COVID-19 and people with disabilities

Assessing the impact of the crisis and informing disability-inclusive next steps

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1 Executive summary

Disability inclusivity of disaster and recovery planning

In the spring of 2020, the public initiatives in relation to COVID-19 consisted of a rapid closure of many functions in society, which stopped the first wave of the pandemic.[1] This first closure took place on 11 March, when 10 persons were in hospital with COVID-19 and 1 300 in quarantine.[2] As the pandemic had not really taken hold, it caused the first wave to be cut off with a maximum of 535 in hospital on the 1 April 2020.

After just over a month, the government took initiatives to involve the civil society in the decision process in the form of so-called sector partnerships. As a result, the opening up and the following closure in the second wave in the autumn of 2020 became more nuanced and took also smaller groups such as groups of people with disabilities into account.
Initially, there was a lack of protective equipment and the test capacity was small because the health system, in spite of several warnings from researchers over the past two decades, was not prepared for a pandemic to come. Therefore, the first shutdown had to be done with very rough means. The second shutdown in the autumn 2020 was more gradual and with more regard to people with disabilities.

Tine Rostgaard's report[3] provides a detailed description of the development in the first two months and its significance for elderly care. In its summary of results, it mentions the following:

> "factors that may have exacerbated the situation:
> - The testing strategy has changed a number of times and did not initially consider the need to test nursing home residents and staff.
> - Initially, Personal Protective Equipment (PPE) was prioritised for the health care sector, so municipal care providers had to find alternative ways to secure protection.
> - The guidelines regarding the use of PPE in the nursing home sector have been inconsistent."

From June 2020, efforts against COVID-19 have been characterized by the active participation of civil society, there has been plenty of protective equipment and the test capacity has been expanded very strongly. In this way, it has been possible to adapt the efforts better to the specific society, including to people with disabilities. Thus, we have the background to see that public initiatives in relation to COVID-19 have in particular entailed the following four special disadvantages for people with disabilities:

1. Uncertainty about belonging to risk groups. Worry if one does. Especially for persons who also have responsibility for staff who are exposed to the risk of infection, and who pose a risk of infection.

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1 A recent report of the corona policy in spring 2020 by professor Jørgen Grønnegård: https://www.ft.dk/da/aktuelt/nyheder/2021/01/udredning-om-covid_19.
2 https://da.wikipedia.org/wiki/Coronaviruspandemien.
3 Tine Rostgaard: The COVID-19 Long-Term Care situation in Denmark. May 2020 https://ltccovid.org/.

2. Difficulty with using mask. Problems with understanding what happens when other people are using mask or other protective means.
3. Restrictions on visits to institutions and residences. For most residents, it has meant loneliness, while one group has experienced consequences of not understanding what is happening.
4. Employment and training schemes for certain target groups have been closed down. It has been difficult for some people both to understand that it has happened, and to function without the schemes.
   The current restrictions can be found on the Central Disability Council's website.[4]

Impact of the virus on mortality among people with disabilities

There are many indications that at the beginning of the pandemic in the spring of 2020, there was an excess mortality of residents in nursing homes. The system was not prepared for a pandemic, and there was not enough of adequate protective equipment. In terms of protective equipment, hospitals were prioritised so that there were not enough supplies for nursing homes and home care.

There are no statistics yet on how the mortality rate in nursing homes compared to other places went. Nor are there statistics on mortality for people with intellectual disabilities who live in their own homes. But it is possible to investigate.

Outline of key concerns about a disproportionately negative impact of the COVID-19 crisis on people with disabilities

The 3 most significant disproportionately negative impacts of the COVID-19 crisis on people with disabilities are:

1. In the spring, when the fear of COVID-19 was great and very little was known about it, almost everything was shut down. As a result, many people with disabilities lost much of the support they had received so far. (Chapter 2).
2. For some groups: Isolation. In case of restrictions on visits to institutions. Or because they have difficulty understanding the situation, if they are demented or have intellectual disabilities. (Chapter 7).
3. For other groups, difficulty using a mask, or watching others doing so. (Chapter 6).

Examples of good practice

1. At the reopening in the spring, sector partnerships were established in many areas.
2. Funds have been set aside to meet loneliness.
3. In the autumn of 2020, every effort has been made to avoid hitting people with disabilities. In connection with several of the restrictions, the social area is exempt.

[4] https://dch.dk/nyheder/nyhed/ny-information-om-coronavirus-opdateres-loebende.

Recommendations and opportunities for change

1. The use of digitalisation and technological solutions for the benefit of people with disabilities has accelerated. In a short time, digital solutions such as video consultations, telephone consultations, have been implemented. Both the National Board of Health and the National Association of Local Authorities expect that these solutions are here to stay. It has also been mentioned that these changes may help to improve employment efforts for people with disabilities, because people have become more aware of the possibilities of filling more work functions from home, and because these opportunities have been expanded during the pandemic.
2. There is a widespread recognition that the socially disadvantaged are also in a vulnerable position in the field of health.
3. In one of the studies behind its Evaluation,[5] the Danish Disability Organisations conclude, among other things: “The health crisis has shown that very close cooperation between disability organizations and authorities is absolutely crucial. There has largely been a close and centralized collaboration, and the authorities should take this on as an important experience.”

[5] Danish Disability Organisations have prepared a comprehensive Evaluation of the disability areas challenges in connection with COVID-19 (Evaluering af handicapområdets udfordringer i forbindelse med COVID-19), based on several studies they have conducted. It will be used many times in the following and referred to as DH Evaluation. The report with its 11 appendices can be found on DH’s homepage: https://handicap.dk/nyheder/ny-rapport-handicaporganisationerne-tager-stort-ansvar-under-coronakrisen.

2 Disability-inclusive disaster and recovery planning

Article 11 – Situations of risk and humanitarian emergencies & Article 4(3) – involvement of persons with disabilities

2.1 Commitments to disability in disaster management and recovery strategies

One of the five action tracks in the social partnership is: A social preparedness during health crises and increased national focus on the disability area.[6]

There was no contingency plan that could be followed in the event of a pandemic, and therefore there were no plans for how to take into account the circumstances of people with disabilities in such a situation.

The social partnerships have talked about making a social contingency plan, but have not yet started to do it. But we can expect that the parties, even after the COVID-19 crisis is over, will continue the work with a social emergency plan that deals with how to take care of, among other things, people with disabilities in a disaster situation.

Social partnerships have been an important element in the efforts towards COVID-19 from the first reopening began after some weeks of the closure, which was carried out very suddenly under the impression of the scenes seen at the time from northern Italy. They are the result of an agreement between the Government and all parties in the Danish Parliament (Folketinget) and were mentioned in a statement from the Government of 17 April 2020.[7]

The announcement from the government states, among other things:

> "Elderly and vulnerable as well as vulnerable young people: Partnerships are established across authorities, civil society, cultural institutions, private actors and the public sector that can develop initiatives that counteract loneliness, vulnerability and support socially disadvantaged children and young people. There are new methods to support visits from family and relatives in a safe way."

The partnerships deal with all issues related to the pandemic and the efforts in relation to it that arise for the groups concerned.

The COVID-19 crisis has also affected people with disabilities in the sense that their organisations have been subject to the same restrictions as other organisations. The organisations had to change activities and adapt communication and counselling with days' notice, at the same time as they had to send employees home for homework and cancel planned events. It hit their economy hard. The general compensation schemes and aid packages have been crucial to the organisations' ability to support their members and volunteers throughout the crisis.

Most disability organisations have a number of projects that are supported by foundations and authorities, where they have committed to performing specific

[6] DH Evaluation, Appendix 7.

[7] https://www.regeringen.dk/nyheder/2020/aftale-vedrorende-udvidelse -of-the-first-phase-of-a-controlled-reopening/.

activities.[8] The COVID-19 crisis meant that they incurred additional expenses. It also meant that they were prevented from performing most of the promised activities. However, foundations and authorities have announced that they understand that fixed expenses are incurred. And in this connection, they will not demand that the organisations quickly catch up with all the planned activities, or that all goals for the projects are achieved.

2.2 Involvement of people with disabilities in disaster management and recovery strategies

Social partnerships: The involvement of people with disabilities in disaster and reopening planning has taken place in the way that the authorities have negotiated, among other things, with the disability organisations about the content of the plans. These negotiations have taken place within the framework of the social partnerships. The social partnerships were set up in connection with the reopening in the summer of 2020, where sector partnerships were set up in many different ministerial areas, three of them in the social field: the disabled, the socially disadvantaged and children.[9]

A sectoral partnership is a working group in which representatives of civil society participate together with relevant authorities. Some of the participating organisations facilitate the partnership work. The disability organizations participate in the sectoral partnerships in the social field. The three mentioned partnerships, which together are called "The social partnership", sometimes hold meetings together and meet with the Minister of Social Affairs at least once a month.[10]

The partnerships were created by an agreement in April 2020 between all parliamentary parties. The purpose was to help the vulnerable groups through the reopening and the difficulties of social isolation and a changed everyday life. A total of EUR 29 million was allocated. Of this, EUR 17.6 million for special assistance for vulnerable children and young people, for example relatives of people with alcohol or drug abuse, EUR 5 million for the homeless, victims of violence, people with substance abuse and people with mental illness; EUR 4.8 million to combat loneliness among people with disabilities; EUR 1.3 million for the social commitment of the folk high schools and the cultural, sports and association life. Three partnerships were established, one for vulnerable children and young people, one for vulnerable adults and one for people with disabilities. The partnerships between civil society and public authorities were created in order to develop new solutions and uncover the special challenges for vulnerable groups that were expected to come when society is reopened. The partnerships shall function until the reopening of society is completed.

