Tasmanian NPM National Preventive Mechanism

Expectations on the treatment of people deprived of their liberty under **mental health law**

Version 1.1 – June 2024

Acknowledgment of Traditional Owners

In recognition of the deep history and culture of this Island, we acknowledge Tasmanian Aboriginal people, the original and continuing Custodians of the Land, Waterways, Sea and Sky.

We acknowledge and pay our respects to all Tasmanian Aboriginal people, all of whom have survived invasion and dispossession, and continue to maintain their identity, culture and Aboriginal rights.

We commit to working respectfully to honour their ongoing cultural and spiritual connections to this land.

About the Tasmanian NPM

The **Tasmanian National Preventive Mechanism** (NPM) is an independent statutory body established in accordance with the *OPCAT Implementation Act 2021* (Tas). The purpose of the Tasmanian NPM is to prevent the torture and ill-treatment of people deprived of their liberty by embedding best practice human rights. It does this through proactive oversight of settings where people are or may be deprived of their liberty, ongoing cooperation with government and relevant authorities, and by providing education and advice.

The Tasmanian NPM works alongside NPM's across Australia to ensure the fulfilment of Australia's obligations under the Optional Protocol to the Convention against Torture, Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

Further information about the Tasmanian NPM and its activities is available at www.npm.tas.gov.au

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Introduction

Mental health

Detention settings covered by these Expectations	**Forensic and other closed mental health settings, mental health care in hospitals and related settings, specialised mental health service providers, and residential mental health care.**
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Around Tasmania, people are or may be deprived of their liberty by law on mental health grounds, chiefly under the *Mental Health Act 2013* (Tas). These expectations have been created with the intention of upholding their human rights when this deprivation of liberty occurs. They are designed to prevent torture and other cruel, inhuman or degrading treatment or punishment.

This version of the expectations was prepared between 2023 and 2024, as part of the Tasmanian NPM implementation project. Development of the expectations was led by subject matter experts, Ms Sarah Cooke OBE[1] and Ms Louise Finer.[2]

The expectations were drawn up after extensive consultation and are based on, and referenced against, international and domestic human rights instruments. A complete list of the materials considered and referred to in the document is provided at Appendix 1: Abbreviations and references.

Preparation of these expectations involved in-person visits to the Wilfred Lopes Centre; Royal Hobart Hospital (Mental Health Impatient Unit); Spencer Clinic, North West Regional Hospital; Northside Mental Health Unit, Launceston General Hospital; and the Roy Fagan Centre.

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[2] Louise Finer is a former Head of the National Preventive Mechanism Secretariat for the United Kingdom. She is a policy expert on detention, torture prevention and human rights, and provides consulting services to international and national NGOs, and detention monitoring bodies. She is a visiting fellow at the University of Bristol and the University of Essex Human Rights Centres.

These expectations are published in accordance with section 9(i) of the *OPCAT Implementation Act 2021* (Tas).

What are expectations?

Expectations documents are commonly released by NPM bodies to help people understand some of the matters that will be considered when exercising these functions. They are also working documents; used to support the Tasmanian NPM and its staff when examining different settings. The publication of these expectations is a demonstration of the NPM's independence.

To meet Australia's obligations under OPCAT, the Tasmanian NPM exercises its functions to ensure that international human rights standards are met. Expectations documents are created in line with guidance provided by the United Nations Subcommittee on the Prevention of Torture.

The experience of people deprived of their liberty is at the heart of each expectations document. They serve as a guide to assist with identifying areas of concern, rather than to identify if a practice or situation may constitute a human rights violation. Following this approach, they are designed to focus on outcomes for the person rather than processes.

Each document is organised into overarching topics, followed by expectations, which are underpinned by a series of indicators. These indicators guide the NPM in making a judgment about whether the corresponding expectation is being met by setting out some of the primary ways this occurs (some of which may be essential safeguards, underpinned by law, or in human rights standards). Importantly, indicators are not designed to be a tick-box exercise for compliance, and do not exclude additional or other ways of achieving the expected outcome for the person deprived of their liberty.

For example, a facility may meet an expectation in a different way from what the indicators suggest. We may also decide to use different indicators if circumstances require this.

Where a child or young person is deprived of their liberty under mental health law, these expectations will be supplemented by the Tasmanian NPM's *Expectations on the treatment of children and young people deprived of their liberty* [available at www.npm.tas.gov.au].

The United Nations Convention against Torture and the Optional Protocol

The United Nations General Assembly adopted the *Convention against Torture and Other Cruel, Inhuman or Degrading Punishment or Treatment* in 1984. Australia signed the Convention in 1985 and ratified it in 1989.

People often use the word 'torture' to refer to cases where one person inflicts pain on another person to obtain information. The Convention defines torture more broadly, to mean any form of 'cruel, inhuman or degrading punishment or treatment'. Importantly, a person's treatment can be cruel, inhuman or degrading because of poor conditions, mismanagement or poor processes rather than deliberate acts by another person.

In 2002, the United Nations General Assembly adopted the *Optional Protocol to the Convention against Torture* (OPCAT) and established the Sub-committee on the Prevention of Torture (SPT) to monitor its implementation. Australia signed OPCAT in 2009 and ratified it in 2017. The primary goal of OPCAT is to prevent torture and ill-treatment in places where people are or may be deprived of their liberty ('places of detention').

A critical element in prevention is to have a system for independent visits to all places of detention. In ratifying OPCAT, the Commonwealth government committed the whole of Australia to setting up National Preventive Mechanisms ('NPMs') to visit and inspect all places of detention. The SPT also has the right to visit.

In July 2018, the Commonwealth government appointed the Commonwealth Ombudsman as Australia's NPM. The States and Territories are responsible for establishing NPMs to inspect places of detention within their jurisdiction. The Commonwealth Ombudsman is responsible for inspecting Commonwealth places of detention. It is also the national coordinating NPM, with responsibility for collating country-wide information and for reporting to the SPT.

In 2021, the Tasmanian Parliament passed the *OPCAT Implementation Act*, establishing Tasmania's NPM legal framework and enabling visits to Tasmanian places of detention by the SPT. In February 2022, the Tasmanian government nominated Mr Richard Connock to be the State's first NPM. To that end, Mr Connock has developed 'expectations' for every place of detention that he will examine as Tasmanian NPM.

For many places where people are deprived of their liberty, OPCAT implementation will be the first time there has been a system of independent, visit-based inspections focused on human rights.

This is an evolving document

This is the first draft of the Tasmanian NPM's *Expectations on the treatment of people deprived of their liberty under mental health law*. These expectations will be updated in response to feedback and changes in international and local best practice. The Tasmanian NPM welcomes feedback from all stakeholders, particularly people with lived experience.

