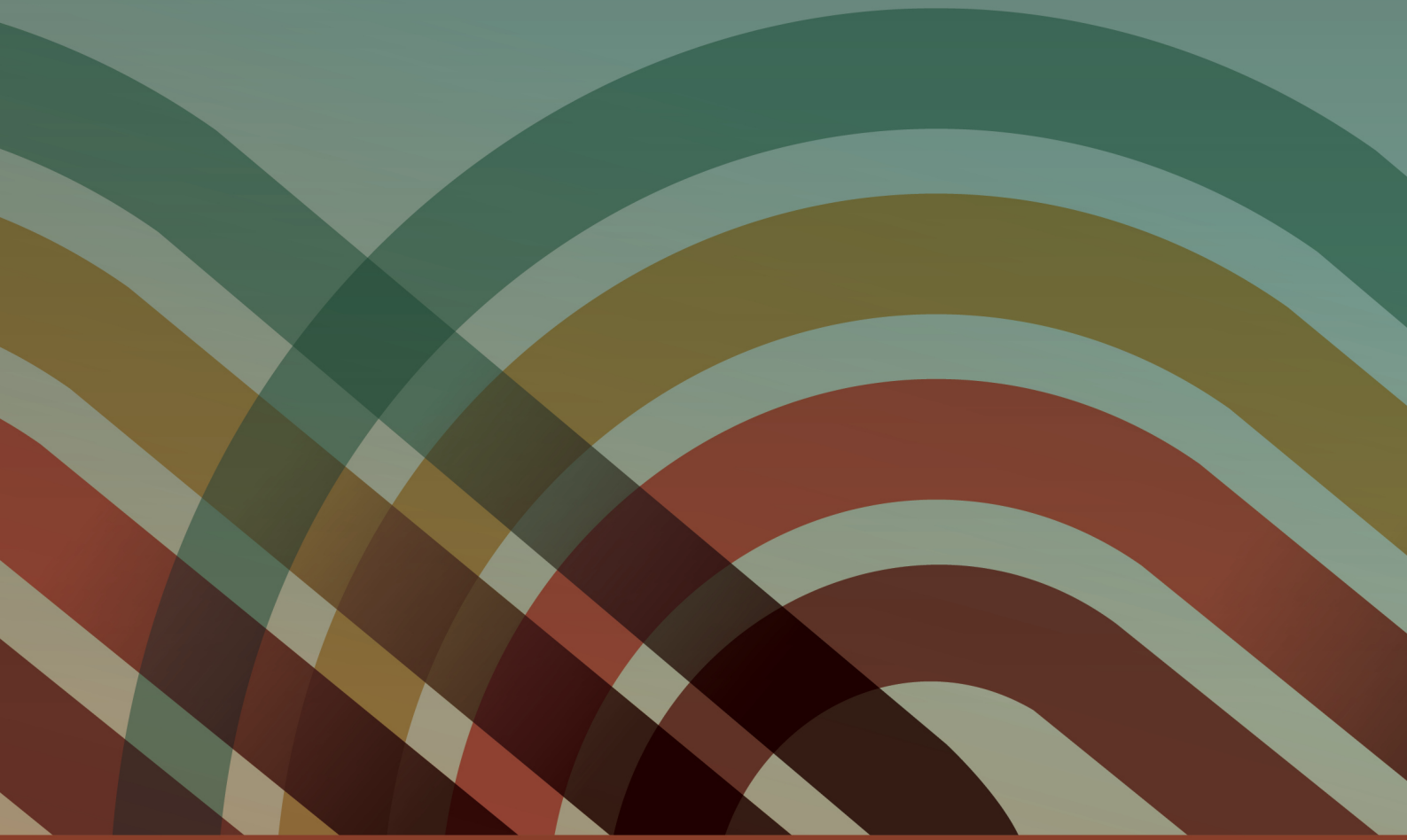
Tasmanian NPM
National Preventive Mechanism



Preventing torture and ill-treatment in Tasmania

Supplementary report to the Tasmanian Government focusing on health and social care and update on the implementation of the Tasmanian National Preventive Mechanism under the *OPCAT Implementation Act 2021*

2024 Annual Report

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2024 Annual Report

November 2024

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Website: www.npm.tas.gov.au

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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.

Content warning

This report provides information that includes discussion about torture, cruel, inhuman or degrading treatment or punishment. No individual events are discussed in this report, however readers should be aware that some content may cause discomfort or distress.

About the Tasmanian NPM and this report

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, cruel, inhuman or degrading treatment or punishment of people deprived of their liberty by embedding best practice human rights. It does this through proactive oversight of places 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 NPMs 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).*

This is the second and final implementation report to be presented by the Tasmanian NPM, following the *Preventing torture and ill-treatment in Tasmania* report released in December 2023. The focus of this report is on the exercise of the Tasmanian NPM's functions in community-based residential health and social care settings where a person is or may be deprived of their liberty including disability support accommodation, related settings, and aged residential care. The report provides foundational information, detailed analysis, and additional recommendations related to office implementation.

In addition, this report describes the functions and operations of the Tasmanian NPM for the year ending 30 June 2024, in the section 'Annual Report 2024'.

Contents

Glossary of terms

2023 Report	*Preventing torture and ill-treatment in Tasmania* Report to the Tasmanian Government on the Implementation of the Tasmanian National Preventive Mechanism under the *OPCAT Implementation Act 2021*, December 2023 (ISBN: 978-0-646-88962-7)
ABS	Australian Bureau of Statistics
Advisory Council	The Tasmania NPM Civil Society Advisory Council
APT	Association for the Prevention of Torture
CAT	The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.
Civil society	This includes a wide range of organisations, including non-governmental organisations and associations, professional associations, trade unions, academia, and faith-based groups.
Commission of Inquiry	Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings (Report, 31 August 2023).
Custodial centre	A prison within the meaning of the *Corrections Act 1997*; and a detention centre within the meaning of the *Youth Justice Act 1997*.
Deprivation of liberty	"Any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority. (OPCAT, Article 4(2))
Disability Royal Commission	Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Final Report, 29 September 2023).

Elm	Elm Consulting Australia
Health and social care	In this report, health and social care means, but is not limited to, the following types of community-based services: disability group homes, specialised disability accommodation residences, supported independent living services, community-based accommodation, and aged residential care homes, including within hospital/medical centres, nursing homes and dementia units.
Home care	Refers to services provided to older individuals who wish to remain living independently in their own homes for as long as possible. These services are designed to support the elderly with daily tasks and activities that they may find challenging due to age-related limitations.
ill-treatment	All forms of cruel, inhuman or degrading treatment or punishment.
NDIA	National Disability Insurance Agency
NPM	National preventive mechanism.
NDIS	National Disability Insurance Scheme.
OHCHR	Office of the High Commissioner for Human Rights
OPCAT	Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.
Paris Principles	Principles relating to the Status of National Institutions.
Place of detention (or 'setting')	Any place under [a State Party's] jurisdiction and control where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence. (OPCAT, Article 4(1)).
Respite	Respite care (also known as short-term care) is a form of support for carers or care recipients
Restrictive practices	Practices or interventions that have the effect of restricting the rights or freedom of movement of a person.
SDA	Specialised disability accommodation for people with disability, provided under the NDIS. SDA services are

	housing designed for people with significant functional impairment or very high support needs.
SIL	Supported independent living services for people with disability, provided under the NDIS. SIL services enable individuals with disabilities to live independently in shared or individual homes, receiving customised support services for daily tasks.
SPT	Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.
TASCAT	Tasmanian Civil and Administrative Tribunal
Tasmanian NPM	Tasmanian National Preventive Mechanism
Torture	"Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing them for an act they or a third person has committed or is suspected of having committed, or intimidating or coercing them or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions. (CAT, Article 1)
'the Act'	OPCAT Implementation Act 2021 (Tas).
UN	United Nations

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Foreword & Annual Report 2024

Richard Connock,
Tasmanian National Preventive Mechanism

I am delighted to present this supplementary report on the implementation of my Tasmanian NPM office. In accordance with section 24 of the *OPCAT Implementation Act 2021* (Tas), this report also constitutes my Annual Report for 2024.