The partnership in the field of disability consists of: Danish Disability Organizations, the Social Educators, the National Association of the Intellectually Disabled, the Danish Red Cross, the Danish Association of Social Workers, the Association of Public Employees, the National Association for Social Services, the Danish Disability Sports Association, the Danish Sports Association (DIF), the Danish Gymnastics Association, the Danish Youth Council, The Popular Movement against Loneliness, the Association

8 DH Evaluation, Appendix 9.
9 DH Evaluation, Appendix 7.
10 https://sim.dk/nyheder/nyhedsarkiv/2020/apr/alle-partier-indgaar-aftale-om-hjaelp-til-saarbare-og-udsatte-grupper/.

of Danish folk high schools, Nota (Danish Blind Library), the Association Equal Worth, The National Association of Local Authorities and Danish Regions.

The Social Educators and the Danish Disability Organizations (DH) have been appointed to be facilitators for the partnership in the field of disability. DH has attached a working group among the member organizations to the partnership. A sector partnership has been established for the social area, consisting of the facilitators for each partnership as well as the representatives of the Ministry of Social Affairs, Danish Regions, The National Association of Local Authorities and the Danish Patient Safety Authority. The sector partnership is the gateway to the Minister of Social Affairs, who will take the partnerships' input into the political negotiations on reopening.

The Sector Partnership is a forum where representatives of civil society present the experiences, they have had in society about the restrictions introduced, and where these can be communicated to the Minister quickly, so that corrections can be implemented in cases where the restrictions have seemed inappropriate. When you intervene quickly, you will often implement something square without including the nuances. The sector partnerships can help to ensure that small groups are also taken into account.

The partnership has held three meetings in 2020. Among other things the partnership has prepared a proposal for a strategy to combat loneliness with a focus on five lines of action:

1. De-tabooing and enlightenment;
2. Inclusion and accessibility (access to communities);
3. Involvement and empowerment (link between communities and people with disabilities);
4. Local cooperation and anchoring (ensuring local involvement);
5. A social preparedness during health crises and increased national focus on the field of disability.

The partnership will submit its input to a social contingency plan to the Minister of Social Affairs, the Minister of Health and the Prime Minister. Among the topics the social partnerships have discussed are: Recommendations across the partnerships, Loneliness Strategy for Vulnerable Children and Adolescents, Loneliness Strategy for Vulnerable Adults, Loneliness Strategy for People with Disabilities, Mapping on Vulnerable Children and Adolescents, Recommendations on Vulnerable Children and Adolescents, Survey on vulnerable adults.[11]

Funds have been set aside to combat the loneliness that occurs in particularly vulnerable groups during the COVID-19 crisis because they have to maintain stronger restrictions than other people. The Danish Disability organizations administer part of these funds.

In Evaluation,[12] DH describes some key lessons learned from partnership in the field of disability:

[11] Unpublished material from the social partnerships.
[12] DH Evaluation, Appendix 7.

”• The partnership has provided the opportunity for knowledge sharing across various actors in the field of disability in relation to the COVID-19 situation
- It can be difficult to use the partnership as a starting point for concrete initiatives, as the partnership must first get to know each other, gain ownership of the partnership and there is no earmarked money for initiatives in the partnership.
- The partnership has been the starting point for the proposal for a social emergency plan. The proposal is shared by the other partnerships in the social field.
- The Sector Partnership is a fruitful forum for direct dialogue between the Minister, the central authorities, user organizations and professional organisations.
- Many of DH's member organisations have been in direct dialogue with people with disabilities, e.g. through counselling services. Through this, the organizations have gained an insight into the challenges and concerns among people with disabilities during COVID-19 and in connection with the reopening. Through the affiliated DH working group to the partnership, DH has gained access to the member organisations' knowledge, which form the basis for DH's contribution to the partnership. It is our experience that DH's member organisations have also benefited from being in *mutual* dialogue through the working group. The participating organisations have expressed that they were happy with the knowledge sharing that takes place in the working group. It is, for example, rewarding to hear about the other organisations' initiatives and considerations on various topics, e.g. for and against a special marking of keeping a distance, such as a badge or vest."

2.3 Disability impact assessments and research to inform disaster management and recovery planning

Danish Disability Organizations have made a study of how the crisis has affected people with disabilities.[13] The survey was conducted 7 to 25 May 2020 among members of the DH Panel, which is composed of people with disabilities and their relatives, who were invited via email to answer an online questionnaire. There were responses from 892 respondents.

The respondents include people with all types of disabilities, mental disorders (schizophrenia, anxiety, bipolar disorder, etc.), cognitive disabilities (ADHD, autism, epilepsy, intellectual disabilities, etc.), sensory disabilities (visual impairment, hearing impairment, brain damage, etc.) and physical disabilities (muscle wasting, arthritis, sclerosis, cerebral palsy, etc.).

The survey shows that more than half of the respondents have experienced a reduction in their training (7/8 of those who had planned training). For most of these, it has affected their health or functioning. Over half have had scheduled visits or treatment postponed (3/4 of those who had appointments), and for most, it has also affected their health and functioning. Almost half of those who receive support from the municipality have experienced changes in their support, and these changes have in almost all cases affected their lives negatively. 7/8 do not experience that the changes in the support have been made on the basis of an individual assessment (as the social

[13] DH Evaluation, Appendix 2.

legislation says they should). Just over 1/3 do not find that the changes made were reasonable.

Among respondents with hearing loss, about 1/5 believe that the information from press conferences has not been accessible (there has been sign language interpretation). The figure is slightly higher for other live broadcasts where there has generally been no interpretation. 1/3 of the respondents with visual impairment have not experienced that the information about COVID-19 on websites and social media was accessible, and about 1/5 have not experienced that information on public authorities' websites and the hotline offered was accessible.

In the field of mental disorders, the association Better Psychiatry conducted a study[14] in April 2020. It shows that closures, visit restrictions and social restrictions have had major negative consequences for people with mental illness and their relatives. The survey is based on responses from relatives, 2/3 of whom are parents. Approx. 700 relatives of people with mental illness have participated in an online survey. Most respondents are members of Better Psychiatry.

A large majority of the relatives assess that the patient's illness will worsen as a result of the COVID-19 crisis, that it has become more difficult for the patient to get the necessary help and that the relatives have been extraordinarily stressed. Half of the relatives experience that the municipalities' support for the sick person at home or in residence has ceased temporarily, been reduced or has changed to telephone or video calls. A large majority express that the patient feels highly or somewhat isolated. Fear of infection, visit restrictions and reduced home support (*bostøtte*) and home visits are major causes. Half of the relatives believe that the municipality underestimates the mental strain of the mentally ill.

"One of us" is a campaign which was launched in 2010 by a network consisting of a large fund, some authorities and psychiatric associations. It aims to destigmatize mental illness, and it conducted a survey[15] in April 2020. The 680 respondents are members of the One of Us panel who all have or have had mental illness. The purpose of the study is a temperature measurement of how the changed conditions in everyday life affect people who have a mental illness. There is a representative spread of diagnoses, but relatively many of the men live alone. Most respondents are in the age group 30-49 years.

Only a few have experienced themselves being infected with COVID-19. Approximately 2/3 experience that their daily rhythm crumbles in the crisis, and almost 3/4 indicate a lack of outgoing social activities. At the same time, 2/3 also indicate that they have begun to reflect more on life and its possibilities for action. Over half state that they will be more aware of their social relationships, and 1/3 have developed new routines and habits that they will stick to. Among those who live alone, disturbed sleep rhythm and skin hunger[16] are a bigger problem than in the total group. More than half experience that the crisis must give others a better understanding of loneliness. Approximately 1/3 have needed to seek professional help for (aggravation of) their

[14] https://bedrepsykiatri.dk/udspilsvar/corona-krisen-rammer-psykisk-syge-og-paaroerende/.
[15] http://www.en-af-os.dk/Raad%20og%20Viden/EN%20AF%20OS-undersoegelser.aspx.
[16] Direct translation of an expression used in Denmark about the lack of feeling other people, giving hugs and kisses, and in general having a warm human relationship.

mental illness as a result of the crisis. Over half have been in contact with professional assistance. Less than 10 % have used voluntary services.

The mentioned studies were all completed in the spring of 2020. They have thus been known for most of the time the social partnerships have been working. Of course, it gives organizations more weight when they come up with their examples of things that seem inappropriate that they can support their cases with broader studies like the ones mentioned.