Summary of expectations

Topic 1: Material conditions

1.1 Patients are safe in a clean and well-maintained environment. Safety and comfort

1.2 Patients can move freely around a range of areas within the facility.

1.3 The living environment is comfortable.

1.4 Patients with varied needs are appropriately catered for.

1.5 Patients have privacy and comfort in their bedrooms.

1.6 Children are held separately from adults.

Topic 2: Procedural safeguards

2.1 Patients are given all information relevant to their involuntary status in a clear and accessible way.

2.2 Patients receive effective communication regarding their rights and status as involuntary patients.

2.3 Patients can access an effective complaints mechanism.

2.4 Patients can freely access their legal representative and advocate.

Topic 3: Healthcare

3.1 Physical and mental health needs of patients are assessed and addressed appropriately by suitably qualified professionals.

3.2 Patients can access a range of treatments to support holistic, person-centred care.

3.3 Patients make their own choices regarding their care, support and treatment wherever possible.

3.4 The right to privacy and medical confidentiality of each patient is respected.

Topic 4: Contact with the outside world

4.1 Patients can communicate freely and with privacy respected. Any restrictions on contact are individually justified, proportionate and fully explained.

4.2 The fullest visiting arrangements possible are facilitated. Visits are as comfortable and easy as possible for the patient and visitors. Any restrictions on visits are individually justified, proportionate and fully explained.

4.3 Confidential contact with legal representatives and others is facilitated.

4.4 Patients are held in facilities that are as close as reasonably possible to their home or support networks.

4.5 Patients are able to request leave which is granted wherever possible.

Topic 5: Equity and non-discrimination

5.1 Patients' individual needs are identified, understood and met.

5.2 Patients from Aboriginal and Torres Strait Islander backgrounds are able to exercise their cultural rights and are protected from harm.

5.3 Patients live in an environment where tolerance and understanding are actively promoted, and where discriminatory conduct, bullying, harassment are not tolerated and any instances are challenged.

5.4 Patients are treated fairly and swift action is taken to address any evidence of discriminatory processes or treatment.

5.5 Patient confidentiality is safeguarded.

Topic 6: Safety, order, discipline, and restrictive practices

6.1 All searches are undertaken with proper legal authority, are proportionate to an identified risk and carried out with due regard to and respect for a person's dignity and privacy.

6.2 All efforts are made to eliminate the use of restraint. Restraint is only used as a matter of last resort, for the shortest time possible and

causes the minimum interference possible with a persons' autonomy, dignity and privacy.

6.3 All efforts are made to eliminate the use of seclusion. When used, it is only as a last resort, for the shortest time possible and causes the minimum interference possible with a person's autonomy, dignity and privacy. Solitary confinement is never used.

6.4 Patients are held in the least restrictive level of security possible and moved promptly where their level of risk changes. Decision-making is fair and transparent. Conditions in the facility ensure security without unnecessarily restricting liberty.

6.5 All mental health facilities provide a safe and therapeutic culture which prioritises the assessment and minimisation of the risk of deliberate self-harm and suicide.

Topic 7: Life in detention

7.1 Staff engage with all those within their care with dignity and respect.

7.2 There is access to meaningful activities.

7.3 Adequate amounts of nutritious food which promotes health and wellbeing are available.

7.4 There is access to appropriate clothing and laundry facilities.

7.5 There is timely access to personal possessions and property.

7.6 Patients can freely practice their religion and take part in customs in accordance with their cultural belief or background.

Topic 8: Governance and culture

8.1 Leaders are committed to and take responsibility for providing safe, high quality, person centred, trauma informed care.

8.2 Leaders are committed to and promote policies, practices, strategies and behaviours which respect diversity and create an inclusive and organisational culture.

8.3 Leaders demonstrate, operationalise and promote a human rights based approach to providing care and treatment.

8.4 People with lived experience are involved in governance and decision making processes. Relevant to mental health detention.

Expectations and indicators

Topic 1: Material conditions

Overarching expectation: The environment in the facility is safe, welcoming, comfortable and conducive to recovery; it ensures the dignity, wellbeing and privacy of all patients.

Expectations	Indicators
1.1 Patients are safe in a clean and well-maintained environment.	• All areas are in a good state of repair, decorated and regularly cleaned. • Sleeping, washing and communal areas are organised in a way that ensures the safety of patients of different genders, using appropriate measures (such as cohorting) to address risks or vulnerabilities and ensure physical, sexual and psychological safety. • Washing and toilet facilities are sufficient for the number of patients. They are in good working order, clean and hygienic and ensure privacy. • All areas are safe for patients and staff, including from fire risk, with a view to eliminating the risk of self-harm.
1.2 Patients can move freely around a range of areas within the facility.	• There are areas for leisure and communal time as well as quiet time. • Patients can access different areas on a regular basis and where necessary are facilitated to do so. • Outdoor areas include seating and shelter, access to the natural environment and can be used for exercise and social interaction. • Facilities for faith and worship provide for all patients. • Signage is clear, in appropriate formats, and reflects patients' linguistic diversity.
1.3 The living environment is comfortable.	• Occupancy levels are appropriate, facilities are not crowded. • Living areas all have natural light. • Living areas are an appropriate temperature, with heating and ventilation where needed.

1.4 Patients with varied needs are appropriately catered for.	• Patients can physically access all areas they have a right to be in. • The sensory environment and its design features minimise stress and tension, and take into account patients' acoustic sensitivities. • There are areas that provide a sanctuary from stress, where people can experience their feelings, seek or avoid sensory input as needed, and relieve discomforts in privacy.
1.5 Patients have privacy and comfort in their bedrooms.	• The privacy of patients is respected (e.g. closing blinds or curtains, ability to lock their room door) with due regard to concerns for safety. • Rooms are as quiet as possible at night time. • Rooms are of adequate size, having regard to a patient's physical accessibility needs and therapeutic care requirements. • Patients can personalise rooms including with their own possessions, with due regard to safety. • Rooms include an adequately sized place to securely store belongings. • Rooms have natural light and patients can control artificial lighting including blinds or curtains. • Rooms are kept at an appropriate temperature with heating and ventilation as needed. • Hygienic, clean and private sanitary and washing facilities in good working order are available to all patients.
1.6 Children are held separately from adults.	• Children are held in age-appropriate facilities that can meet their needs. • Children are kept separate from adults, and any deviation from this rule is individually justified on the basis of the child's best interests.

Explanatory note

The physical environment in places of deprivation of liberty is crucial to patients' recovery and wellbeing. Their experience of safety, privacy and comfort within

this environment must be at the heart of the design, maintenance and use of the facilities.

The expectations above should apply regardless of the type of facility although there are likely to be different ways of achieving these outcomes in different types of settings.

Specific standards and sources

International

- Convention on the Rights of Persons with Disabilities (CRPD) Article 14 paragraph 2
- Convention on the Rights of the Child, Article 37
- CRPD Guidelines on Article 14, paras.17-18
- UN Principles for the protection of persons with mental illness (Principle 13.2)
- UN Special Rapporteur on Torture report on protecting persons with disabilities from torture, and solitary confinement (2008), paras 52-54
- World Health Organisations (WHO) QualityRights Toolkit, Theme 1

National

- *Mental Health Act 2013* (Tas) Schedule 1.
- National Standards for Mental Health Services 2010, Key Principles

Topic 2: Procedural safeguards

Overarching Expectation: All processes and safeguards relating to the status and treatment of involuntary patients in mental health facilities are fair and transparent in their nature and application.