As foreshadowed in my December 2023 implementation report *Preventing torture and ill-treatment in Tasmania* (the 2023 Report),[1] this supplementary report presents the results of in-depth research, analysis, and consultation to implement my NPM office in relation to health and social care settings. It forms the second and final component of my project to comprehensively scope and design a Tasmanian NPM operating model that is most appropriate for our state and meets the requirements of OPCAT.

Arising from this work are four additional recommendations related to the office's organisational design, operations, and legislative reform. This brings the total recommendations arising from my implementation activities to 12. I consider full implementation of these recommendations critical to keeping some of the most vulnerable people around our state safe from harm.

Importantly, these recommendations have been designed to enable the office to operate in compliance with recommendations 8.2, 11.7, 11.11, 11.16 of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (the Disability Royal Commission); and, to effectively exercise functions of the Tasmanian NPM in respect of aged residential care settings where people may be deprived of their liberty. I take this opportunity to acknowledge the Tasmanian Government for accepting in principle the Disability Royal Commission's OPCAT recommendations and for acknowledging the work that my office was completing to facilitate compliance.

This supplementary report on health and social care has been released separately to my 2023 Report due to its complexity, and because of resource and timing factors. I understand that this is the first report of its kind to be released in Australia, focusing on the application of the OPCAT where deprivation of liberty occurs in the delivery of health and social care services. I am honoured to have

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[1] Available at: https://npm.tas.gov.au/.

been able to lead this nationally significant project, and I take this opportunity to recognise the Tasmanian Government for providing implementation resourcing. By funding my office to complete this essential work, Tasmania has established itself as a leader among Australian jurisdictions on OPCAT and the prevention of torture and ill-treatment. It is demonstrative of the depth of expertise in our state, and our capacity to lead on nationally significant projects.

Although this report may be novel for Australia given its more recent ratification of OPCAT, I want to emphasise that it has been informed by the longstanding practice of existing NPM bodies worldwide that oversee their state's health and social care sector. It is additionally reflective of guidance provided by the Subcommittee on the Prevention of Torture (SPT) and the Association for the Prevention of Torture (APT). Its final outcomes have been shaped to meet the Tasmanian and wider Australian context through extensive local consultation.

I extend my gratitude to the many experts, stakeholders and government representatives who provided feedback and assisted with this report's development, as well as their ongoing engagement with my office. Without their assistance my project team would not have been able to acquire a detailed understanding of Tasmania's health and social care landscape, succeed in developing cogent insights, and provide informed recommendations.

In particular, I acknowledge the assistance of the NDIS Commission, Mary Mallett, the Office of the Senior Practitioner, Homes Tasmania, disability support and aged care service providers around Tasmania, as well as the Department of Health for facilitating visits to the Roy Fagan Centre and the Flinders Island Multi-Purpose Centre. In addition, I extend my appreciation to National Disability Services Tasmania and the Aged & Community Care Providers Association (Tasmania) for distributing important information about my implementation activities to their respective members. Finally, I thank Janis McKenna and her team at Elm Consulting Australia, who as part of the project team led development of the report's segmentation analysis, journey mapping, and organisational design components.[2]

As a first for Australia, I am proud to include in this supplementary report my draft *Expectations on the treatment of people deprived of their liberty in health and social care: aged residential care, disability support and related environments*

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[2] The project team included Director, Office of the Tasmanian NPM; the Office of the Custodial Inspector; and, expert consultants ELM Consulting Australia and Dr Yvette Maker, who were engaged to advise on the design and expectations components of the project respectively.

(Appendix 9). In line with Disability Royal Commission recommendation 11.11, the development of this document was led by subject-matter expert, Dr Yvette Maker, in codesign with representative and advocacy organisations of persons with disability, older persons, and group residential aged care and disability support services. I extend my sincere gratitude to the codesign participants for their feedback and support. This document is now open for public consultation until the end of January 2025.[3]

Under section 24(2) of the *OPCAT Implementation Act 2021* I am required to include in my Annual Report an evaluation of the response of relevant authorities to recommendations or advice that I have provided. I note that on 5 June 2024 I received correspondence from the Attorney-General, the Hon Guy Barnett MP, acknowledging my 2023 Report. However, as of 30 June 2024, I have not received a response to its recommendations, nor have I been provided with the resources needed to fulfil my functions. This includes positions related to recommendations arising from the Commission of Inquiry into the Tasmanian Government's responses to Child Sexual Abuse in Institutional Settings (Commission of Inquiry) to visit children and young people deprived of their liberty in non-custodial environments.

I am aware of the complexity arising from my recommendations and its overlap with the forthcoming Commission for Children and Young People. The recommendations contained in my 2023 Report, repeated in this report, propose a collocated and consolidated model of independent oversight, whereby the Tasmanian NPM works side by side with the Commission for Children and Young People, and the Disability Commissioner, to coordinate and lead comprehensive inspections of all places where people may be deprived of their liberty in the state.

On 23 December 2023, I wrote to the Attorney-General seeking an opportunity to receive a briefing and to provide feedback in relation to the establishment of the new Commission and my NPM office, and to engage with the Department in relation to implementation. Unfortunately, as at 30 June 2024 I have not received a response to this request, and my NPM office has not received a briefing or been invited to contribute feedback. As a result, I am unaware of the proposed design of the forthcoming Commission for Children and Young People, and the extent to which my recommendations have been considered in the policy framework. I acknowledge that the Government has set a July 2026 implementation date for

[3] Further information is available at www.npm.tas.gov.au

these NPM-related recommendations, however I emphasise that my NPM office is ready and able to commence these activities now with appropriate resourcing.

I take this opportunity to reiterate my primary recommendation that the Tasmanian NPM must be established as a standalone, specialised entity that is separate to the Ombudsman, and that it be fully resourced to independently fulfil its functions across all places of deprivation of liberty under the Tasmanian NPM jurisdiction. A single NPM and colocation are essential requirements for my proposed organisational design to be effective, and I now extend this recommendation to include the forthcoming Disability Commissioner.

The governance model and full-time equivalent (FTE) staff proposed in this report incorporates all Tasmanian NPM oversight positions associated with these collocated jurisdictions in respect of youth justice, out of home care, and restrictive practices. Specifically, four dedicated FTE focused on examining the treatment of children and young people, including at Ashley Youth Detention Centre; and four FTE focused on the treatment of people with disability and/or subject to restrictive practices. In addition to these positions, specific positions are recommended to visit secure mental health settings, and aged residential care facilities.

