, which is a function of guardianship legislation.

##### **GZK [2020] NSWCATGD 5**

GZK was a 76-year-old Aboriginal man who lived with his wife. He had a history of persecutory type delusional disorder, was a bilateral below-knee amputee, and had long-term brittle diabetes. He had no capacity to understand the risk of COVID-19 to his health. The Public Guardian of New South Wales had previously been appointed as guardian for GZK but requested that the Tribunal grant an additional power to restrict GZK from wandering around and endangering himself. The Tribunal granted the Public Guardian a 'COVID-19 power' to restrict GZK movements and to make decisions regarding his accommodation including 'authorising the use of physical restraint, environmental restraint or seclusion if required'. Likewise, the Tribunal in this case gave greater weight to the need to promote and protect GZK's welfare and interests and for him to be protected from neglect, thus under a guardianship function.

person's conduct, forcible detention, testing, and treatment of any person reasonably suspected of being COVID-19 positive. Table 2 sets out the various Australian state and territory legislation, and relevant sections that outline these powers (Kerridge *et al.* 2013).

**TABLE 1** Restrictive practices regulation in Australia

Jurisdiction	Legislation
Commonwealth	National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018
NSW	Mental Health Act 2007 Guardianship Act 1987
Qld	Mental Health Act 2016
SA	Guardianship and Administration Act 2000 Mental Health Act 2009 Advance Care Directives Act 2013 Guardianship and Administration Act 1993
Tas	Mental Health Act 2013
Vic	Mental Health 2014 Guardianship and Administration Act 2019 Medical Treatment Planning and Decisions Act 2016
WA	Mental Health Act 2014 Guardianship and Administration Act 1990
ACT	Mental Health Act 2015 Guardianship and Management of Property Act 1991
NT	Mental Health and Related Services Act 1998 Guardianship of Adults Act 2016

**TABLE 2** Compulsory testing, treatment and detention powers

Jurisdiction	Legislation
Commonwealth	Biosecurity Act 2015
NSW	Public Health Act 2010, ss 60-76
Qld	Public Health Act 2005, ss 113-116
SA	South Australian Public Health Act 2011, ss 69-84
Tas	Public Health Act 1997, ss 41-42
Vic	Public Health and Wellbeing Act 2008, ss 113, 116-125
WA	Public Health Act 2016, ss 115-117
ACT	Public Health Act 1997, ss 113-117
NT	Notifiable Diseases Act 1981, s 11

## ISSUES FOR CONCERN

The use of restrictive practices in public health orders raises a number of challenges for mental health practitioners (Arnold *et al.* 2019). Firstly, public health orders lack the kinds of tight regulation of restrictive practices that we see in mental health and guardianship law, especially in how they lack a principle of the 'least restrictive means'. The use of public health powers comes with the risk that the governance of restrictive practices may loosen.

Secondly, mental health teams are unlikely to have a working knowledge of public health law but may never-

theless be asked to act in accordance with it (Power *et al.* 2020). Poor knowledge of regulation may lead healthcare practitioners to illegally authorize restrictive practice (Lamont *et al.* 2016, 2019).

Thirdly, some health practitioners have in the past been uncomfortable and reluctant to enforce public health orders, due to a conflicting sense of feeling like a 'jailer' (Kerridge *et al.*, 2013). Any such reluctance needs to be considered in relation to the protection of others (Coker 2003) and of course protecting oneself (Matheny Antommara 2020).

## CONCLUSIONS AND SUGGESTIONS

Australian mental health practitioners need to lawfully navigate the challenges raised by COVID-19. Firstly, mental health practitioners must familiarize themselves with the relevant regulation of restrictive practices (see Tables 1 and 2; Ryan 2018). Restrictive practices, applied to a patient with suspected or confirmed COVID-19 infection, are only defensible when made in accordance with mental health, guardianship, or public health legislation (Carter 2020).

Secondly, we believe that there needs to be careful monitoring of restrictive practices authorized by public health orders so that the nature, frequency, and extent of these orders become known (Carter 2020). Such requirements exist under mental health and guardianship regulation so we believe this should be mirrored in the public health regulation.

Thirdly, discourse needs to be established between clinical teams in mental health and local public health units, who primarily have governance in this context (Khan *et al.* 2017). Mental health units and public health units need to be aware of each other and establish lines of communication so that they can work together on the kinds of restrictive practice have been ordered for patients.

Fourthly, consideration needs to be given once again to a nationally uniform approach to restrictive practices across the regulatory map of mental health, guardianship, disability, and public health. While these health systems have different aims, the concerns about use of restrictive practice are the same. Policy needs to be clear, transparent, and unambiguous, in mitigating against anxiety, fear, and uncertainty (Khan *et al.*, 2017). A nationally consistent regulation is the best way to encourage best practice, fair decision-making, the protection of human rights, and the promotion of public safety.

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