Expectations	Indicators
2.1 Patients are given all information relevant to their involuntary status in a clear and accessible way.	• Clear and comprehensive medical and legal records are maintained for all patients. • Patients are informed about their status as involuntary patients in a clear and timely way appropriate to their circumstances. • Patients are told the factual and legal basis for the decision to subject them to involuntary placement or involuntary treatment, the length of time it will continue and the criteria for the potential extension or termination of such a decision. This information is also given to a patient's legal representative if they have one. • Patients receive clear, accurate, accessible and timely information about their rights, and their right to make a complaint or seek a review including: • their right to have access to legal advice/representation; • available complaint mechanisms and the circumstances in which a complaint can be made; • their right to apply to the Mental Health Tribunal; and • their right to contact Mental Health Official Visitors. • Patients are reminded of their rights on a regular basis and at crucial milestones of their care and treatment such as when there is a change in treatment or if their detention is renewed for a further period. • Staff regularly check that information has been understood and is adapted and/or delivered differently if necessary, for example with the assistance of a peer support worker.
2.2 Patients receive effective communication	• Patients' communication needs are assessed bearing in mind any hearing or visual impairments, any learning disability, any neurodiversity, difficulties in

regarding their rights and status as involuntary patients.	reading or writing, and whether they are being communicated with in their first language. • All steps are taken to overcome barriers to effective communication including avoiding technical terms or jargon as much as possible. • Patients are communicated with in a way that is appropriate to their sex, religion or belief, cultural background, dialect and age. • Children and young people have information explained in a way they can understand and in a format appropriate to their age. • Interpreters are selected who are appropriate to the needs of the individual patient. • Patients are given information orally and in writing, including in accessible formats where appropriate and in a language they understand. Peer support workers are used, when appropriate, to aid in the communication and understanding of information.

2.3 Patients can access an effective complaints mechanism.	• Feedback from patients is actively sought, considered and used to inform and improve service planning and delivery. • Efforts are made, through trauma-informed and culturally sensitive approaches, to build trust in complaints processes to ensure all patients, especially those from Aboriginal and Torres Strait Island backgrounds, are able and motivated to report misconduct or other concerns. • Patients are able, and supported where necessary, to make complaints to independent oversight bodies and receive responses which are timely, effective and transparent. • Patients are able, and supported where necessary, to request a visit from the Mental Health Official Visitors. • Those who raise concerns, make complaints or give feedback can do so without fear of negative consequences.
2.4 Patients can freely access their legal representative and advocate.	• Patients are able to have access to their legal representative at any reasonable time and by any reasonable means. • Patients are aware of and are able to access advocacy services in a timely way. Patients are encouraged and supported to access advocacy services. • Aboriginal and Torres Strait Islander patients are supported in accessing legal advice from representative organisations

Explanatory note

Effective procedural safeguards must be at the heart of efforts to ensure the rights to liberty and the prohibition of torture in any type of detention setting. In the mental health context, they are of particular importance in avoiding unlawful and arbitrary detention. Examining the existence and effectiveness of procedural safeguards is therefore necessarily central to the approach of detention monitoring bodies. Fair and transparent due process is crucial in relation to the specific procedures and practices that deal with the rights of involuntary patients in mental health facilities and are integral to the Expectations above.

Specific standards and sources

International

- International Covenant on Civil and Political Rights (ICCPR) Article 9.
- UN Human Rights Committee General Comment 35 on Article 9 (16/12/2014).
- UN Principles for the protection of persons with mental illness: Principle 1.6, Principle 12, Principle 18, Principle 21.
- Council of Europe, Committee of Ministers, Recommendation no REC (2004)10 concerning the protection of the human rights and dignity of persons with mental disorder: Article 6, Article 20, Article 22.
- WHO QualityRights Toolkit, Theme 3.
- UN Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), Approach of the SPT to prevention (30/12/2010), para.5(c) (g)

National

- *Mental Health Act 2013* (Tas) s 62(a), 62(d), 62(f), 108(a), 108(d), 108(p) 108(q).
- National Standards for Mental Health Services 2010 Standard 1 (rights and responsibilities), Standard 6 (consumers).
- Australian Charter of Healthcare Rights: sections on information & giving feedback.

Topic 3: Healthcare

Overarching Expectation: People in mental health facilities enjoy the highest attainable standard of physical and mental health.

Expectations	Indicators
3.1 Physical and mental health needs of patients are assessed and addressed appropriately by suitably qualified professionals.	• Patients with a mental illness receive physical healthcare that is equivalent to that received by people without a mental disorder. • Patients are offered a comprehensive health assessment, covering physical and psychological needs, on admission to a mental health facility and this should be repeated regularly thereafter. • Patients, and where appropriate their families and/or carers, are fully involved in all health assessments and informed of their outcome. • Any physical or mental health conditions revealed at assessment receive timely medical attention and all care and treatment promotes continuity of care. • Treatment needs of patients are met by staff who are qualified and competent. • Care, support and treatment are given in accordance with up-to-date national guidance and current best practice from professional bodies.
3.2 Patients can access a range of treatments to support holistic, person-centred care.	• Patients are offered a range of treatment options and approaches as appropriate including trauma-informed care, psychological therapy, occupational therapy and other therapeutic interventions to promote recovery. • Each patient has a recovery plan which reflects their choices and preferences and includes social, medical, employment and education goals and objectives for recovery. • Where a health intervention is required that cannot be provided in the mental health facility, patients are referred to appropriate health services in a timely manner.
3.3 Patients make their own choices regarding their care,	• Patients, and their families and/or carers where appropriate, are provided the fullest opportunity to

support and treatment wherever possible.	participate actively in all discussions and decisions about their care, support and treatment. • Involuntary patients have their choices, opinions and feelings respected in all aspects of their care, support and treatment wherever possible and to the fullest extent possible. Voluntary patients are only ever treated with their consent. • Treatment decisions taken contradictory to the views of involuntary patients are minimised and, when they are taken, the reasons for doing so are clearly explained and documented.
3.4 The right to privacy and medical confidentiality of each patient is respected.	• Information about a patient's health is kept confidential. • Patients are entitled to know any information collected about their health, but if they wish not to be informed this should be respected.

Explanatory note
The right to the enjoyment of the highest attainable standard of physical and mental health is a fundamental human right referred to in several human rights instruments. It is dealt with most comprehensively in the International Covenant on Economic Social and Cultural Rights (ICESCR) Article 12. It is closely related to other human rights, including respect for human dignity, non-discrimination, equality, the prohibition of torture and ill treatment and the right to respect for private life, which are integral components of the right to health.