Building on the 2023 Report, in this report I now recommend the creation of a shared office in Launceston, dedicated to facilitating the exercise of statutory functions across our northern regions, many of which are not readily accessible from Hobart. An updated organisation design and detailed costings have been provided to incorporate the outcomes arising in this report.

The recommended governance model for the Office of the Tasmanian NPM contained in this report has been structured to be agile, multidisciplinary, and collaborative. It is an approach that is intended to reduce expenditure on external subject-matter experts by building internal capacity, and has been specifically designed to avoid the all too common siloing of information that occurs in government by fostering a culture of proactive cooperation through colocation and clear lines of responsibility.

This approach directly responds to key Commission of Inquiry findings and observations that Tasmania's existing oversight and integrity model was overly complex and siloed, hindering proactive information sharing. Under my recommended model, all preventive monitoring of people deprived of their liberty in Tasmania will sit under one independent and accountable statutory body, which will work proactively with related specialist entities in the Commission for Children and Young People, and the Disability Commissioner. I consider that this model

builds upon and aligns with the spirit of the Commission of Inquiry's recommendations and findings in relation to the Tasmanian NPM.

From among the different NPM implementation options available, this independent single NPM model has been evaluated as the most economical, efficient, and effective for Tasmania. The employment positions identified in this office model reflect an intentionally lean baseline assessment. That is, all positions proposed are essential to the office fulfilling its statutory requirements. It will enable the Tasmanian NPM to build a skilled and diverse office that includes people with disability and Aboriginal and Torres Strait Islander peoples.

Each of the office's practice streams will cover a large, and in some instances significant number of deprivation of liberty settings in Tasmania, many of which contain a diversity of resident populations. By way of comparison, my Custodial Inspector office is currently resourced for four staff, who inspect five custodial centres and one youth detention centre. The revised Tasmanian NPM and Custodial Inspector office model proposed in this report recommends 18 FTE dedicated to fulfilling all combined statutory oversight functions[4] across about 200 deprivation of liberty settings, and six FTE to fulfil all corporate and administrative functions and duties. This represents a 400% increase in staff to a 3300% increase in places over those currently exercised by my Custodial Inspector office.

Given the proposed significant increase in ratio of staff to places to be visited, my revised governance model recommends the creation of specific practice streams that focus on different types of deprivation of liberty environments, staffed by relevantly experienced persons. This will enable the office Director to adopt an agile and risk-based management approach, coordinating relevant staff from across practice streams to attend visits, with the added involvement of related independent offices and consultant experts where necessary.

Finally, it is appropriate for me to highlight that the estimated cost of establishing this new office represents a small fraction of the combined resources allocated each year to the agencies who operate or have responsibility for the places that the office will visit. It is an investment in our shared future prosperity, with the economic and wellbeing gains achievable through this office's effective preventive operations capable of generating a significant return on investment. To ensure resourcing is appropriately allocated and scrutinised by Parliament, I have

[4] I.e. Including the Commission for Children and Young People, Disability Commissioner, Custodial Inspector, and Tasmanian NPM, and corporate and administrative staff.

recommended amendments to the *Integrity Commission Act 2009* to extend the functions of the Joint Standing Committee on Integrity.

Events of torture and ill-treatment can have a profound, devastating, and long-lasting impact on society. Its impression may span for generations beyond the individuals directly harmed and impact communities, such as by fomenting distrust of government and important institutions. The economic consequences of systemic abuse can be similarly significant, affecting workforce productivity and giving rise to large compensation obligations, which may also diminish a state's reputation. Delayed identification of systemic issues can stymie opportunities for early and preventive intervention through effective policy or procedural reform.

It is axiomatic that a state which resources and promotes independent oversight of places where society's most vulnerable people are located and actively seeks opportunities to continuously improve service delivery best positions itself to minimise the risk of torture and ill-treatment. It is no surprise therefore that recent Commissions, which have made findings of serious wrongdoing, have recommended OPCAT implementation as a result.

I note that the Tasmanian Government has committed to NPM implementation and I strongly encourage it to accept all implementation recommendations as a matter of priority.

I now provide a report on my activities for the 2023 – 2024 financial year.

I am proud to say that this has been a period of milestones in the establishment of the Tasmanian NPM, with implementation activities approaching their completion and my office, through the Custodial Inspector, taking its first steps to commence NPM activities.

Implementation Report and expectations development

As I mentioned earlier, in December 2023 I publicly released my implementation report *Preventing torture and ill-treatment in Tasmania*.[5] This Australia-first report followed 12 months of extensive engagement with experts, stakeholders, and public consultation. It presented eight recommendations designed to establish an NPM that is best suited to Tasmania and fully independent, and which will work closely with civil society.

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[5] Available at: https://npm.tas.gov.au/.

Accompanying the report were four draft expectations documents, related to the treatment of children and young people deprived of their liberty, people in police or court custody, people in mental health settings, and people in adult custody centres. These draft expectations were open for consultation until March 2024, and I am pleased to announce that the first three documents are now finalised and are available on my website, with the adult custody centres document also nearing completion.

To finalise these documents, the respective experts who led their development travelled to Hobart, met with stakeholders, and conducted additional orientation visits. I sincerely thank Megan Mitchell AM, Sarah Cooke OBE, Louise Finer, Scott Tilyard APM GAICD, and Emeritus Professor Neil Morgan AM for their continued support. As an important first step, I have now engaged the Australian Human Rights Commission to work with my office to create accessible materials to accompany my adult custody centres expectations, which will be distributed throughout Tasmania's prisons and available on my website.

Further to these materials, as I outlined earlier, this year I also progressed development of my health and social care expectations, led by subject matter expert Dr Yvette Maker at the University of Tasmania in codesign with representative and advocacy organisations. I also acknowledge and thank Mary Mallett, Tasmanian Interim Disability Commissioner, for her participation and assistance in this process.

Custodial Inspector activities

In connection with the finalisation of these expectations and aligned with recommendation 2 in my 2023 Report, my Custodial Inspector office has now begun to exercise NPM functions in respect of custodial centres, including youth detention.

In May 2024 my Custodial Inspector staff conducted an inspection of Ashley Youth Detention Centre, using my new expectations on the treatment of children and young people deprived of their liberty.[6] The inspection report associated with this visit will be released within the 2024-25 financial year and captured in my next Annual Report.

[6] Which have now superseded my Custodial Inspector inspection standards for youth custodial centres in Tasmania. *See*: https://www.custodialinspector.tas.gov.au/standards_And_guidelines.

I additionally note that my Custodial Inspector team finalised several thematic inspection reports, which were released in July and August 2024.[7] These include:

- Youth Wellbeing Inspection Report 2024
- Youth Health Care Inspection Report 2023
- Adult Health Care Inspection Report 2023
- Inhumane Treatment in Dry Cells - Review Report 2024

Upon their tabling in Parliament these reports are published on my Custodial Inspector website. Relevant to OPCAT and my functions as NPM, I note that in these reports I made findings that practices in settings inspected fell below Australia's human rights obligations. This was notably the case within the context of dry cells and their equivalence to prolonged solitary confinement, which I found to be a form of inhumane and degrading treatment that was being imposed on people in detention suspected of concealing contraband.