2.4 Use of disaster management and recovery planning funds

No special funds have been set aside for disability in disaster and reopening planning. However, as mentioned, funds have been provided to combat loneliness, a problem that affects groups of people with disabilities more than others. It has happened through the social partnership. These funds are managed by civil society organizations, including Danish Disability Organizations. And through the social partnerships, disability organizations have a say in how all disaster and reopening resources are used.

3 Mortality connected to COVID-19 among people with disabilities

Article 10 – The right to life

3.1 Are official statistics available concerning the overall mortality rate of people with disabilities?

No official statistics have been produced that shed light on the mortality of people with disabilities compared to other people.

However, there are data sets that will make it possible to shed light on the problem. For example, the panel survey SHILD, which is conducted by VIVE, has drawn random samples of the Danish population, where it is highlighted who has a disability. Based on these, it will be possible to investigate whether the mortality of people with disabilities develops differently than the mortality of other people in the period 2018-2020.

In addition, the National Institute of Public Health is on its way with studies on 'Health profile for adults with health-related activity limitation and physical disability' and 'Health status among adults with intellectual disabilities', and the Ministry of Social Affairs is on its way with a Social Policy and Disability Policy statement, which may also help to shed light on the issues.

It will probably be very limited how much initial analyses can contribute. It takes a couple of years before the relevant data has entered the registers, and only then can a more comprehensive analysis begin.

3.2 Are official statistics available concerning the mortality rate of people with disabilities who have died from complications connected to COVID-19?

No official statistics have been produced that shed light on mortality with COVID-19 for people with disabilities, compared to mortality with COVID-19 for other people. However, there are data sets that will make it possible to shed light on the problem. As in point 3.1, this can be done on the basis of VIVE's study SHILD and the other studies mentioned above.

4 Access to health

Article 25 – Health

4.1 Emergency measures

Some types of disability can cause the person to be classified as belonging to a risk group. In some cases, this will mean that safety is strengthened, for example by more use of protective equipment or by increasing safety in some other way. For example, institutions are generally open for visits, but if they have residents who belong to the risk group, it can be decided locally that a restriction on access to visits is implemented.

Disability in itself does not mean that a person is classified as belonging to a risk group. It is medically defined risk, for example weakened lungs or general weakness in the body that is crucial.

Housing form has been used as a criterion for restrictions. During the first closure in the spring of 2020, visits to all residences and institutions were severely restricted. During the closure in the autumn of 2020, on the other hand, residences and institutions were generally kept open. However, it was possible to implement local restrictions if there was a specific outbreak of disease or if there were members of risk groups among the residents.

However, disability has not been used as a criterion in the treatment of COVID-19, for example for whether a person has been hospitalised in connection with the treatment. Residence form (at home, at a residence, at an institution nor age have been used as a criterion for hospitalisation or treatment in general.

In the vaccination of the population against COVID-19, the most vulnerable groups are given priority first. First older people who receive help and people with a number of chronic diseases, as well as the staff who are in direct contact with them, later older people in general down to an age limit, which is gradually lowered. This means that some forms of disability, age and type of housing are used as criteria when it comes to vaccination against COVID-19.

Danish Disability Organizations' Evaluation[17] gives a summary of experiences about visit restrictions on residences: “The visit restrictions on residences have been eased in connection with the reopening. Local time-limited restrictions have since been introduced in cities with local outbreaks that differentiate between residents and employees in risk groups.” However, DH has wanted larger groups of people with disabilities and their helpers in all cases to be given priority first in the vaccination. The reason for this desire is that people with extensive personal assistance and their helpers due to the actual work situation will be so prone to infection that this in itself makes it reasonable that they be prioritised up in the vaccination.

On 15 October, the European Commission published a communication to the European Parliament and Council, ‘Preparedness for COVID-19 vaccination strategies and vaccine deployment’.[18]

[17] DH Evaluation, Appendix 6.
[18] https://ec.europa.eu/health/sites/health/files/vaccination/docs/2020_strategies_deployment_en.pdf.

DH Evaluation[19] cites from this publication:

> "Why, if this is the case, are person with disabilities not identified as a priority group for vaccination? Why their personal assistants or people working in support services for persons with disabilities not identified as essential workers and / or as workers unable to physically distance? There is a table on page 14 of the communication, with a list of population groups to consider for priority access to vaccination and no mention of persons with disabilities. This is another proof of the invisibility of Europe's 100 million persons with disabilities."

4.2 Access to hospital treatment for COVID-19

There is no information on disability in treatment data for COVID-19. In the spring of 2020, when the pandemic came to the country, there was at the beginning a shortage of protective equipment, which meant that the disease spread more in nursing homes than would have been the case if there had been enough protective equipment. It is therefore likely that the prevalence of COVID-19 in nursing homes and other institutions in the first months has been relatively greater than it has later become. However, data will be collected for the Danish registers which will make it possible later to make a survey that sheds light on whether the prevalence of COVID-19 (to the extent that it is registered) has been relatively greater among people living in institutions than among people living at home.

4.3 Treatment for COVID-19 in congregate settings

There is no information on disability in treatment data for COVID-19. Regarding treatment in residences and institutions instead of in hospital, however, it can be said that residents have not been prevented from admission to hospital. There has been no reason to exclude them from hospital treatment, because there has always been enough space for COVID-19 patients.

Danish disability organizations have not received reports about difficulties with people in institutions not being able to receive the same treatment for COVID-19, including treatment in hospital, as other people.

4.4 Public health promotion and testing during the pandemic

On 16 March 2020, the National Association of the Deaf, in collaboration with CFD Counselling, the Red Cross and the National Police, established a Corona line in Danish sign language.[20] Until 15 May,[21] the Corona line made it possible, through Skype and Facebook, to watch COVID-19-related news in sign language. In addition to disseminating news, the Corona line also answered questions. Through Facebook Messenger and Skype, it was possible to approach the Corona line with questions and any concerns. It was also possible to explain new initiatives from the government in sign language.

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19 DH Evaluation, Appendix 10.

20 https://socialstyrelsen.dk/tvaergaende-omrader/corona/idebank/handicap/coronalinje-pa-dansk-tegnsprog-1.

21 It is not stated why the corona line was shut down.

The Corona line originally opened for inquiries Monday-Sunday from 9-15. A large group of volunteers quickly made it possible to extend the opening hours so that the Corona line also became available in the evening hours. As mentioned, the Corona line in sign language is ready to open up again if needed.

In their Evaluation,[22] Danish Disability Organizations state two key lessons, the first of which deals with mainstream communication and crisis preparedness:

> "It is clear that there has been a lack of easy-to-read communication, written interpretation, consistent deaf interpretation, the possibility of e-mail and chat etc. Public authorities should consistently include people with disabilities in their crisis communication and preparedness and invite a dialogue with disability organizations on this."

Danmarks Almene Boliger (Danish non-profit housing, BL) has pointed out in the social partnership that there has been a lack of information about corona in many languages.[23]

BL has pointed out that they very quickly became aware that some of their residents had difficulty understanding the authorities' announcements. This is due to various things: Some have difficulty understanding the Danish language and do not follow the many press conferences. Others have difficulty reading at all or lack confidence in the authorities.

The individual housing departments have solved the problems in different ways. For example, in Gellerup, they have made live translations of all press conferences into Arabic. A resident of Sydhavnen has made a children's book about corona, which has already been translated into several languages and shared on many platforms.

Several housing organizations communicate via Facebook and other social media and have hung up posters with the health authorities' guidelines where the residents move around. Residents with weak Danish skills and others who cannot orient themselves in written material have been called by telephone.

BL has entered into a collaboration with Mino Danmark (an organization that works for ethnic equality) to translate information about COVID-19 into more than 25 languages in writing and video for the housing organizations.

Efforts against COVID-19 have largely relied on testing, including home testing. A test program has been carried out as quickly as possible, where a large number of people have been tested. Among other things, it has contained the "society track", i.e. an opportunity for all citizens to get a free test. There has been a waiting time for tests in some periods, but the number has been increased to keep up with demand. By the end of 2020, there have been periods of more than 100 000 tests a day.

It has always been possible to be tested at home if you are prevented from coming to a test site by disability or illness, such as COVID-19. This has not been widely publicised, but has been communicated to those concerned through doctors and organisations. If the elderly or people with disabilities have called the doctor with

[22] DH Evaluation, Appendix 3.
[23] Unpublished material from the social partnerships.

symptoms, the doctor has sent a tester out to those concerned and tested them, either at the door or in their bed.

4.5 Impact of the COVID-19 crisis on access to health services for general or pre-existing physical or mental health conditions

In the spring of 2020, non-emergency hospital treatment was partially shut down while a large part of the staff was trained to take care of COVID-19 patients. The treatment guarantees were temporarily suspended. This should ensure that the hospitals were equipped to receive a large number of patients with COVID-19 at the same time. Only vital treatments were performed.

Everything that could be postponed without risk to the patient was exposed. It turned out, however, that there was no need for as much treatment capacity for COVID-19 as had been feared on the basis of experience from other countries. The closure of the country meant that the number of COVID-19 cases rapidly decreased. A large part of the postponed treatments were subsequently carried out during the summer of 2020.