The Committee on Economic, Social and Cultural Rights has set out that the right to health contains the following essential elements in relation to healthcare facilities, goods and services (i) availability in sufficient quantity to meet the needs of the population (ii) accessibility without discrimination (ii) acceptability - they are respectful of medical ethics and culturally appropriate as well as being design to respect confidentiality and improve health (iv) Good quality - scientifically and medically appropriate.

Specific standards and sources

International

- ICESCR Article 12: The right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
- Committee on Economic, Social and Culture Rights, General Comment 14 (2000)
- Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard on physical and mental health, 28/03/2017 (Thematic Report on Mental Health).
- UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment – Principle 24
- CRPD Article 3, Article 12, Article 22, Article 25.
- UN Principles for the protection of persons with mental illness: Principle 1.1, Principle 8.1, Principle 9, Principle 11, Principle 19.
- Council of Europe: Convention on human rights and biomedicine: Article 3, Article 6, Article 7, Article 10.
- Council of Europe, Committee of Ministers, Recommendation No REC (2004)10 concerning the protection of the human rights and dignity of persons with mental disorder – Article 10, Article 11, Article 13, Article 17 – 21, Article 22.
- WHO QualityRights Toolkit, Theme 2.

National

- *Mental Health Act 2013* (Tas) s 62(a), 62(b), 62(g), 108(a), 108(b), 108(f)
- Schedule 1 – Service delivery principles
- Tasmania's Chief Civil Psychiatrist and Chief Forensic Psychiatrist Clinical Guideline 2: decision making capacity.
- National Standards for Mental Health Services 2010. Key principles, Standard 1 (rights and responsibilities), Standard 3 (consumer and carer participation), Standard 6 (consumers).
- Australian Charter of Healthcare Rights: sections on access, safety, respect & privacy.
- Australian Safety and Quality Framework for Health Care (Australian Commission on Safety and Quality in Health Care) Principle 1: Consumer Centred.

Topic 4: Contact with the outside world

Overarching Expectation: Patients are encouraged and able to maintain contact with family, friends and others through a range of measures they freely choose. Any restrictions to this right are strictly limited and individually justified.

Expectations	Indicators
4.1 Patients can communicate freely and with privacy respected. Any restrictions on contact are individually justified, proportionate and fully explained.	• Proactive efforts are made to assist patients in maintaining contact with friends, families, advocates and wider support groups/networks. • Patients have access to phones, correspondence, electronic devices and the internet unless a current individual risk assessment has indicated some restrictions are necessary. They are able to do so in privacy and in the language of their choice. • There are no blanket restrictions, and any individual restrictions are justified, proportionate, documented and subject to review. • There is a published policy on any restrictions which is made available to all patients in appropriate formats. • Patients are aware of the reasons for any restrictions on the use of devices in certain areas to ensure wider wellbeing (e.g. to ensure there are quiet areas). • Restrictions on the use of devices with cameras or video/sound recording, justified on the basis of the privacy of other patients and staff, are reasonable and fully explained. • Managers regularly monitor restrictions imposed to assess their proportionality and justification.
4.2 The fullest visiting arrangements possible are facilitated. Visits are as comfortable and easy as possible for the patient and visitors. Any restrictions on visits are individually	• Visitors are made to feel welcome. • Visits take place in an environment that is private, accessible, safe and comfortable. • Patients choose whom they want and do not want to see. • Visits take place at any reasonable time and regularity and take into account any travel or logistical challenges faced by visitors.

justified, proportionate and fully explained.	• All possible efforts are made to encourage and facilitate regular contact between children and their families and others close to them.
4.3 Confidential contact with legal representatives and others is facilitated.	• Patients understand their rights to confidential ("privileged") visits and correspondence and with whom these rights apply. • The confidentiality of correspondence with legal representatives and other relevant authorities and professionals is guaranteed. • Confidential visits are facilitated and not subject to cancellation or suspension unless in exceptional circumstances.
4.4 Patients are held in facilities that are as close as reasonably possible to their home or support networks.	• Placement decisions take into account the patient's family or friendship ties.
4.5 Patients are able to request leave which is granted wherever possible.	• Leave away from the facility is actively and regularly considered. Leave is offered and facilitated to the fullest extent possible. • The benefits to a patient's recovery and health are fully taken into account in considering requests for leave. • The patient's wishes, alongside those of family, friends and other carers, are fully taken into account in considering requests for leave. • Requests to attend significant events, such as weddings or funerals, are facilitated by staff wherever possible. • Leave requests are assessed promptly and decisions are clearly explained. • All efforts are made to mitigate and prevent security or safety risks.

Explanatory note

Maintaining contact with family and friends is a key element in a patient's care, treatment and recovery and should be facilitated through visits, communication and leave. The right to maintain contact with families is a key element of the rights of children in detention.

Restrictions may be justified and proportionate in some circumstances, based on security, clinical grounds, privacy and/or safeguarding concerns, but should be justifiable on an individual basis through transparent processes that protect against arbitrariness. Patients should also be able to refuse contact or visits. The right to confidential communications and visits with legal representatives and designated authorities is an essential aspect of the rights of patients in detention.

Specific standards and sources

International

- CRPD Article 22, ICCPR Article 17 (right to privacy)
- CRC Article 37
- WHO QualityRights (Theme 1, Standard 1.5)
- UN Principles for the protection of persons with mental illness (Principle 13.1)
- European Court of Human Rights, Solcan v. Romania; Herczegfalvy v. Austria.

National

- *Mental Health Act 2013* (Tas) Division 4-6, sections 97-108

Topic 5: Equity and non-discrimination

Overarching Expectation: The diversity of the patient group is welcomed and informs their treatment. The distinct needs of patients are fully met, including their experiences of trauma. Organisational policies, culture, processes and practice ensure patients are not subject to discrimination, bullying or harassment.

Expectations	Indicators
5.1 Patients' individual needs are identified, understood and met.	• Proactive efforts are made to identify and address patients' individual needs at the outset of detention and as they evolve over time. • Care plans specify clear actions required to address these needs. • Planning and commissioning of services are based on understanding of the diverse backgrounds of patients. • Patients are offered and able to access support from outside including from community groups or external agencies and advocates.
5.2 Patients from Aboriginal and Torres Strait Islander backgrounds are able to disclose their identity and exercise their cultural rights in a safe and welcoming environment. They are protected from harm.	• Respect for Aboriginal and Torres Strait Islander patients' cultural identity and connections are at the heart of all decisions made about their treatment and care. Their treatment and care takes into account their individual and collective experience of trauma. • Aboriginal and Torres Strait Islander patients are protected from racism, unfair treatment, harassment, bullying and abuse. • Efforts are made to ensure cultural safety, including through staff training and involvement of community groups.
5.3 Patients live in an environment where tolerance and understanding are actively promoted, and where discriminatory conduct, bullying,	• Proactive efforts are made, (e.g. through activities, visual displays, celebrations), to recognise and celebrate the diversity of patients. • All forms of discriminatory language and conduct, (including stereotyping and unconscious bias), bullying, harassment are challenged by staff.

harassment are not tolerated and any instances are challenged.	• Patients feel able to raise concerns about discrimination through complaints processes. • Complaints about discrimination are thoroughly investigated and responses take into account the context and individual experiences of the patient. Patients are able to make a complaint externally, (such as to Equal Opportunity Tasmania).
5.4 Patients are treated fairly and swift action is taken to address any evidence of discriminatory processes or treatment.	• Rules and processes are understood by patients and applied fairly by staff. • There is routine internal monitoring to identify any disproportionality or unfairness, for example in the application of restrictive measures or in access to activities, visits or other areas. • Where disproportionality or unfairness is identified or suspected, swift action is taken to address this.
5.5 Patient confidentiality is safeguarded.	• Aspects of a patient's identity (e.g. transgender status, sexuality, criminal record) that may lead to bullying or discrimination are kept confidential.