In the 2024-25 financial year I would like my Custodial Inspector office to begin visits to police and court cells using my Expectations on the treatment of people deprived of their liberty in police and court custody.[8] The capacity of my Custodial Inspector office to undertake regular visits to these settings is dependent on additional resourcing being provided, as detailed in my 2023 Report and in this report.

National Symposium

On 18 and 19 March 2024 my office hosted a two-day national OPCAT symposium, at the Bahá'í Centre in Hobart. The overarching theme of event was 'the NPM in practice,' involving discussions on a variety of topics such as the scope of the NPM mandate, how it is applied in different settings, strategic planning, and civil society engagement. As Australia's implementation of OPCAT continues to progress, the symposium was designed to gather NPMs, leading experts, and civil society over two days to discuss key practice issues, provide insights, and share learnings.

The opening addresses for each day were delivered by Justice Shujune Muhammad and Associate Professor Jakub Czepek, from the United Nations

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[7] Available at https://www.custodialinspector.tas.gov.au/inspection_reports

[8] *See*: https://npm.tas.gov.au/home/our-expectations. This will include court cells in Hobart, Launceston, Devonport and Burnie; and police cells in Hobart, Launceston, Devonport, Burnie, Queenstown, and on King Island and Flinders Island.

Subcommittee on Prevention of Torture; and National Children's Commissioner, Anne Hollonds. I also acknowledge contributions made by:

- Dr Claire Achmad, Chief Children's Commissioner, Mana Mokopuna (New Zealand);
- Iain Anderson, Commonwealth Ombudsman;
- Rosemary Kayess, National Disability Discrimination Commissioner;
- Mary Mallett, Interim Disability Commissioner Tasmania;
- Leanne McLean, Commissioner for Children and Young People Tasmania;
- Rebecca Minty, Inspector of Custodial Services for the Australian Capital Territory;
- Uncle Rodney Dillon, Palawa Nation elder, Weetapoona Aboriginal Corporation chair and Amnesty International advisor; and
- Eamon Ryan, Inspector of Custodial Services Western Australia.

Figure 1: *Symposium session on NPM expectations on the treatment of children and young people, 19 March 2024*. Panellists from left: Anne Hollonds, National Children's Commissioner (2020 - present); Megan Mitchell AM, National Children's Commissioner (2013-2020); Leanne McLean, Commissioner for Children and Young People Tasmania (2018-2024); Isabelle Crompton, Office of the Commissioner for Children and Young People Tasmania. On screen: Dr Claire Achmad, Chief Children's Commissioner, Mana Mokopuna New Zealand.

I was heartened by the event's significant attendance, with participants travelling to Tasmania from across Australia and New Zealand, as well as joining online. It underscored the increasing goodwill that my office, and Tasmania, has been able to build as this implementation project has progressed in consultation with civil society. And, importantly, it highlighted the growing awareness of OPCAT, and the value of the NPM as an essential framework to strengthen human rights protections among society's most vulnerable.

Staff professional development

In addition to activities occurring within my office, I have been encouraged by the continued momentum of related activities occurring around Australia, and in particular the ongoing work of the Commonwealth Ombudsman to coordinate the Australian National Preventive Mechanism.

In May 2024, staff from my NPM and Custodial Inspector offices travelled to Canberra for NPM training led by representatives from the Switzerland-based Association for the Prevention of Torture, and the United Kingdom NPM, which was organised in cooperation with the Australian Human Rights Commission. At the event, attendees from the Australian NPM obtained valuable insights in relation to how NPM bodies approach the exercise of their functions across different deprivation of liberty environments. The event also doubled as a valuable opportunity for Australian NPM strategic planning.

I note that following this event, my NPM office is engaging with the Association for the Prevention of Torture about further collaboration opportunities, and to increase awareness of OPCAT and the NPM in Tasmania.

In addition to this NPM-specific training, my NPM and Custodial Inspector staff completed comprehensive training in investigations practices, trauma informed practice, safeguarding children, and trauma responsive practice when working with young people in detention.

Civil Society Advisory Council

In May 2024 I appointed the members of my inaugural Civil Society Advisory Council (Advisory Council), giving effect to recommendation 6 in my 2023 Report. This followed a public expression of interest process through which I received applications from across Australia. As outlined in the 2023 Report, the Advisory Council will be a permanent body, integrated into the office's governance structure. The Advisory Council initially consists of seven independent members,

each holding experience or expertise in one or more of the following areas and serving for a two-year term:

- children and young people;
- people with disability;
- aboriginal and Torres Strait Islander peoples;
- health and social services;
- lived experience of deprivation of liberty;
- custodial settings; and
- expertise in human rights law.

The Advisory Council framework will enable individuals with specialised knowledge and lived experience of deprivation of liberty to inform the delivery of the Tasmanian NPM's functions. Its primary role will be to informally report and provide advice in relation to Tasmanian NPM activities, on the exercise of functions, and promote regular civil society engagement with my NPM office. I have included a copy of the Advisory Council's Charter at **Appendix 1.** I warmly congratulate the Advisory Council members on their appointment:

- Maggie Blanden
- Anthony Bull
- Monique Hurley
- Heidi La Paglia
- Jacob Smith
- Tash Smyth
- Peter Williams

Following the practice of similar advisory committees, a communique will be released on my NPM website following each meeting.[9]

With my term of appointment coming to an end, I note that this will be my final Annual Report as Tasmanian NPM. I take this opportunity to reiterate the honour that it has been to serve as Tasmania's inaugural NPM, and to have been provided the opportunity to complete this comprehensive implementation project. I also acknowledge and thank my office Director, Mark Huber, for his support leading the project and progressing the operationalisation of this important office, and my Custodial Inspector team for their valuable assistance.

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[9] *See*: https://npm.tas.gov.au/

I strongly encourage the Tasmanian Government, and all Australian governments to continue to work in cooperation to fully implement OPCAT in Australia, and to provide NPMs with the resourcing necessary to exercise their functions effectively, so that as a nation we can be confident that Australia is upholding its obligation to protect the inalienable rights of society's most vulnerable and prevent torture and ill-treatment.

Introduction to the report

Mark Huber
Director, Office of the Tasmanian NPM

This supplementary report presents the results of comprehensive information gathering, consultation, and expert analysis to implement the Tasmanian NPM in community-based health and social care places where people are or may be deprived of their liberty. It delivers an evidence-based operating framework and comprehensive organisational model evaluated as most appropriate to establish the Office of the Tasmanian NPM, enabling it to effectively fulfil its statutory functions across the state.

Across Tasmania, every day, people in positions of vulnerability receive care and support in the community and, associated with the delivery of those services, are deprived of their liberty to freely leave the place they are in. These people may live with disability, be experiencing cognitive impairment or ill-health, or require specialised support to perform everyday tasks. People in these circumstances are inherently exposed to an elevated risk of abuse, and even death, when service providers fail to provide appropriate care or support consistent with fundamental human rights.

In many instances, community-based deprivation of liberty is approved to maintain a person's welfare or control their behaviour. It may also arise from the nature of the care or support provided, or it can manifest from denial of service because a person is unable to freely leave without physical support. These interactions between the person, their physical environment, the support and care they receive, and the restrictions on their movements are regulated by Tasmanian and Commonwealth law. The main frameworks through which these activities are authorised are the National Disability Insurance Scheme (NDIS), Tasmania's Restrictive Practices and Guardianship processes, and the Aged Care Quality Framework.