For people with disabilities, the limitations in the treatment of old disorders have especially meant that many have had their physiotherapy restricted or cancelled for a few months in the spring of 2020. In the autumn there has been a bit of the same situation, but the problem has not been nearly as big here as in the spring.

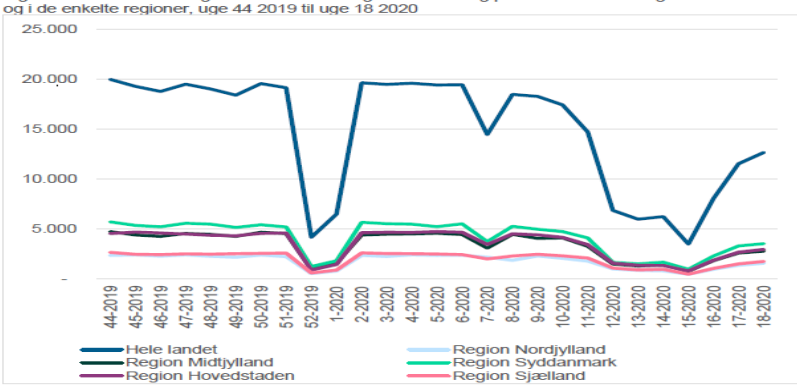
In the autumn of 2020 and the beginning of 2021, the hospitals will be kept open. This means that diseases other than COVID-19 are still being processed. However, it has also occurred during this period that non-acute treatments have been postponed or that patients have been moved to another part of the country where the hospitals had better space.

It appears from the National Board of Health's monitoring[24] that the general activity in the hospital system in several areas was reduced to a level that is in line with the level during the Christmas holidays, but the reduction in the spring took place over a time period two to three times as long.

The figure from the National Board of Health's monitoring shows the development in the number of referrals for assessment at somatic wards for the whole country and in the individual regions. The report shows a number of other measures of hospital activity, most of which show that the activity is reduced to the same or a slightly higher level than during the Christmas holidays, but that this reduction applies to a period that is two to three times longer.

[24] The National Board of Health's monitoring: https://www.sst.dk/da/udgivelser/2020/covid-19-monitorering-af-aktivitet-i-sundhedsvaesenet.

Figur 1 Graf over udviklingen i antal henvisninger til udredning på somatiske afdelinger for hele landet og i de enkelte regioner, uge 44 2019 til uge 18 2020



The decline in non-acute hospital activity in the spring of 2020 occurred, as mentioned, in order to train a large proportion of the staff in COVID-19 treatment. As a large part of the health staff has now received the necessary training to be able to step in if the COVID-19 pandemic leads to a high number of hospitalizations, it is not necessary now or in the near future to reduce the usual activity with "old" disorders in the same way as it was in the spring.

It appears from the first report in the National Board of Health's monitoring that the National Board of Health in its management of the COVID-19 situation will especially think of people in vulnerable situations, such as people with chronic diseases, people who get the first symptoms of something that can be life-threatening diseases, and people with mental illness. The National Board of Health is aware that these groups are not downgraded when it has serious consequences and do not become too reluctant to seek treatment:[25]

> "In this assessment, the National Board of Health will be based on a broad public health perspective and have a sharpened focus on those groups whose state of health may have been particularly affected as part of both an intentional and unintentional decline in activity in the health care system. This may have meant that, for example, patients with chronic diseases do not receive help with the necessary adjustment of medication and patients with symptoms of cancer wait longer than usual before contacting their doctor, which can be of great importance for their further course of treatment. There may also be people with mental disorders who do not seek treatment, even if they experience worsening of, for example, anxiety symptoms or depression, during a pandemic with increased fear of illness and less access to social networks.
> In monitoring the gradually increasing activity, the National Board of Health will have a special focus on giving these patients access to the necessary treatment. The National Board of Health has continuously supported this with an intensified communication effort to the citizens to remember to consult their own doctor and not cancel agreed consultations, etc."

4.6 Vaccination programmes

The prioritisation is based on a health professional assessment of how best to protect the most vulnerable citizens and frontline staff and at the same time ensure that the

[25] The National Board of Health's monitoring, p. 6: https://www.sst.dk/da/udgivelser/2020/covid-19-monitorering-af-aktivitet-i-sundhedsvaesenet.

spread of infection is slowed down. The National Board of Health has divided the population into 12 target groups and gives in its home page the following description of the order in which the population will be offered to be vaccinated:[26]

"1. Persons living in nursing homes, etc.
2. Persons aged ≥ 65 years who receive both personal care and practical help.
3. Persons aged ≥ 85 years.
4. Personnel in the health, elderly and selected parts of the social sector who are at particular risk of infection or who perform a critical function.
5. Selected persons with conditions and diseases which entail a particularly increased risk of a serious course of COVID-19.
   Selected relatives of persons with a particularly increased risk of a serious course of COVID-19 or relatives, who are indispensable caregivers.
7. Persons aged 80-84 years.
8. Persons aged 75-79 years.
9. Persons aged 65-74 years.
10. Persons under the age of 65 who have conditions and diseases that increase the risk of severe COVID-19.
11. Personnel who perform other socially critical functions.
12. Other population, segmented by age."

Some groups such as pregnant women, breast-feeding mothers and children under the age of 16 cannot be vaccinated because the vaccines are not approved for them. The individual citizen receives information about vaccination in his e-box. Citizens who are exempt from e-boxing will receive a letter in the mail. The citizen must then book an appointment for the vaccination. Citizens who receive personal help from the municipality will also receive help for this.

[26] https://www.sst.dk/da/corona/vaccination-mod-covid-19/hvem-skal-vaccineres.

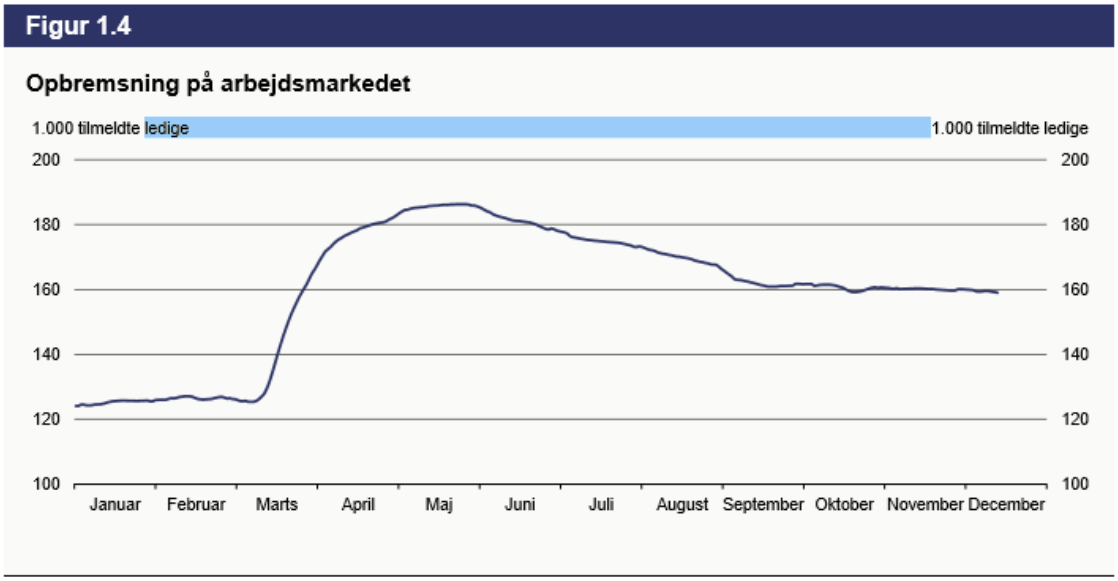
5 Income and access to food and essential items

Article 28 – Adequate standard of living and social protection

5.1 Emergency measures

During the COVID-19 crisis, the state has implemented various aid packages which have meant that the growth in unemployment has been significantly less than in many other countries. Among other things, there is a so-called “arbejdsfordeling”, which means that the employers are able to send their employees home during periods, and they will then receive unemployment support.

The figure shows the development in unemployment, from 125 000 before COVID-19 to 160 000 now:[27]



Anm.: Figuren viser personer, som er tilmeldt som ledige på Jobnet. Egen sæsonkorrektion.
Kilde: Styrelsen for Arbejdsmarked og Rekruttering.

However, there was already a social safety net, which means that the population is largely protected against poverty. The main features are as follows:

An employee who becomes unemployed and who has been a member of an unemployment fund for at least one year is entitled to benefits for up to two years. This period has been extended by the time there has been a closure in 2020. The subsidy is EUR 2 590 per month if the income has been approx. EUR 3 000 or more, and otherwise on 90 % of former income. The citizen who receives support is obliged to participate in various programs that aim to help him or her get back to work.

A citizen of 18-66 years who has no income is entitled to social assistance (kontanthjælp). It depends on age and family circumstances, often in the order of EUR 2 000 per month. This means tested benefit does not have an explicit disability dimension, but many people with disabilities live off it.

[27] From Økonomisk Redegørelse (Economy report of the Government) https://fm.dk/udgivelser/2020/december/oekonomisk-redegoerelse-december-2020/.