Explanatory note

The core human rights principles of equality and non-discrimination must be applied to the treatment and care of individuals who are deprived of liberty on mental health grounds. This includes the multiple or intersecting grounds on which individuals may be subject to discrimination in addition to their disability. This is known by the Committee on the Rights of Persons with Disabilities as inclusive equality.

The grounds on which patients may be subject to indirect and/or direct discrimination include faith or religion, spirituality, sexuality, gender identity, nationality, Aboriginal and Torres Strait Islander background, age, or other grounds which include the 'attributes' in Tasmanian anti-discrimination legislation (noted below).

Achieving equality and eliminating discrimination requires a range of positive measures relating to the care and treatment of individuals but also requires monitoring. In particular, the disproportionately high levels of ill health and severe psychological distress experienced by people with Aboriginal and Torres Strait Islander backgrounds mean they are likely to be overrepresented in mental health detention facilities. As a result they are more likely to experience

the inadequate provision or ill treatment that occurs within detention facilities. The NPM should take a proactive approach to understanding the specific experiences and needs of Aboriginal and Torres Strait Islander patients.

Specific standards and sources:

International

- Convention against Torture, Article 2
- CRPD, Article 3
- Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, Principle 5(1) and (2)
- CRPD General Comment 6, including paragraphs 19 and 20).
- UN High Commissioner for Human Rights, Annual Report on Mental Health and Human Rights (2017) paras 15-16
- WHO QualityRights, Theme 2, Standard 2.1

National

- Anti-Discrimination Act 1998 (Tas)
- Mental Health Act 2013 (Tas), Schedule 1(d)
- National Standards for Mental Health Services 2010 Standard 4

Topic 6: Safety, order and restrictive practices

Overarching Expectation: Patients are safe and live with a minimum level of security and restrictions. Understanding of any vulnerabilities, trauma and their diverse backgrounds informs all aspects of safety and security.

Expectations	Indicators
6.1 All searches are undertaken with proper legal authority, are proportionate to an identified risk and carried out with due regard to and respect for a person's dignity and privacy.	• Searches of people and their property are carried out in a way that minimises to the greatest extent possible the intrusion into a person's privacy, maintains their dignity and respects issues of gender, culture and faith. • Mental health facilities maintain an up-to-date policy on searching which is consistent with creating and maintaining a therapeutic environment in which care and treatment may take place, and ensures the safety of patients, staff and the public as well as the security of the building. • Patients, staff and visitors are informed there is a policy on searching and are provided with its details in readily available and accessible formats. • Staff seek the consent of the person to be searched before conducting a search, and that person is kept informed as to what is happening and why. • Searches without a person's consent only take place if they are strictly necessary and if there is no clinical objection to doing so. • Records of all searches are documented and audited. Any patient items taken are appropriately logged and stored securely. Patient items are transferred with that patient if they move facilities. • Support is available for those who are affected by the process of searching.
6.2 Preventative strategies aimed at minimising the use of restraint are in place in relation to those patients who have communication and sensory	• Facilities are making efforts to reduce the use of restraint and aim towards its elimination. • Restraint is never used to punish or with the intention of inflicting pain, suffering or humiliation. • Restraint is only used where there is a real possibility of harm to the person, staff, the public or others if no action is taken.

differences, past experiences of trauma, or who are assessed as being likely to present with behavioural disturbances. **Preventive strategies meet the unique needs of each patient**	• Restraint is only ever used as a last resort and alternatives to restraint are in place and widely used. Forms of restraint that can cause harm such as restricting circulation or breathing are not used. • The nature of the techniques used to restrict are proportionate to the risk of harm and its seriousness. • Any restriction is the least restrictive option and causes the minimum interference to a person's autonomy, privacy and dignity. • Any restriction is imposed for no longer than absolutely necessary. • All incidences of restraint are formally and transparently documented and audited including a record of the reasons for the use of restraint, its authorisation, how it was implemented and the patient's response. • There is a debrief, which includes discussion and provision of support, after each episode of restraint which involves the patient. • Staff receive training in relation to alternatives to restraint including de-escalation techniques as well as in the use of safe restraint techniques. • Preventative strategies aimed at minimising the use of restraint are in place in relation to those patients who are assessed as being likely to present with behavioural disturbances and which meets the unique of each patient. • Policies concerning use of restraint are kept under ongoing review to ensure consistency with best practice and human rights standards. • No form of restraint is ever used to manage patients as a substitute for adequate staffing or facility design.
6.3 Seclusion All efforts are made to eliminate the use of seclusion. When used, it is only as a last resort, for the shortest time possible	• Facilities are making efforts to reduce the use of seclusion and aim towards its elimination. Alternatives to the use of seclusion are in place and widely used. • Seclusion is never used to punish or as a threat or with the intention of inflicting suffering or humiliation. It is never used to manage self-harming behaviour.

and causes the minimum interference possible with a person's autonomy, dignity and privacy. Solitary confinement is never used.	• Informal seclusion is never used. • Seclusion is only used when absolutely necessary and all less restrictive ways of managing patient behaviour have been thoroughly considered and explored • Seclusion causes the minimum interference to a person's autonomy, privacy and dignity, for example seclusion settings provide adequate toileting facilities. • Seclusion is not imposed for any longer than absolutely necessary. • All efforts are made to mitigate the potential harm of seclusion. • Patients in seclusion have access to appropriate sensory stimuli. • All incidences of seclusion are formally and transparently documented and audited and include a record of the reasons for its use, the efforts made to avoid it, its authorisation and any reviews, and how the patient's needs were met during the period of seclusion. • Every incidence of seclusion has an exit strategy and target end point that is known and understood by the patient. • Where patients request or seek to be isolated, efforts are made to identify the reasons for this and address the root causes. • There is a debrief involving the patient at the end of any period of seclusion, which includes discussion and provision of support and ways to avoid isolation in future. • Staff receive training in relation to alternatives to seclusion. • Policies regarding the use of seclusion are kept under ongoing review to ensure consistency with human rights standards and best practice. • Seclusion is never used because of inadequate staffing or facility design.