The Tasmanian NPM has an obligation to exercise its mandate in these circumstances, to prevent torture and ill-treatment. In its General Comment on Article 4 of OPCAT, the United Nations Subcommittee on Prevention of Torture (SPT) makes it clear that NPMs are expected to examine deprivation of liberty in

health and social care environments (Appendix 2).[10] Within Australia, the report of the Disability Royal Commission (rec 8.2, 11.11, 11.16) and the Commission of Inquiry (rec 12.39) made specific recommendations to implement the NPM and resource it to visit places where people with disability and children and young people are deprived of their liberty. The reports, and those of others such as the Aged Care Royal Commission, emphasise that if their findings go unheeded and reform is not implemented there is a real risk that identified cycles of harm will continue. It is following this direction and with a view to adhering to relevant recommendations that this report has been completed.

The Tasmanian NPM's 2023 Report, *Preventing torture and ill-treatment in Tasmania*, provides a description of the outcomes of extensive stakeholder, expert and government consultation to understand the types of places in Tasmania that fall within its mandate. Within the context of health and social care, places identified included disability group homes, specialised disability accommodation (SDA) residences, closed community-based accommodation and residences for people with disability, and aged residential care facilities (including in hospital/medical centres). People using supported independent living (SIL) services may also be included, depending on the nature of services provided.

A common theme across many of these places is the use of restrictive practices. Fundamentally, these are actions that violate a person's rights. They are typically justified on the basis that they are necessary to maintain a person's safety. In relation to deprivation of liberty, restrictive practices circumstances described by stakeholders included people being physically or mechanically restrained, confined to a particular room or area within a building, being placed on/in an object or vehicle from which the person cannot freely remove themselves, subjected to a chemical restraint, or requiring permission to leave before being allowed to do so. In some places, this deprivation of liberty was confined to a designated area, such as a room or secure unit, and in others it was applied to external features, such as the authorised locking of doors or gates for specific individuals to prevent their exit.

The Disability Royal Commission was unequivocal that restrictive practices can amount to breaches of international law, recommending reform to significantly reduce their use and in some instances eliminate them altogether.[11] Any deprivation of liberty and use of restrictive practices that rises to the level of torture

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[10] Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *General Comment No. 1 (2024) on Article 4 of the Optional Protocol (Places of Deprivation of Liberty)*, 53rd sess, UN Doc CAT/OP/GC/1 (4 July 2024).

[11] E.g. Recommendation 6.35.

and cruel, inhuman or degrading treatment or punishment must be prohibited. The Tasmanian NPM's principal function will be visiting and examining places where restrictive practices are approved with a view to strengthening, if necessary, the protection of people whose liberty has been deprived. It is only by opening-up such places to proactive, independent scrutiny and creating opportunities for early intervention that essential human rights can be protected, and the potential for abuse is minimised.

The purpose of this supplementary report is to set up the Office of the Tasmanian NPM to perform its functions economically, efficiently, and effectively, to provide the greatest benefit to the Tasmanian public. Its chief focus is the development of an appropriate operating model, organisational design, and an accurate resource estimate. Achieving these objectives required answering six overarching questions in three stages –

Stage 1: Foundations

1. What is the Tasmanian NPM's mandate in health and social care?
2. When does deprivation of liberty occur?

Stage 2: Analysis and application

3. How should the Tasmanian NPM exercise its functions?
4. Where should the Tasmanian NPM prioritise its work?

Stage 3: Implementation assessment and budget

5. What is the most appropriate organisational model for the Tasmanian NPM?
6. What are the Tasmanian NPM's expectations on the treatment of people deprived of their liberty in health and social care?

The structure of this report is designed to mirror this project sequence, with each part stepping through the methodologies adopted, findings, and analysis to assist readers in understanding how each stage has informed progression of the next.

Overall, the report makes four additional recommendations necessary to progress implementation of the Tasmanian NPM. This brings the total recommendations of the Tasmanian NPM implementation project to 12. An executive summary of the report, including the final list of implementation recommendations and proposed organisational design is provided in the next section.

To assist the office in completing this work, Tasmania-based subject matter experts, Elm Consulting Australia were engaged to provide advice. In view of the complex and dynamic service delivery landscape, for the office to obtain a comprehensive understanding and develop an appropriate response this engagement included providing:

- service design analysis;
- advising on a risk framework to prioritise visits;
- office organisational design; and
- related budget modelling to update figures included in the 2023 Report.

The results of this analysis are included at Appendices 3 to 7.

Alongside these activities, Dr Yvette Maker[12] was engaged to develop appropriate expectations on the treatment of people deprived of their liberty in codesign with stakeholders. This follows the approach detailed in the 2023 Report,[13] and is addressed at Part 6.

To complete this project and obtain an accurate picture of the Tasmanian deprivation of liberty landscape in health and social care, the project team engaged actively with the NDIS Commission, the Office of the Senior Practitioner, Homes Tasmania, as well as aged residential care and disability support service providers and stakeholders. Information received included on all specialised disability accommodation and supported independent living places in Tasmania, the use of restrictive practices, and the identification of aged residential care settings and their populations.

Before proceeding to Stage 1 of the report it is relevant to point out that the outcomes detailed in this report are reflective of desktop research and stakeholder information provided up to mid-2024. As an evolving and dynamic service sector, the number and locations of health and social care places visited by the Tasmanian NPM will likely change year on year. For example, as restrictive practices are approved, varied, or removed, and as new aged residential care

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[12] Dr Maker is a Senior Lecturer in the Faculty of Law, College of Arts, Law and Education at The University of Tasmania and an Honorary Senior Fellow at Melbourne Law School, the University of Melbourne. Dr Maker has a background in law and social policy and her work focuses on the disability- and gender-related dimensions of law, policy, and practice. This includes providing research support to the Chair of the United Nations Committee on the Rights of Persons with Disabilities and the Office of the High Commissioner for Human Rights on topics including sexual and reproductive rights, the right to education and the right to liberty and security of the person.
[13] 2023 Report, Part 4.

places open or close, or admit residents with advanced dementia. This changing landscape is in contrast with the deprivation of liberty settings covered in the 2023 Report, which are predominantly fixed locations designated under legislation.

Additionally, while every effort has been made to develop a comprehensive picture of deprivation of liberty in health and social care and attendant risks of torture and ill-treatment, desktop evaluations are not a direct substitute for in-person NPM visits. Due to staffing and project limitations no in-person visits were conducted to non-government facilities. Where limited or conflicting information is received, visits by Tasmanian NPM staff may be necessary to determine jurisdiction and any matters that merit examination. These drop-in visits to assess deprivation of liberty and the physical environment are commonly conducted by NPM's,[14] and are not limited to places based on their stated purpose or official designation. The SPT has emphasised this point in its General Comment:[15]

> [M]indful of the wide variety of circumstances in which deprivation of liberty occurs or may occur, the Subcommittee underlines that the key element in deciding whether a place is or may be a place of deprivation of liberty is the status of the persons who are or may be deprived of their liberty rather than any official title accorded or description allocated by the national authorities and/or national legislation or others. In this regard, it is paramount that the autonomy and functional independence of the Subcommittee and national preventive mechanisms are fully ensured in practice to enable both to make a fully independent decision as to whether a particular place constitutes or may constitute a place of deprivation of liberty and therefore comes under their respective mandates.