A citizen aged 40-66 who is unable to find work for health reasons can be granted a disability pension. It is EUR 2 595 per month for singles and a little less for cohabitants. When the citizen turns 66, the disability pension is replaced by the lower national pension.

Citizens over the age of 66 are entitled to a national pension. It is EUR 1 860 per month for singles, but less if you are cohabiting or have other income. There are also labour market pensions that citizens and their employers have paid into for a number of years. As it is different when the schemes are established in the different subjects, it cannot be stated how large it will be.

There is no labour market pension for those who receive cash benefits, and only a relatively new scheme for those who receive disability pension, so after the age of 66, many people with disabilities will not receive anything other than national pension.

5.2 Impact of the COVID-19 crisis

No studies have been conducted on how much the COVID-19 crisis has meant financially for people with disabilities compared to other people. The AE Council, which is the organisation that has carried out most studies of the prevalence of poverty in Denmark, has not heard that this problem has been investigated. Disability organisations have not either.

There is no immediate indication that the COVID-19 crisis has meant more to the economy of people with disabilities than it has to other people. The aid packages have meant that there have not been as many firings as there would have been without aid packages, and there have been fewer bankruptcies than in previous years. However, some firings have occurred, and in this connection, we know that it will often be more difficult for people with disabilities to get back to work than for other people.[28] Whether this effect is so great that it will be visible in an overall statistic is doubtful, however.

In the autumn of 2020, large sums of money were released to get the economy going again. People who were in the labour market were given the opportunity to be released a larger amount, which originated from a reorganization of the scheme for holiday pay a few years ago, and which should actually have been paid out when the citizens in question retired. The amount depends on income. If you did not want the money out, they will stay until you retire as originally intended. For many people it has been EUR 3 500 or more. At the same time, people on transfer income, many of whom have disabilities, received an amount of EUR 135 as compensation.

It is difficult to judge whether this is fair or whether it is discrimination. On the one hand, the amount that people in the labour market could get paid often was 25 times greater than what people on transfer income received, on the other hand, the money the first group received in advance was their own money, it was only the time of payment that has been changed.

[28] Mona Larsen, Vibeke Jakobsen & Christian Højgaard Mikkelsen: Handicap og beskæftigelse 2019 (Disability and Employment 2019), Vive 2020.

6 Access to transportation and the public spaces

Article 9 – Accessibility

6.1 Emergency measures

There have been restrictions on the number of passengers in public transport (bus and train) for a few months in the spring of 2020 when larger shops and shopping centres were closed and there was a social distance of two meters in shops and queues. The social distance was later reduced to one meter, but was again raised to two meters in January 2021. Assemblies of more than 10 people were banned, with the exception of demonstrations. Later, the limit was raised so that more people could gather. Kindergartens, schools and places of education were closed. Public employees in non-critical functions were sent home for homework. In the spring, there was no requirement to wear mouth bandage. The National Board of Health and Welfare did not think it was necessary with the low infection pressure we had during this period.

In the autumn of 2020, we have experienced a significantly higher infection pressure and up to twice as many hospitalized with COVID-19 as in the spring. There are now requirements for mouth bandages in buses and trains as well as in all shops. Assemblies of more than 10 people have again been banned. Around Christmas and New Year, the restrictions have been tightened, the permitted size for assemblies has been reduced to 5, all shops that do not sell groceries, medicines or health products have been temporarily closed. The other initiatives from the spring have also been introduced again. Partly because we now have the second wave of COVID-19, partly to slow down the new more contagious variant coming in from England.

For some of the restrictions, it has proved necessary to take into account people with some special disabilities who have difficulty following some of the restrictions. There is therefore an explicit disability dimension, which consists of special exceptions:

With regard to requirements for mouth bandage, there have been exceptions for people who, for example, for mental reasons are unable to wear them. However, it has been difficult for those concerned to move around in shops and public transport because they have been shamed by other citizens for going without the mandatory protective equipment. A badge has now been made that you can wear to show that you are for some reason exempt from the requirement for a mouth bandage in public transport and shops.[29]

The rules that have been introduced regarding requirements for mouth bandages, etc. in public transport[30] states in more detail what the exceptions mentioned consist of.

Section 1 of the Executive Order states that travellers with public transport of 12 years or older must wear a mouth bandage or visor. However, some of the following paragraphs state some exceptions. Section 3 of the Executive Order states that the requirement for a mouth bandage or visor does not apply to "persons with reduced level of consciousness, physical or mental impairments or anything else that makes them unable to wear a mouth bandage or visor". Section 4 states that a mouth bandage or visor can be removed for recognizable reasons, such as while taking medication,

[29] The National Board of Health press release 07.01.21 https://www.sst.dk/da/nyheder.
[30] The Executive Order https://www.retsinformation.dk/eli/lta/2020/1221.

during conversations with persons who read the mouth, or if the mouth bandage or visor causes difficulty with breathing or suffocation.

The Ministry of Transport has also published a number of recommendations for travellers, which, among other things, call for special attention to be paid not to cough or sneeze in the vicinity of elderly fellow travellers.

With regard to children's institutions, there has been so-called emergency care, for example for children from families who cannot function with the burden of having children at home. This applies, among other things, to a number of people with mental disorders. The reason may also be that the child has a disability. However, emergency care is not a good solution, and not at all for children with disabilities. Parents of children with ADHD have thus stated that their children do not receive the necessary care in the emergency care.[31]

There have been no problems with transporting around, as all bus and rail routes have been maintained throughout the pandemic in almost the entire country. A couple of weeks in the autumn of 2020, there was a restriction in traffic in seven municipalities in northern Jutland, where there was a mutation of COVID-19, which came from mink farms and which it was feared would spread.

The Ministry of Health recommended[32] that you as a citizen in one of the seven municipalities do not move beyond the municipal boundaries unless you perform a critical function. Critical functions in this context include personnel employed in the health and care sector (excluding cosmetic treatment, etc.), elderly care, the child and education sector, the police, the probation service, the defence authorities, the emergency services, the meat control, in the area of the socially disadvantaged, and for the maintenance of the necessary supply business, including e.g. the food supply, the grocery market, the pharmacy, energy, water, waste management, telecommunications and IT infrastructure, financial infrastructure.

These rules apply to actual healthcare services. On the other hand, physiotherapists who work in sports, leisure and association activities, including fitness, are not covered by the exception. Training in the pool will, however, be affected because swimming pools will have to be closed down. It appears from the description on fysio.dk that the physiotherapists can move across the otherwise blocked municipal boundaries to perform treatment, but not to participate in the fitness or sports context.

6.2 Impact of the COVID-19 crisis

There are no reports that access to transport and to public space during the COVID-19 crisis has been restricted in a way that has been more to the detriment of people with disabilities than of other people. However, it should be mentioned that the precautionary measure introduced with the use of mouth bandages has been more to the detriment of certain groups, as mentioned in section 6.1. Although exceptions have been introduced for these groups, it has not been without problems for them to move out because, as mentioned, some citizens have been busy correcting them.

[31] DH's Evaluation, Appendix 1.
[32] https://www.fysio.dk/nyheder/nyheder-2020/coronarestriktioner-i-nordjylland.

In the spring of 2020, it was first recommended that a distance of 2 meters be maintained, for example in queues in supermarkets. At one point, it was reduced to 1 meter. This reduction in social distance made some people in the risk groups nervous. A "keep distance" badge was then made that they could wear to make people aware that they were at a special risk and therefore needed to be better protected. These badges were handed out at pharmacies and by disability organizations and there was great rift about them.

The requirement for mouth bandages in public transport and shops in the autumn of 2020 has kept a number of people with disabilities at home. This applies to groups that are prevented from wearing mouth bandages, e.g. due to anxiety. Although exempt from the requirement, they are often reprimanded by other people and have therefore felt uncomfortable getting into shops and means of transportation. Now, however, a badge has been made that this group can wear to make them aware that they are exempt from the requirement for a mouth bandage.

The physical availability of public transport has not changed during the COVID-19 crisis. However, people at increased risk of a serious course of illness with COVID-19 have minimized their use of public transport to avoid traveling with several different strangers. Some people may be in the risk group because of their disability.

There have been no restrictions on individual disability driving. People with disabilities have continued to have the opportunity to be transported by granted driving and to make use of the so-called flex traffic.[33]

[33] Driving arrangements aimed at an audience of people with disabilities. Some of them must be visited by the municipality, while one of the schemes is open to everyone.

7 Involuntary detention or treatment

Article 14 – Liberty and security of person
Article 15 – Freedom of torture or cruel, inhuman or degrading treatment or punishment
Article 16 – Freedom from exploitation, violence and abuse
Article 17 – Protecting the integrity of the person

7.1 Emergency measures

Pandemic legislation allows for involuntary disease treatment. All regions have set up isolation centres where citizens can be admitted under pandemic law. However, the Danish Regions do not know whether or how much these places have been used.