6.4 Security and safety in the facility: Patients are held in the least restrictive level of security possible and moved promptly where their level of risk changes. Decision-making is fair and transparent. Conditions in the facility ensure security without unnecessarily restricting liberty.	• Conditions of enhanced security are used only in exceptional and individually justified circumstances, where all other options have been exhausted. • Decisions made to impose enhanced security, or increase or decrease security levels, are clearly recorded; patients understand what steps they must take to come out of enhanced security and are encouraged to do so. • Decisions around security levels are made fairly. • Delays in moving between security levels are monitored and raised with appropriate authorities. • Patients are aware of specific steps they need to achieve to come out of enhanced security. • Voluntary patients can leave the mental health facility without restriction when they wish to do so.
6.5 Suicide prevention: All mental health facilities provide a safe and therapeutic culture which prioritises the assessment and minimisation of the risk of deliberate self-harm and suicide.	• The environment minimises to the fullest extent possible the risk of self-harm and suicide. • Patients are assessed regarding their risk of self-harm and suicide at appropriately regular intervals bearing in mind particular times and events which may escalate these risks. • Staff regularly check on patients according to their assessed risk of self-harm and suicide, particularly in more private areas of a facility, while being mindful to minimise intrusion into a patient's privacy as much as possible. • The use of tear-proof clothing is never a first-line response to risks of self-harm or suicide and should never be used as a substitute for enhanced levels of observation and support. Its use is proportionate to the assessed risk and documented evidence shows it is used only as long as absolutely necessary. Where used it should fit the patient so as to preserve their dignity. It should never be used in seclusion.

Explanatory note

It is the responsibility of mental health detention facilities to keep all patients safe, including those who are at risk of behavioural disturbances. If all the measures set out in these expectations are met this will contribute to a safe

environment. It is also crucial that the therapeutic purpose of detention informs all aspects of safety and order. These issues are integral to some of the most fundamental human rights standards including the protection against torture and ill treatment, the right to life, the right to equality and non-discrimination, the right to privacy and protection of physical and mental integrity.

Restrictive measures including restraint and seclusion can cause harm. International human rights standards set a clear direction towards their reduction and eventual elimination, requiring demonstrable steps to be taken towards this aim. Where unavoidable as a last resort, any restrictions or security measures should be kept to a minimum, individually justified and subject to clear and accountable processes. The expectations and indicators on restraint apply across all forms of restraint including chemical, mechanical and physical methods and apply to all of those involved in restraint.

Specific standards and sources:

International

- IPPR Art 6, 7, 10,17, 26
- CPRD Art 3, 5, 12, 15, 16, 17
- UN Principles of medical ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment (1982) GA Re 37/194: Principle 5
- WHO QualityRights Tool Kit: Theme 4
- ECHR Research report, Rights of persons in relation to involuntary placement and treatment in mental healthcare facilities, para .32, with reference to M.S. v. Croatia (no.2) and Aggerholm v. Denmark.
- UN Special Rapporteur on Torture, report on solitary confinement (2011)
- Mandela Rules
- Approach of the SPT to persons institutionalised and treated medically without informed consent (paras 9, 10).

National

- *Mental Health Act 2013* (Tas) Part 3 Division 5 (force, seclusion, restraint – involuntary patients), Part 3 Division 7 (patient rights – involuntary patients), Part 5 Division 3 (force, seclusion, restraint – forensic patients) Part 5 Division 6 (Further rights – forensic patients); Service delivery principles 1(a), 1(b), 1(c), 1(f), 1(g) 1(j) 1(m).
- Office of the Chief Psychiatrist (Tasmania), Standing Orders and Clinical Guidelines 9 (seclusion), 10 (chemical restraint), 10A (mechanical and

physical restraint) National Standards for Mental Health Services 2010, Key Principles, Standard 2 (Safety).

- Australian Charter of Healthcare Rights: Headings on safety, respect & privacy.
- Australian Safety and Quality Framework for Health Care (Australian Commission on Safety and Quality in Health Care) Principle 3: organised for safety.

Topic 7: Life in detention

Overarching Expectation: An environment that promotes dignity, respect, autonomy, well-being and recovery.

Expectations	Indicators
7.1 Staff engage with all those within their care with dignity and respect.	• Patients are treated appropriately and respectfully by staff who support the creation of a therapeutic and recovery focussed environment. • Staff listen to and act on patient views to the fullest extent possible. • There is an effective procedure by which patients can raise complaints about staff behaviour.
7.2 There is access to meaningful activities.	• A range of regularly scheduled activities are available that are relevant and age appropriate. • Activities are available with a view to supporting patients in their recovery. • Space is provided that is specifically designated for leisure activities. • Outdoor space is available to be used for recreation and social interaction, and activities are scheduled to facilitate this. • Rules and schedules for accessing different areas and activities are understood and adhered to. • Patients can access activities in the community, information is provided about such activities and patients are facilitated to attend these.
7.3 Adequate amounts of nutritious food which promotes health and wellbeing are available.	• Safe drinking water and nutritious food of sufficient quality and quantity is available to all patients. • There are varied choices regarding food and drinks. • Patients have choice and input about what, when and where they can eat. • Patients can access dietary advice that takes into account their individual health needs. Patients have access to food options that satisfy any recommendations included in that advice. • Patients have independent access to food outside of mealtimes.

	• Food is available that meets the religious, cultural and personal preference of patients.
7.4 There is access to appropriate clothing and laundry facilities.	• Patients are able to wear their own clothes. • If patients are unable to wear their own clothing they are provided with good quality clothing that meets their needs and preferences and is suitable for the climate. • There are adequate laundry facilities and practices.
7.5 There is timely access to personal possessions and property.	• Patients can access their own possessions in a timely way. • There are adequate and dignified arrangements for the storage (and transfer where necessary) of patients' personal possessions.
7.6 Patients can freely practice their religion and take part in customs in accordance with their cultural belief or background.	• Patients have access to people who can provide cultural and/or spiritual support. • Patients are provided with appropriate materials, opportunities and private space to engage in religious and/or cultural practices to the fullest extent possible.

Explanatory note

The way patients experience life in detention engages several fundamental human rights standards. This includes the prohibition on torture and ill treatment, which is closely bound up with the respect for human dignity. It also includes the protection of privacy and physical and mental integrity, which are associated with individual autonomy including the freedom to make one's own choices. These are human rights which the state must refrain from breaching (known as negative obligations) but which the state must actively protect by taking positive measures (known as positive obligations). Detention monitoring bodies need to adopt a range of different methods to capture these issues fully, including speaking to patients in private, speaking to families/carers, observing staff/patient relations and looking at documentary sources of evidence.

In mental health facilities all patients must be treated with humanity, dignity and respect which reflects and meets different individual needs and abilities and promotes wellbeing and recovery. This gives a strong indication that blanket approaches to interaction, care and treatment should be avoided. Patients should be able to live their lives as they choose to the greatest extent possible

and have their basic needs met in a way that is humane and protects their dignity. For example, there should be a recognition that food is an important aspect of personal identity and dignity and this should be reflected in practice around food provision and choice.