Finally, I take this opportunity to acknowledge and sincerely thank all stakeholders for their participation and providing the information needed for this project to succeed. As the first report of its kind to be released in Australia focusing on deprivation of liberty in health and social care, I hope that it serves as a valuable guide for other jurisdictions and stakeholders embarking on their own NPM implementation journeys, and contributes to enhanced quality of care for some of the most vulnerable people in our society.

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[14] 2023 Report, Part 5.2, pg. 88.
[15] Appendix 2, [55]

Summary and recommendations

This supplementary report presents the results of detailed research and analysis to implement the Tasmanian NPM across Tasmania's health and social care sector. It builds on the results of the 2023 Report, *Preventing torture and ill-treatment in Tasmania*, presenting a framework to give effect to NPM-specific Disability Royal Commission recommendations. Going further, and to conclude the Tasmanian NPM implementation project, this report provides an updated organisational design to operationalise the Office of the Tasmanian NPM and Custodial Inspector as a combined entity, and a revised budget estimate for 2025 – 2029.

The report commences with a foundational analysis. It considers how the Tasmanian NPM should fulfil its mandate within the health and social care sector, and what deprivation of liberty looks like and key risks. This analysis is completed through engagement with experts and NPM counterparts, who provide insight and practical guidance into how NPM bodies approach deprivation of liberty within these community-based settings. Further consultation with local stakeholders and government agencies provides insight into how Tasmania's different regulatory frameworks authorise comparable practices in this state.

An important outcome of this first stage of enquiry is the identification of deprivation of liberty circumstances within the aged residential care and disability support sectors. Key area of focus to arise are dementia care, SDA and SIL services, and the use of restrictive and related practices. Substantial information is obtained from regulators, enabling the identification of places in which deprivation of liberty is likely occurring in Tasmania, the form of deprivation of liberty, and related conditions of treatment.

Through this discovery process, 69 aged residential care and 369 disability support settings in Tasmania where deprivation of liberty is likely occurring are identified, which correspondingly fall within the Tasmanian NPM's jurisdiction. Among these identified settings, 165 include the use of approved restrictive practices (66 aged residential care and 99 disability support services), 43 of which are approved for use on children and young people. Table 1 below provides a breakdown by region. Further data and analysis is provided at Part 2.

Table 1: *Aged residential care and disability support services by region.*[16]

Region	Aged care organisations	Disability services organisations	Total	Percentage
North and North-West	37	170	207	47.3%
South	32	199	231	52.7%
Grand total	**69**	**369**	**438**	

Given the large volume of identified places of deprivation of liberty, the report turns to develop a comprehensive risk analysis framework. The purpose of this framework is to enable the Tasmanian NPM to accurately assess risk of torture or ill-treatment down to an individual setting level, categorise this risk (as low, medium, high, or very-high), and prioritise places for visiting and examination by relevant staff.

The first step in the risk discovery process is a detailed segmentation analysis and journey mapping of service providers and users engaged in the aged residential care and disability support sectors. Adopting contemporary service design methodologies, this process included extensive Tasmanian service provider consultation and surveys. Resulting from the segmentation component was the identification of seven unique user segments, each of which addresses distinct service user risks and care requirements, from social isolation and communication barriers to complex medical management and cultural sensitivities:

- Physical disability (Moderate Risk)
- Sensory impairments (Moderate Risk)
- Dementia (Very High Risk)
- Complex Medical Needs (High Risk)
- Psychosocial Disability (High Risk)

[16] Aged residential care includes group residential care and SIL providers, and excludes care at home services. Disability support includes all disability services organisations that are non-individual. The 369 disability support settings identified facilities are operated by 71 different organisations.

- Developmental Disability (High Risk)
- Diverse needs (Moderate Risk)

Across these segments, three primary demographic groups were identified: people in aged care, disability services participants, and children and young people. Information about these segments and demographic groups is provided at Part 3.2, with detailed analysis included at Appendix 5.

A journey mapping process was then followed to integrate the segmentation analysis results and consider the individual characteristics and needs of each segment in depth. Each segment's unique pathway and interaction with service providers were traced providing a comprehensive picture of the user experience, pinpointing gaps and commonalities both within specific segments and across the service. Further detail about the journey maps is provided at Part 3.3 and are included in full at Appendix 6.

Drawing on the results of the segmentation and journey mapping analysis, the project team developed a comprehensive risk assessment framework and toolkit to systematically categorise places of deprivation of liberty according to identified risk of torture or ill-treatment. The purpose of this framework is to enhance risk visibility, prioritise areas for intervention, support informed decision-making, and ensure that the Tasmanian NPM is best positioned to exercise its functions effectively to prevent torture and ill-treatment. Information about the framework and risk assessment process is provided at Part 4.

The risk evaluation processes commence by incorporating the results of this segmentation and journey mapping analysis to develop a baseline risk assessment of different disability support and aged residential care settings identified at Table 1. Table 2 below provides an overview of the different baseline risk ratings.

Table 2: *Baseline risk rating by service provided.*

	Service	Customer segments served	Service risk rating
Disability services	**Supported Independent living**	Physical Disability, Sensory Impairments, Psychosocial Disability, Developmental Disability, Diverse Needs	High
	Specialist Disability Accommodation	As above plus Complex Medical Needs	High
	Respite	As above	High
Aged care services	**Residential Aged Care**	Physical Disability, Complex Medical Needs, Diverse Needs	High
	Respite	As above	High
	Secure Dementia Unit	As above plus Dementia	Very High
	Secure Garden	As above	Very High
	Supported Independent Living	Physical Disability, Sensory Impairments, Diverse Needs	Moderate

Following this baseline assessment, further information was subsequently sought from regulators, government agencies, and service providers to develop enhanced risk ratings for each identified setting. An interactive assessment toolkit, built in Microsoft Excel, was developed to assess 41 risk variables and key indicators to produce individualised risk assessments for each of the 438 aged residential care and disability support settings in Tasmania identified at Table 1. Applying the risk assessment framework, 280 settings were evaluated as low risk, 136 were medium risk, and 22 high risk.[17] Tables 3 and 4 provide a breakdown of this information by region.

[17] No very high-risk ratings have been produced at this time because this rating will predominantly materialise by inputting insights arising from in-person visits and additional information collected from individual settings.

Table 3: *Aged residential care setting risk assessment ratings, by region.*

Region	Low risk	Medium risk	High risk
North-West	1	9	7
North	1	13	6
South	1	23	8

Table 4: *Disability support setting risk assessment ratings, by region.*

Region	Low risk	Medium risk	High risk
North-West	71	24	0
North	56	19	0
South	150	48	1

Adopting a proportionate risk-based approach to visit planning, the report recommends that the Tasmanian NPM be appropriately resourced to exercise its functions over the 158 priority places of deprivation of liberty assessed as having a heightened risk of torture or ill-treatment.

Following the results of this analysis the report progresses to design an optimal organisational model for the Tasmanian NPM to fulfil its mandate in the health and social care sector, and incorporate these outcomes into the overall governance model for the Office of the Tasmanian NPM and Custodial Inspector. Key results of this analysis are that nine additional full time equivalent (FTE) staff will be required to fulfil the Tasmanian NPM's functions across priority health and social care settings to an acceptable baseline standard; and a recommendation that a second office be established in Launceston.