There has been some pressure towards COVID-19 treatment and restrictions aimed at preventing outbreaks of the disease in institutions. The rules are set out in the National Board of Health's guidelines.[34]

Some quotations from these guidelines show that they prescribe that coercion from the social services may not be used on the basis of COVID-19:

From the National Board of Health and Welfare's guidelines page 2:

> “It is crucial to minimize the infection so that employees, citizens and visitors do not show up in social services if they have symptoms and so that they leave the place immediately at the sign of infection. In a residence, the citizen must be isolated. It is, however, important to be aware of the citizen's rights, which means that isolation can only be done if the citizen himself agrees and cooperates. The staff at a residence cannot carry out isolation, as it is considered the citizen's own home. Intervention in a citizen's own home requires clear legal authority unless the citizen himself agrees to a form of self-isolation.”

From the National Board of Health and Welfare's guidelines page 9:

> “If a citizen cannot or will not give consent to follow measures to deal with the spread of infection, such as Covid testing and use of mouth bandages, it is recommended to enter into a dialogue with the citizen, acknowledge the citizen's perspective and make compromises. If it is not possible to enter into a dialogue, for example due to the citizen's cognitive functional level, other measures such as shielding the citizen without the use of force, changing routines in relation to socializing and eating situations with other users, more frequent cleaning, may remedy and contain the problems."

From the National Board of Health and Welfare's guidelines page 10:

> "If situations arise where the Service Act's rules on the use of force are not sufficient, for example if there is doubt as to whether a citizen who cannot explain himself is infected, the employees can turn to the health authorities, who have other powers, with a view to resolution of the situation."

[34] https://sim.dk/media/38381/retningslinjer-for-haandtering-af-covid-19-paa-socialomraadet-7-udgave.pdf.

From the National Board of Health and Welfare's guidelines page 32 (on persons in housing):

> "In connection with the efforts against COVID-19, the general rules on the use of force that apply in the social area have not been changed. In relation to adults, these are the rules on the use of force and other interventions in the right to self-determination vis-à-vis adults in the Service Act. Dealing with acute situations with citizens in residential housing who are presumed to be infected or possibly infected with the consequent need to isolate the citizen from other citizens in the residential housing, therefore follows the general rules of use of force in the social area. According to these rules, the staff must always try to handle the situation with social pedagogical means…"

However, there are many indications that these guidelines were far from being complied with, but on the contrary, restrictions were introduced which went far beyond what was permitted. One heard in the press about heart-breaking scenes in nursing homes where old dementia sufferers did not understand that they were suddenly not allowed to see their children and grandchildren and were unhappy and deeply depressed. Even in hospices, where people were hospitalised for a few months because they were going to die, their contact with their loved ones was severely restricted.

In June 2020, the Institute of Human Rights (IMR) conducted a study[35] of how restrictions on housing have been implemented in practice and what consequences the restrictions have had for residents. The study is based on 20 qualitative interviews with relatives of residents.

The report finds that in some places there were restrictions so that the residents were not allowed to be visited by relatives, and in some cases the residents were banned from leaving the institution on their own and visiting relatives in their homes. In several cases, the visit restrictions have gone beyond what the rules allowed and have been without any legal basis. The possibilities of making an exception to the visit restrictions have only been used to a very limited extent. This means that the restrictions have hit harder than intended.

7.2 Impact of the COVID-19 crisis

Danish Disability Organisations have no reports of involuntary detention or treatment in institutions or within the social system in general. On the contrary, the Minister of Social Affairs has emphasised that the rules on coercion are the same as before the pandemic.[36]

As mentioned in section 4.1, there have been restrictions on visits to social institutions. In the spring of 2020, many institutions as mentioned in 7.1 were completely closed to visitors. This was due to the fear that COVID-19 would spread rapidly and paralyze large sections of society as we saw in northern Italy, and there was no time to look at nuances. After the first closure, however, civil society has become more involved.

[35] IMR's report (June 2020): Visitation restrictions on residential housing - Consequences of COVID-19 for residents https://menneskeret.dk/udgivelser/besoegsrestriktioner-paa-botilbud-konsekvenser-covid-19-beboere-paa-botilbud.

[36] https://www.altinget.dk/artikel/ministerbeslutning-nu-kan-tvangsmetoder-tages-i-brug-mod-corona.

Through the mentioned sector partnerships, they have looked in more detail at where it hurts the most to shut down, and what must be kept open so that it does not become too much of a strain for people with disabilities. Danish Disability Organizations have channelled the problems forward from the individual disability organizations, and they have then been channelled on to the Minister of Social Affairs.

In the spring of 2020, there was a general temporary ban on social housing, so visits could only take place outdoors. It was repealed in June. In the autumn of 2020, visits to residential housing are permitted. However, it is possible for the individual residence to introduce visit restrictions. The management can do so if there is an outbreak of infection in the residence, or if one or more citizens belong to a risk group.[37]

However, citizens always have the right to visits from 1-2 regular visitors. Furthermore, management cannot prohibit visits from a close relative of a critically ill or dying person. Nor can the management prohibit close relatives' visits to a child less than 18 years of age. Nor can it prohibit close relatives' visits to an adult with a cognitive impairment who lacks the ability to understand and accept the purpose of the visit restrictions.[38]

[37] Q&A. https://sim.dk/nyheder/nyhedsarkiv/2020/mar/opdateres-loebende-informationer-om-coronavirus-og-socialomraadet-med-faqs/#faq.

[38] Q&A. https://sim.dk/nyheder/nyhedsarkiv/2020/mar/opdateres-loebende-informationer-om-coronavirus-og-socialomraadet-med-faqs/#faq.

8 Violence, exploitation or abuse

Article 16 – Freedom from violence, exploitation and abuse

8.1 Emergency measures

None of the measures taken by public authorities due to the COVID-19 crisis have to do with violence or the like. The Ministry of Justice states that they are not aware of measures of this kind.[39]

8.2 Impact of the COVID-19 crisis

The closure in the spring meant that reports of violence declined sharply because there was no longer the same nightlife as before. In turn, the shutdown meant a growth in partner violence in the home. This emerges from a study by the organisation Live without Violence,[40] which was conducted by asking a number of professionals. The analysis is based on interviews with 32 professionals from 25 authorities, shelters and specialized outpatient counselling and treatment services. The interviews are supplemented with inquiry statistics from several of the organisations and the authorities.

The study has three main conclusions. 1: Several of the victims and their children have needed help during the shutdown, and the violence in some families has become more frequent and more serious. There has also been violence in families where there was no violence before. 2: The opportunities to seek and get help have been limited. This is especially true for children, because during the closure there was a lack of professionals when schools and day-care was shut down. 3: Internet counselling and treatment has meant that organisations have been able to offer help to a number of people that it was more difficult to reach in the past. The Internet form has also made it possible to reach the users at several times of the day.

Furthermore, Live without Violence's investigation shows that some divorce conflicts have worsened during the COVID-19 crisis because the authorities have postponed the cases. It has prolonged treatment time and created frustrations and led to increased conflict between some parents. Disagreement about the severity of the risk of infection and the lack of a neutral place to hand over the child has also increased the level of conflict.

However, in some cases the closure has reduced the violence. The everyday for many has been calmer due to a lower level of activity. Cancellations of meetings in the job centre can also create greater peace in everyday life in families living on cash benefits, because the citizen is faced with fewer demands. Some abused women have experienced more security as they have had less risk of meeting their former partner.

It is not possible to find statistics or statements from authorities that shed light on how much violence has affected people with disabilities during the COVID-19 crisis. It's not there. With regard to question 8.2, the Ministry of Justice has asked the National Police whether they have relevant data. The National Police has stated that the police do not register whether victims of violence have a disability. The National Police further states

[39] Informed by the Ministry of Justice by email 12.01.21.
[40] https://levudenvold.dk/category/publikationer/partnervold-under-covid-19.

that as a result, it will require a manual review of all cases of violence to answer question 8.2, which will be extremely resource demanding.[41]

The information obtained here raises a question: should the police register disability in the registration of crime? Disability is one of the conditions that sometimes give rise to hate crimes, and if this problem is to be elucidated in statistics, it is crucial that disability is registered.

[41] Informed by the Ministry of Justice by email 12.01.21.

9 Independent living

Article 19 – Living independently and being included in the community

9.1 Emergency measures

At the start of the COVID-19 pandemic in March 2020, everything was shut down very suddenly, except for the most critical functions. This meant, among other things, that many people with disabilities had their personal assistance severely cut.[42] This was due to the risk of infection they were exposed to by having helpers, the risk the helpers were exposed to, and the spread of infection that would take place when different helpers came to the same citizen. It happened according to an emergency order, which meant that one could not complain. However, this did not mean that the municipalities were exempted from having to make an individual assessment. But many people with disabilities found that no individual assessment was made.

When the day care centres for children closed down, many families with disabled children had a greater need for relief at home. In some cases, applications for this were rejected on the grounds of emergency. However, this was illegal, as the applications, despite the COVID-19 pandemic, had to be treated as ordinary applications for support and assessed according to the specific, individual circumstances.