Specific standards and sources

International

- ICCPR – Art 7, Art 10(1), Art 11.
- Human Rights Committee, General Comment on Art 10 of ICCPR, 10/04/1992.
- ICSECR – Art 11.
- CRPD – Art 3, Art 5, Art 12, Art 15, Art 16, Art 17, Art 19, Art 22, Art 26, Art 28, Art 30.
- Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment – Principle 1, Principle 6.
- UN Principles for the protection of persons with mental illness: Principle 1, Principle 8, Principle 9, Principle 11, Principle 13.
- Council of Europe, Committee of Ministers, Recommendation no REC (2004)10 concerning the protection of the human rights and dignity of persons with mental disorder: Article Art 3, 4, 7, 8, 9.
- WHO QualityRights Toolkit, Theme 1, 3, 4 & 5.

National

- *Mental Health Act 2013* (Tas) s 62(a), (62(b), 62(h), 62(j), 62(k). Service Delivery Principles 1(a), 1(b), 1(d), 1(j), 1(m)
- National Standards for Mental Health Services 2010. Key principles, 1 (rights and responsibilities), Standard 3 (Consumer and carer participation), Standard 4 (Diversity responsiveness), Standard 6 (Consumers).
- Australian Charter of Healthcare Rights: Headings on respect, partnership & privacy.
- Australian Safety and Quality Framework for Health Care (Australian Commission on Safety and Quality in Health Care) Principle 1: Consumer Centred.

Topic 8: Leadership and culture

Overarching Expectation: The leadership and culture in places of mental health detention promotes and protects the rights of patients.

Expectations	Indicators
8.1 Leaders are committed to and take responsibility for providing safe, high quality, person centred, trauma informed care.	• There are appropriate levels of staffing and other resources to provide care and treatment which is safe, high quality, person centred and trauma informed. • Staff receive regular training to ensure cultural competence and the ability to provide care and treatment which is safe, high quality, person centred and trauma informed. • Leaders are in touch with what happens on a day-to-day basis in the unit, including issues raised through complaints and the challenges faced by staff. • There is a commitment to quality improvement which is based on understanding of patient experience, the strengths and weaknesses of the relevant facility and where outcomes need to improve. • External scrutiny is welcomed and encouraged by those in leadership positions. Recommendations made by external bodies inform changes to practice and service improvement. • Leaders ensure effective, accurate reporting in relation to all safety (including sexual safety) incidents and provide rigorous management scrutiny and oversight of the same. • There are robust disciplinary procedures to deal with staff underperformance and allegations of abuse. • Whistleblowing procedures are known, understood and trusted by staff.
8.2 Leaders are committed to and promote policies, practices, strategies and behaviours which respect diversity and create an inclusive	• Leaders and staff model non-discriminatory attitudes and behaviours. They address any evidence of discriminatory attitudes or behaviours through appropriate procedures. • Fair and non-discriminatory processes are deployed at all levels within a facility including when meeting the needs of people with an Aboriginal or Torres Strait Islander background

and organisational culture.	• Leaders proactively seek engagement with patients with an Aboriginal or Torres Strait Islander background, their families and their communities with the aim of building trust and to inform service delivery and co-design.
8.3 Leaders demonstrate, operationalise and promote a human rights based approach to providing care and treatment.	• There is a demonstrable commitment from leaders to treating all patients with dignity and respect. • Staff understand and share the aim of delivering a human rights based approach to care and treatment. • Staff receive training and information regarding relevant human rights standards, including the prohibition against torture and other forms of cruel and inhuman and degrading treatment and the rights of persons with disabilities. Such training emphasises how human rights fundamentally underpin the provision of safe, high quality, person centred, trauma informed care and treatment.
8.4 People with lived experience are involved in governance and decision making processes. Relevant to mental health detention.	• Appropriate efforts are made to secure lived experience representation at all levels of organisational governance.

Explanatory note

Leadership and organisational culture must underpin efforts to meet all of the expectations in this document. The expectations in this section focus on specific areas where the approach of leaders and the organisational culture are crucial to the prevention of torture and ill treatment. The term “leader” refers to anyone with leadership or management responsibility in the facility and wider system.

Specific standards and sources

International

- WHO Quality Rights, all themes.
- UN Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), Approach of the SPT to prevention (30/12/2010) paragraph 5.

National

- *Mental Health Act 2013* (Tas), Schedule 1 (Mental health service delivery principles) and sections on the rights of patients (in particular s62 and s108).
- National Standards for Mental Health Services 2010 Standard 1 (rights and responsibilities), Standard 6 (consumers).

Appendix 1: Abbreviations and references

Abbreviation	Full title	References/key points
ICCPR	International Covenant on Civil and Political Rights (1966) https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights	• Article 7 (no-one shall be subjected to torture or cruel, inhuman or degrading treatment or punishment)
ICESCR	International Covenant on Economic, Social and Cultural Rights (1966) https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights	• Article 11 (right to adequate standard of living) • Article 12 (right to highest attainable standard of physical and mental health)
CAT	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-against-torture-and-other-cruel-inhuman-or-degrading	• Article 1 (definition of torture) • Article 2 (State responsibility to take effective measures to prevent torture) • Article 4 (criminalisation of torture) • Article 10 (education and information on torture prohibition to be included in training of all those involved in custody) • Article 11 (systematic review of methods, practices, arrangements of custody) • Article 12 (prompt and impartial investigation) • Article 13 (complaints to competent authority and protection from reprisals) • Article 14 (redress) • Article 16 (prevention of CIDT)
OPCAT	Optional Protocol to the Convention against Torture (2002) https://www.ohchr.org/en/instruments-mechanisms/instruments/optional-	All articles

	protocol-convention-against-torture-and-other-cruel	
CRPD	Convention on the Rights of Persons with Disabilities (2006) *Note Australia declaration https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities	• Article 3 (general principles) • Article 9 (accessibility) • Article 12 (equal recognition before the law) • Article 14 (liberty and security of person) • Article 15 (freedom from torture and inhuman treatment) • Article 17 (physical and mental integrity) • Article 19 (living independently) • Article 22 (privacy) • Article 25 (right to health) • Article 26 (habilitation and rehabilitation) • Article 28 (adequate standard of living)
CRC	Convention on the Rights of the Child https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child	• Article 37 (prohibition of torture; rights in detention)
ECHR	European Convention on Human Rights https://www.echr.coe.int/documents/convention_eng.pdf	• Article 3 (prohibition of torture) • Article 5 (right to liberty and security) • Article 8 (right to respect for private and family life) • Article 14 (prohibition of discrimination)
A/72/55 (Annex)	CRPD Guidelines on Article 14 https://www.ohchr.org/en/documents/reports/a7255-report-committee-rights-persons-disabilities-13th-through-16th-sessions	CRPD Guidelines to clarify Article 14 which is “essentially a non-discrimination provision”. Sets out absolute prohibition on detention on the basis of impairment, non-consensual treatment, protection from violence, abuse and ill treatment, conditions of detention.