This Launceston Office will be responsible for leading visits in the North and North-West regions of Tasmania, which are home to 207 aged residential care and disability support organisations and settings that provide 47.3% of services within the scope of oversight of the Tasmanian NPM. Moreover, the creation of a second office in Launceston provides a valuable opportunity to improve productivity in the delivery of all statutory functions exercised by the Office of the Tasmanian NPM and Custodial Inspector, notably across the state's northern regions.

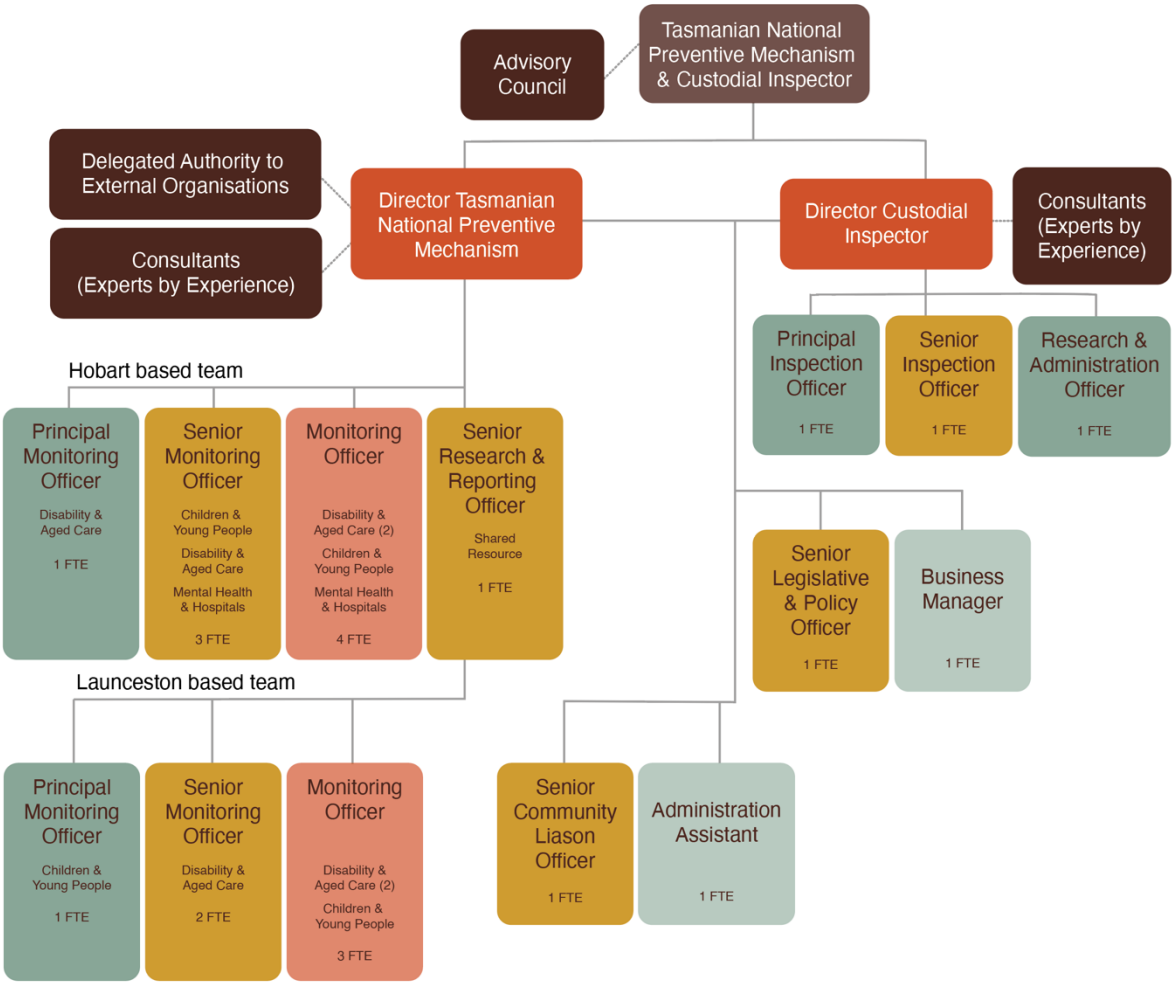
These efficiency gains will occur through the strategic positioning of key staff at the Launceston office, so that they can proactively engage with local stakeholders, service providers, and readily visit northern settings. To realise this opportunity, further analysis is undertaken to update the recommended governance model for the Office of the Tasmanian NPM and Custodial Inspector, incorporating results and recommendations of the health and social care analysis and to optimise staff distribution between Hobart and Launceston.

A total of 24 FTE has been assessed as necessary to fulfil all statutory functions to a satisfactory baseline standard: 18 specialist monitoring staff, and six corporate and administrative staff. The office will exercise jurisdiction over about 200 combined settings in Tasmania where people, including children and young people, are or may be deprived of their liberty and a heightened risk of torture or ill-treatment has been assessed.

As mentioned in the Foreword, this FTE recommendation includes all positions necessary for the Commission for Children and Young People and the Disability Commissioner to relevantly fulfil their overlapping oversight functions in relation to youth justice, out of home care, and restrictive practices monitoring. The consolidated model of independent oversight proposed in this report presents a unique opportunity to seize the productivity gains realisable through the colocation of multidisciplinary subject matter experts, to effectively prevent abuse and uphold human rights.

Figure 2 provides a visual representation of the recommended revised governance model.

Figure 2: *Revised governance model for the Office of the Tasmanian NPM and Custodial Inspector*



The revised governance model proposes four visit function thematic streams:

1. Children and young people (4 FTE)
2. Custodial Inspector (existing jurisdiction, 3 FTE[18])
3. Disability support and aged residential care (8 FTE[19])
4. Mental health and Hospitals (2 FTE)

Following Recommendation 1 in the 2023 Report, the person appointed as Tasmanian NPM and Custodial Inspector will continue to play a direct and full-time role in the exercise of the Tasmanian NPM functions. Each statutory jurisdiction

[18] Excludes Director, which is categorised as a corporate position.

[19] Four FTE each in relation to aged residential care and disability support.

(*OPCAT Implementation Act 2021*, *Custodial Inspector Act 2016*) will be managed by an office Director, which are existing roles.

For each respective thematic stream, a principal officer will be responsible for exercising leadership duties, reporting to the Office Director. These staff will support the Director with overall coordination and planning of office visit and examination activities, reporting, and be responsible for leading visits in circumstances where the Office Director or Tasmanian NPM is not in attendance. Each thematic stream will comprise a senior officer and junior staff with supporting duties. The total number of staff within each stream will be commensurate to the number of priority places it is required to regularly visit.

Non-visit functions will be exercised by a smaller team of three senior staff, each of whom will be responsible for a specific function (advisory, cooperation, and education).[20] Further detail about this revised governance model and the different visit function thematic streams is provided at Part 5.

Accompanying this governance model redesign, and to incorporate the additional FTE required for the health and social care stream, further analysis is completed to update budget figures and findings contained in the 2023 Report. This analysis calculates that a budget of **$4,286,164.90** is required in the 2025 – 2026 financial year for the Tasmanian NPM to satisfactorily fulfil its functions to an appropriate baseline standard.