In the fall of 2020, these problems were minor. Now the municipalities were more aware of what the rules say. Now the problem is more staff resources. Some helpers get COVID-19 like other people, and others are close contacts to people who get COVID-19 and must therefore be quarantined. The effort against COVID-19 is based to a greater extent than before on infection detection, but this means that many people have to be quarantined.

DH's Evaluation provides the results of a survey[43] that DH's chairman, Thorkild Olesen, has sent to the chairmen of DH's local branches on 11 May 2020, in which he asks a number of questions about respectively the social field and the work of the municipal Disability Council in the light of the situation with COVID-19. Thirty DH departments have responded to the email by either answering all or part of the questions. The answers were received in the period from 11-25 May 2020.

Most DH departments answer that in the social area it was especially day activity centres, sheltered employment, the companion scheme and social pedagogical support that were closed down or reorganized during the closure of Denmark in the spring of 2020, but also other support such as practical help at home and the contact person scheme has been closed down or reduced. The reopening took place gradually taking into account the recommendations of the health authorities and in some cases with a limited opening.
The local DH departments point out the following problems: 1- that relatives have to take on more tasks, 2- lack of information for citizens and relatives, 3- the reopening was not coordinated between the municipalities, which is important in the many cases where they buy services from each other, 3- that the open services are used significantly less than they were before, 4- lack of guidelines from the state, 5- unclear health professional guidelines.

[42] DH Evaluation, Appendix 1.
[43] DH Evaluation, Appendix 4.

9.2 Impact of the COVID-19 crisis

The COVID-19 crisis has meant that the possibility of living an independent life for many people with disabilities has been limited. This applies, for example, to people with disabilities who have user-controlled personal assistance and who are very dependent on helpers. They are often nervous that their helpers will get COVID-19 or that they are close contacts to others who get COVID-19, so that they will be quarantined for a period of time. And many of them find that because of the helpers' illness or quarantine, they have less help than they have been granted.

There has been no requirement that staff in nursing homes or residences, or staff assisting citizens in their own homes, have had to be tested for COVID-19. There have also been no special offers for tests for these groups, but they have been able to use the same opportunity for free tests as the rest of the population, in the part of the test strategy which is called the community track (samfundssporet).

The social partnerships have sent out a questionnaire to social organizations, user associations and municipal disability councils. There were 51 responses in the period 7 May - 27 May.[44]

The results of the study show that the social organisations have been involved in the municipalities' work to find common solutions in connection with the closure in connection with prevention of loneliness and isolation. The dialogue between the organisations and the authorities has been strengthened during the closure, and there has been an increased focus on creating solutions together. The COVID-19 crisis has given rise to collaboration with new partners to find solutions across sectors, for example regarding food and accommodation for the homeless.

Many people with mental health problems have had it extra hard during the shutdown - especially due to anxiety and isolation. The organizations expect to see an increased need for social psychiatric treatment during the reopening, and that there is a need for work among placed children and battered women. Many socially disadvantaged people need support and socializing to cope with everyday life. The increased outreach work is of crucial importance for the well-being of the group.

All the social partnerships have developed loneliness strategies, and they note that the work of combating loneliness among these groups is necessary, even when the COVID-19 crisis is over.[45]

[44] Unpublished material from the social partnerships.
[45] Unpublished material from the social partnerships.

10 Access to habilitation and rehabilitation

Article 26 – Habilitation and rehabilitation

10.1 Emergency measures

In the spring of 2020, rehabilitation was virtually shut down. This has had consequences for some patients who have not received the rehabilitation they needed.

The disability organisation Hjernesagen writes 6 July 2020 about treatment and rehabilitation:[46]

> "COVID-19 has for a long period led to a ban on visits to both hospitals and rehabilitation places. The visit ban has been lifted, and it is again possible to visit your next of kin at the hospital or rehabilitation site.
>
> The distance rules in these places are still 2 meters, and you must of course follow instructions from the staff both orally and in writing material. There may be special rules for the individual ward or place of rehabilitation if there are particularly vulnerable patients.
>
> Treatment: Throughout COVID-19, emergency preparedness and treatment for stroke and other types of acquired brain injury have been unaffected by COVID-19. Patients have received the same treatment as before. The patients have also received rehabilitation in hospital as before. The difference has been the relatives' opportunity for involvement in treatment and rehabilitation, which until now has been limited by the ban on visits, which has now been lifted.
>
> Rehabilitation: Rehabilitation according to the Health Act has throughout the COVID-19 pandemic been considered a critical function, provided that the lack of effort would lead to irreparable impairment of function for the person with consequences e.g. after an acquired brain injury. Conversely, if it was not estimated to cause functional loss or exacerbation of critical illness, rehabilitation has not been considered a critical function – and was therefore not maintained during the pandemic. Maintenance training has for example not been considered critical. However, a concrete, individual professional assessment has been made of what is critical for the individual and when something can go from non-critical to critical.
>
> Right to free physiotherapy: As with rehabilitation, it has been possible for some to maintain free physiotherapy if it was considered to be a critical function. However, many have experienced that the clinics have been closed down for a period of time. Today, the physiotherapy clinics have also reopened. Now this problem is not that big anymore. But the activities are locally adapted during COVID-19, so that there are restrictions in the regions most affected by the pandemic. Here, rehabilitation in hospitals has been reduced in scope or converted to digital consultations, for example home training with the use of video."

[46] https://www.hjernesagen.dk/news/behandling-og-genoptraening-under-covid-19/.

10.2 Impact of COVID-19 and/or emergency measures adopted

A number of people with disabilities have refrained from coming to habilitation and rehabilitation centres because they were afraid of being infected with COVID-19. When it comes to people with mental illness, there has been a similar problem. Shelters were in many places closed down in the spring during COVID-19.

It appears from an article in Sygeplejersken (5) 2020[47] that drop-in centres, homeless cafés and other social services in many parts of the country have been closed down, and for many vulnerable citizens their already sparse relationships and contact with the outside world have been significantly reduced. A social nurse at Herlev Hospital, Karen Frampton, finds that the citizens are now starting to have a hard time.

> "The first few weeks were incredibly quiet. There was calm. But little by little we begin to feel that they can no longer hold on to it all. One of my citizens has isolated himself at home and does not even dare to let in the home care. There he has sat and watched the news 24 hours a day. He is convinced that he will die of corona virus at a field hospital. He's dog scared. Then he drinks to be able to endure it, and then it all comes over," she says."

In the autumn of 2020, drop-in centres and similar gathering places for this group have in most cases been open during the pandemic, but it has been a concern of some of the drop-in centres that not as many visitors have come as usual.

[47] https://dsr.dk/sygeplejersken/arkiv/sy-nr-2020-5/udsatte-er-ekstra-presset.

11 Access to justice

Article 13 - Access to justice

11.1 Emergency measures

Danish courts use buildings that live up to the general requirements for accessibility for people with disabilities, which apply to public buildings.

The courts were closed during the first closure in the spring of 2020. It has been discussed if this closure was legal at all, in relation to the threefold division of power. However, this has not affected people with disabilities, residents of institutions or the elderly more than other people.

Incidentally, none of the concrete measures during the COVID-19 crisis have had an explicit disability or elderly dimension, nor have they treated residents of institutions differently than others in terms of justice.[48]

11.2 Impact of COVID-19 crisis

The COVID-19 crisis has meant a postponement of cases, but this has not affected people with disabilities, residents of institutions or elderly more than other people.

In order to catch up with the hump of cases created by the closure, it was sometimes necessary to use temporary courtrooms. The National Board of Justice states that it has arranged these tenancies in order to best support the consideration of accessibility for people with disabilities.[49]

[48] Informed in email from the Ministry of Justice 12.01.21.
[49] Informed in email from the National Board of Justice 12.01.21.

12 Access to education

Article 24 – Education

12.1 Emergency measures

There have been special rules for teaching vulnerable students who have been exempted from home schooling.[50] The following pupils are exempt and must therefore continue to be received at school and, as far as possible, receive regular tuition:

1) Pupils at all grade levels in special schools and special classes according to the primary school law, upper secondary school full-time teaching according to the upper secondary school law and other similar services.
2) Pupils, if this is justified by special social, pedagogical or treatment needs of the pupil, including justified by the conditions in the home.
3) Pupils who are covered by requirements for language tests, if it is assessed that the pupil has special needs that necessitate the school still receiving the pupil for teaching by physical presence at the school.

The Ministry of Education, like several other authorities, has a Q&A on their website. An answer from this may shed light on the special considerations that are taken into account for people with disabilities in connection with the COVID-19 restrictions.[51]

12.2 Impact of the COVID-19 crisis

In the spring of 2020, all schools were closed, in the autumn only the general schools were closed, whereas special schools were held open. The Ministry of Education is not aware of Danish studies on the significance of the crisis for children and adults with disabilities. We know more generally that well-known inequality patterns were reinforced during the period of closure, which may mean that there is an academic backlog for a group of students. However, it is primarily calculated on a socio-economic background and thus not disability.[52]

[50] Email from the Ministry of Education 08.01.21.
[51] https://ufm.dk/uddannelse/videregaende-uddannelse/information-om-covid-19/sporgsmal-og-svar.
[52] Informed in email from the Ministry of Education 08.01.21.