CRPD/C/GC/1	CRPD General Comment No.1 on equal recognition before the law (2014) https://www.ohchr.org/en/documents/general-comments-and-recommendations/general-comment-no-1-article-12-equal-recognition-1	Sets out CRPD Committee's understanding of discriminatory approach to legal and mental capacity, replacing best interests tests, the right to healthcare based on free and informed consent, abolition of forced treatment, deinstitutionalisation
CRPD/C/GC/6	CRPD General Comment No.6 on equality and non-discrimination (2018) https://www.ohchr.org/en/documents/general-comments-and-recommendations/general-comment-no6-equality-and-non-discrimination	Sets out normative content of Article 5 (on equality) and implementation measures, on the understanding that human rights model of disability recognises disability as a social construct therefore not legitimate ground for restriction of human rights. Elaborates concept of inclusive equality (paras 11,19).
CAT/OP/27/2	Approach of the SPT regarding the rights of persons institutionalised and treated medically without informed consent (2016) https://www.ohchr.org/en/treaty-bodies/spt/approaches-prevention	SPT position on involuntary confinement, safeguards against arbitrariness and position on restraint and seclusion/isolation. Also covers informed consent in the context of medical treatment.
CAT/OP/12/6	Approach of the SPT to the concept of prevention of torture and other cruel, inhuman or degrading treatment or punishment (2010) https://www.ohchr.org/en/treaty-bodies/spt/approaches-prevention	SPT position on what is meant by a preventive approach and setting out key principles which guides its approach in this regard.
BOP	Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (1988) https://www.ohchr.org/en/instruments-mechanisms/instruments/body-	Relates to all forms of detention, setting out basic principles on treatment, safeguards, rights in detention.

	principles-protection-all-persons-under-any-form-detention	
PPP	Principles for the protection of persons with mental illness and the improvement of MH care (1991) https://www.ohchr.org/en/instruments-mechanisms/instruments/principles-protection-persons-mental-illness-and-improvement	Pre-CRPD standards focussed broadly on mental health care but covering issues around restrictions, informed consent, individualised care, rights and conditions in MH facilities.
A/HRC/34/32	UN High Commissioner for Human Rights, Annual Report: Mental Health and Human Rights	Overview of UN standards relating to mental health, including CRPD approach on deprivation of liberty and forced treatment; proposes human rights-based approach to guide future policy.
SRHealth 2017 (A/HRC/35/21)	UN Special Rapporteur on Health report on the right to mental health (2017) https://www.ohchr.org/en/documents/thematic-reports/ahrc3521-report-special-rapporteur-right-everyone-enjoyment-highest	Reflecting on slow progress on commitments including on deinstitutionalisation, the SR Health reflects on the continuing dominance of biomedical model of disability and power asymmetries from psychiatry. Applies the right to health framework to proposing steps for better care and support.
SRHealth 2018 (A/HRC/38/36)	UN Special Rapporteur on Health report on the right to health and deprivation of liberty (2018) https://www.ohchr.org/en/documents/thematic-reports/ahrc3836-report-special-rapporteur-right-everyone-enjoyment-highest	Reflecting on the dominance of detention and confinement as responses to issues of public safety and public health. Sets out right to health framework for deprivation of liberty (paras 21-45); relationship between MH and forced confinement (paras 46-52).

SRTorture 2013 (A/HRC/22/53)	UN Special Rapporteur on Torture report on torture in healthcare settings (2013) https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf	Covering the new normative paradigm of CRPD; absolute ban on restraint and seclusion; forced intervention; legal capacity; involuntary detention (paras 58-70)
SRTorture 2011 (A/66/268)	UN Special Rapporteur on Torture report on solitary confinement (2011) https://digitallibrary.un.org/record/710177?ln=en	SR considers imposition of solitary confinement of any duration on a person with mental disabilities is cruel, inhuman or degrading treatment(para 78)
SRTorture 2008 (A/63/175)	UN Special Rapporteur on Torture report on protecting persons with disabilities from torture, and solitary confinement https://digitallibrary.un.org/record/635981?ln=en	Conditions of detention (para 52-54)
COE Rec(2004)10	Council of Europe, Committee of Ministers, Recommendation no REC(2004)10 concerning the protection of the human rights and dignity of persons with mental disorder https://rm.coe.int/rec-2004-10-em-e/168066c7e1	Rights and freedoms for persons with mental disorder including those subject to involuntary placement or treatment. Covers principle of least restriction, procedures for decision-making on involuntary placement/treatment including in emergencies.
	European Court of Human Rights Research report, Rights of persons in relation to involuntary placement and treatment in mental healthcare facilities https://rm.coe.int/rights-of-persons-in-relation-to-involuntary-placement-and-treatment-i/1680ab369a	Overview of ECtHR case law related to mental health under Articles 3,5,8. Focussed specifically on involuntary treatment and placement in healthcare facilities.

CPT (2009) 56 Rev	European Committee for the Prevention of Torture, Checklist for the evaluation of a psychiatric hospital https://rm.coe.int/16806fc231	*Aide memoire* to be used during CPT visits.
CPT/Inf(98)12-part	European Committee for the Prevention of Torture, Involuntary placement in psychiatric establishments https://rm.coe.int/16806cd43e	Extract from CPT's 8th General Report (1998) covering prevention of ill treatment, living conditions and treatment, restraint and seclusion, safeguards in the context of involuntary placement
CPT/Inf/(2017) 6	European Committee for the Prevention of Torture, Means of restraint in psychiatric establishments for adults https://rm.coe.int/16807001c3	Revised standards based on CPT visits, focussed on safeguards including authorisation, duration, supervision, debriefing, recording and reporting, complaints. Also sets out some forms of restraint that should be prohibited.
	UN Global Study on Children Deprived of Liberty https://gchumanrights.org/research/projects/un-global-study/about.html	Comprehensive global study including focus on institutions

Author/ organisation	**Title & Link**	**References/key points**
World Health Organisation	WHO QualityRights Tool Kit: Facility-based assessment report https://apps.who.int/iris/bitstream/handle/10665/70927/9789241548410_facility_eng.pdf;jsessionid=C0C0C4ED778B2AD61A25930E88054986?sequence=6	Widely consulted human-rights based overview of methodology, standards and criteria for assessing mental health facilities
World Health Organisation	Hospital-based mental health services: promoting person-centred and rights-based approaches (2021)	Useful note on terminology (XXII); case studies; action steps for setting up/transforming hospital-based services

	https://www.who.int/publications-detail-redirect/9789240025745	
World Health Organisation	Strategies to end seclusion and restraint: WHO QualityRights specialised training https://apps.who.int/iris/bitstream/handle/10665/329605/9789241516754-eng.pdf	Includes actions to expect of staff and MH services towards elimination of seclusion and restraint (p47-49)

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