13 Working and employment

Article 27 – Work and employment

13.1 Emergency measures

In the measures on work and employment, there was no disability or elderly dimension. As a consequence, a number of people with disabilities were encouraged by the National Board of Health to stay at home. In some cases, it was possible to perform the work from home. In other cases, it was not possible, but in that situation, as a general rule, there was no possibility for the employer to have the cost of the salary covered. It is not known in how many cases the employer has paid a salary even though the employee with disabilities could not perform work, and in how many cases it has led to the dismissal of the employee. However, people in risk groups working in the health, social and elderly sector may be reassigned to other tasks if their work brings them into close contact with people who are at risk of being infected with COVID-19 or have been found infected.[53]

Already in April 2020, however, the group was entitled to sickness benefit. Provisions were added in the Sickness Benefit Act, which made it possible for persons in a special risk group or relatives of persons in a special risk group to receive sickness benefits, provided that they have documentation in the form of a medical certificate and in agreement with the employer.[54]

Although there was no explicit disability dimension in the assistance packages, there was a gap in them that specifically affected people with disabilities. In many cases they were in a dilemma between going to work at risk of health or staying home and risking the job. Therefore, it can be said that the help packages for not discriminating against people with disabilities should have had an explicit disability dimension here.[55]

On 19 March 2020, an agreement was reached on a help package for the business community, which included the possibility of wage compensation and compensation for fixed expenses.[56] The two pools were implemented by the Danish Business Authority.

The pool for temporary salary compensation pays if a company had sent home at least 30 % of the staff or more than 50 employees. The company is not allowed to keep open and have turnover during the compensation period. In addition, a pool is established to compensate for fixed expenses for companies, which can document at least a 35 % decrease in their turnover as a result of COVID-19.

Initially, the pools could not be applied by organisations that received public support, which of course applied to civil society organizations. However, with a broad political agreement on 8 April 2020, the two business aid packages (wage compensation and fixed expenditure compensation) were changed so that social organizations, which

53 https://www.sst.dk/da/nyheder/2020/opdateret-retningslinje_-hvordan-skal-medarbejdere-i-risikogrupper-haandteres.
54 https://www.laeger.dk/coronavirus-og-din-arbejdsplads#%C3%B8get%20risiko.
55 DH Evaluation, Appendix 5.
56 DH Evaluation, Appendix 9.

often have a complex economy with a mix of fundraising, public subsidies, and private memberships were also covered.

13.2 Impact of the COVID-19 crisis

The COVID-19 crisis has had an impact on work and employment for a broad group of people. In that direction, the difference between people with disabilities and other people is not so great. But point 13.1 contains an example of where it has had a greater impact on some people with disabilities. The reason for this difference is that, on the one hand, health guidelines are given by one authority; on the other hand, help packages are designed by another authority, without there being an overview of how this interaction will affect people with disabilities.

The Danish Disability Organizations' Evaluation[57] states in a collection of experiences with a view to the labour market that “the problem exists as long as we have special health guidelines for members of risk groups who say that some should stay at home. When this is the case, the Minister for Employment should, of course, be able to ensure that a security scheme will make it possible.”

[57] DH Evaluation, Appendix 5.

14 Good practices and recommendations

14.1 Examples of good practice

The good practice in the COVID-19 crisis has first and foremost been that there has been a good dialogue between government and civil society. However, the initial response to the pandemic was marked by fears of a collapse in the health care system as we saw it in some countries, and the lack of preparation for a pandemic, despite the fact that researchers in the field in the last two decades had said it was to be expected. It caused the government to decide a sudden and extensive shutdown of society. But in the second instance, when the exponential course of the pandemic had stopped, civil society was involved.

This involvement took the form of social partnerships in many ministerial areas, including in the social field. It provided a fine dialogue between disability organisations, elderly organisations, and other parts of civil society and authorities. The problems that the organizations became aware of were quickly reported to the authorities, who were thus able to do something about them. In a crisis situation there will always be mistakes and in a sudden intervention the nuances are forgotten. Then it is crucial that there is a system that can capture them and patch up the shortcomings.

14.2 Recommendations

In its Evaluation,[58] DH puts forward a number of recommendations. Based on them and the evidence presented under the previous points, I would recommend the following:

1. Closer cooperation between disability organizations and authorities. The organizations can reach out to people who are particularly vulnerable, and the authorities can draw on their knowledge to continuously clarify and improve guidelines and communication when uncertainty arises.
2. The COVID-19 vaccine deployment plan should explicitly address people with disabilities and their personal assistance. It should be clear how employees who provide personal assistance to people with disabilities are placed.
3. A social contingency plan should be prepared so that challenges in future crisis situations can be met.
4. There is a need for clear guidelines for municipalities, institutions and organizations on how a closure or reopening should be handled concretely, so that the closure and reopening takes place uniformly, does not leave too much uncertainty and no more restrictions are made than necessary.
5. Public authorities should consistently think of people with communication disabilities in their crisis communication and preparedness and invite a dialogue with the disability movement about it. Emphasis should be placed on easy-to-read communication, visual interpretation, written interpretation, consistent deaf interpretation, the possibility of e-mail and chat.
6. The mental consequences of the shutdown should fill the consciousness of authorities, politicians and organizations more. It is positive that in the autumn of 2020, funds have again been set aside for the efforts against loneliness among the vulnerable.

[58] DH Evaluation.

In their report,[59] the IMR sets out four recommendations that I can endorse as they stand:

1. That the Ministry of Health and the Ministry of the Elderly respect the residents' right to dispose of their own housing in residences to the greatest possible extent, and that visit restrictions are limited to the common areas.
2. That health authorities and municipalities provide clear guidance on the limits of the intervention options in connection with implementation of visit restrictions in order to counteract the risk of over-implementation. It is clarified that deprivation of liberty is never legal outside the limits of the Pandemic Act's rules on forced quarantine.
3. That the residences ensure that all interventions towards the individual are concretely justified in the resident's circumstances and are proportionate.
4. That the authorities' and residences' communication about the interventions be targeted and accessible to people with disabilities and their relatives and that it be clarified which rights remain in force during the pandemic.

14.3 Other relevant evidence

Under this point, I would like to point out that disability organizations have adapted their business to the crisis and have launched new initiatives. Even though large sections of society closed up and although it again became legal to hold events, the disability world has largely refrained from physical meetings. This has been necessary because many of the participants they usually have for events belong to vulnerable groups.

Instead, meetings have been developed through the Internet, online coping groups and support courses, expanded counselling, letters and phone calls, communication in sign language, online training, counselling for relatives, and social events such as online morning coffee, bingo and movie nights, and guides to video calls, quarantine TV and other content on social media.[60]

The National Association of Local Authorities mentions the same in their report on the reopening of Denmark.[61] The report is based on four surveys for all the country's municipalities, which were conducted in the period between 27 May and 4 June, 83 of the 98 municipalities have responded to the surveys.

It appears from the answers that the vast majority of municipalities have gained experience that they will use in their regular work even after the COVID-19 crisis is over. This applies, for example, to holding meetings outdoors, or virtually, which in some cases feels more secure for the citizen.

Finally, I would like to outline a kind of insider - outsider problem that can be seen, but which it is too early to assess yet.

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[59] IMR's report (June 2020): Visitation restrictions on residential housing - Consequences of COVID-19 for residents https://menneskeret.dk/udgivelser/besoegsrestriktioner-paa-botilbud-konsekvenser-covid-19-beboere-paa-botilbud.

[60] DH Evaluation, Appendix 8.

[61] "Main results for KL's survey on the status of normalisation of efforts in the social area", unpublished report from KL 09.06.2020.

In Denmark, the Government early in COVID-19's first wave chose to make a quick and comprehensive shutdown. The government explained that in the uncertain situation, it would rather do too much too soon than too little too late. It described it as a principle of precaution. Therefore, it chose a strong closure even though the health authorities had recommended a much weaker intervention, more similar to the policy implemented in Sweden.

The principle of precaution had the effect that the COVID-19 pandemic was stopped, and far fewer people died with COVID-19 than in Sweden. It was thus a great advantage for those who are in the risk group for COVID-19.

However, the closure will have an impact on much more than on the spread of COVID-19. The closure of schools and educational institutions means that many children and young people become lonely, and some have mental difficulties, the reduction of visits to institutions means that many older people have problems, sometimes major problems, and there are many more consequences of the closure which harm people and cause a great group a risk they did not have before.

The closure also had the effect that many families were much more together than they had been used to. It happened when the parents had homework and the children were home from school and kindergarten. Some families experienced it as a better life than they had had before. Most, however, have experienced it as a pressured situation. It takes a lot to do your job at the same time as you have to guide your children in their home teaching. In some cases, it has led to conflicts in the family, which may also have consequences for the future.

Applying a precautionary principle is therefore not unequivocally protecting the population. It is too early to assess whether the Danish or the Swedish model for COVID-19 efforts has worked best. In my opinion, a group of people with disabilities benefit from the precautionary principle, but at the same time there is a risk of giving another group of people a disability that they would not otherwise acquire.

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