Table 5 details the office's the total estimated budget requirements over the forward estimates. Further detail is provided at Part 5.5 and assumptions underpinning these estimates are included at Appendix 3.

Table 5: *Total estimated operational expenses for the Tasmanian NPM*

	FY25–26	FY26–27	FY27–28	FY28-29
Total operational expenses	4,286,164.90	4,260,307.41	$4,283,526.34	$4,306,784.66

While this budget is small in comparison to the combined budgets of the agencies which administer the deprivation of liberty places that the Tasmanian NPM will visit, it remains a significant expenditure of public funds. To ensure that the Tasmanian NPM's budget and its expenditure is subject to appropriate and robust oversight by Parliament, a recommendation is made to include the Tasmanian

[20] The Office of the Custodial Inspector will retain its existing Research and Administration Officer.

NPM as a defined integrity entity under the *Integrity Commission Act 2009* (the Custodial Inspector is already included in the Act), and to extend the functions of the Joint Standing Committee on Integrity to enhance scrutiny of all integrity entities' resourcing.

Finally, as part of the implementation project 'expectations' materials have been developed for each type of deprivation of liberty setting that the Tasmanian NPM will visit and examine.[21] Around the world, NPM bodies use similar documents to help people understand the matters that will be considered when exercising their functions, and to support operational staff by setting out the visit process and standards against which the treatment of people deprived of their liberty will be examined. One of the Tasmanian NPM's functions is to develop and publish these documents.[22]

The expectations released in the 2023 Report covered children and young people deprived of their liberty, adult custody centres, police and court custody, and mental health facilities. This supplementary report includes new draft expectations focusing on the treatment of people deprived of their liberty in health and social care.

Recommendation 11.11 of the Disability Royal Commission includes that NPM bodies implement their functions in a disability-inclusive way by involving people with disability in the inspection of places of detention. In compliance with this recommendation, the Office of the Tasmanian NPM and Dr Maker have drawn up these expectations in codesign with representative and advocacy organisations of persons with disability, older persons, and residential aged care and disability support services. Further detail about the methodological approach applied is provided at Part 6, and the draft expectations are included at Appendix 9.

In all, this report makes four additional overarching recommendations to successfully advance the implementation of the Tasmanian NPM and ensure appropriate Parliamentary scrutiny of its activities. The numbering of these recommendations continues from those made in the 2023 Report:

Recommendation 9: That the *OPCAT Implementation Act 2021*, section 5(3) be amended to include reference to aged residential care facilities and disability support residences or similar.

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[21] Available at www.npm.tas.gov.au.

[22] Section 9(1)(j) of the *OPCAT Implementation Act 2021*.

Recommendation 10: That the Tasmanian NPM be appropriately resourced to exercise its functions over places of deprivation of liberty assessed as having a heightened risk of torture or ill-treatment.

Recommendation 11: The Tasmanian NPM establish an office in Launceston to support the delivery of functions in the North and North-West regions. And that this office space be made available for use by staff of the Commission for Children and Young People, and Disability Commissioner.

Recommendation 12: That the *Integrity Commission Act 2009* be amended to include the Tasmanian NPM as a defined integrity entity, and extend the functions of the Joint Standing Committee on Integrity to include scrutiny and approval of integrity entity budgets.

Final recommendations on the implementation of the Tasmanian NPM

Recommendation 1: That the Tasmanian NPM be established as a new specialised institution, separate from the Ombudsman.

Recommendation 2: That the person appointed as Tasmanian NPM concurrently serve as Custodial Inspector, which is also to be separated from the Ombudsman, and the offices combined under the recommended governance model.

Recommendation 3: That the Tasmanian NPM delegate authority to the Commissioner for Children and Young People and establish a joint process agreement for the exercise of functions pertaining to children and young people.

Recommendation 4: That the Commissioner for Children and Young People and the Custodial Inspector be specifically resourced to contribute to the delivery of the Tasmanian NPM.

Recommendation 5: That the Tasmanian NPM and Commissioner for Children and Young People be co-located in a purpose designed office setting.

Recommendation 6: That the Tasmanian NPM establish a formal and permanent Civil Society Advisory Council, which is integrated into its governance structure.

Recommendation 7: That the Tasmanian NPM's corporate services are provided by an agency over which it will not exercise oversight.

Recommendation 8: That the Tasmanian NPM and Commissioner for Children and Young People engage cooperatively and provide advice to Government on an agreed approach to the implementation of Commission of Inquiry recommendations related to OPCAT and youth justice inspections.

Recommendation 9: That the *OPCAT Implementation Act 2021*, section 5(3) be amended to include reference to aged residential care facilities and disability support residences or similar.

Recommendation 10: That the Tasmanian NPM be appropriately resourced to exercise its functions at disability support and aged residential care places of deprivation of liberty assessed as having a heightened risk of torture or ill-treatment.

Recommendation 11: The Tasmanian NPM establish an office in Launceston to support the delivery of functions in the North and North-West regions. And that this office space be made available for use by staff of the Commission for Children and Young People, and Disability Commissioner.

Recommendation 12: That the *Integrity Commission Act 2009* be amended to include the Tasmanian NPM as a defined integrity entity, and extend the functions of the Joint Standing Committee on Integrity to include scrutiny and approval of integrity entity budgets.

Stage 1: Foundations

Building on the results of the 2023 Report, the first stage in this report focuses on developing a foundational understanding of the Tasmanian NPM's mandate within the context of the health and social care sector. Proceeding in two parts, it begins by considering the Tasmanian NPM's jurisdiction, under the *OPCAT Implementation Act 2021*, and as a member of the Australian NPM; followed by a snapshot of what the sector looks like, and the different circumstances that may give rise to deprivation of liberty.

Acquiring a sound understanding of where the Tasmanian NPM may operate at the service system level is an essential step in the implementation planning process. It enables service users, providers, and deprivation of liberty circumstances to be accurately identified. And it ensures that subsequent detailed analysis, and organisational design recommendations provided in the latter stages of this report accurately reflect how the Tasmanian NPM will operate in practice.

Part 1: What is the Tasmanian NPM's mandate in health and social care?

Section 5(2) of the *OPCAT Implementation Act 2021* provides a two-step process for determining where the Tasmanian NPM has jurisdiction to exercise its functions. First, a place needs to be 'subject to the jurisdiction and control of Tasmania'; and second, it needs to be a place that satisfies Article 4 of OPCAT.[23]

These questions are examined in the 2023 Report,[24] however it is helpful to revisit each step with a specific focus on the health and social care sector, and in particular to consider Australia's unique multi-body NPM framework. This is particularly valuable because the *OPCAT Implementation Act 2021* provides limited guidance in relation to the health and social care sector.[25] Each step is discussed below.

To summarise this part, the evaluation identifies that the Tasmanian NPM's mandate extends broadly to aged residential care and disability support services

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[23] Detailed guidance on Article 4 is provided at Appendix 2.

[24] 2023 Report, Part 2.

[25] Section 5(3) provides a non-exhaustive list of places characterisable as places of detention, which relevantly includes "a hospital or other similar place". However, as this report outlines, most health and social care settings are not directly comparable to hospitals.

being delivered in the Tasmanian community where deprivation of liberty is or may be occurring. This mandate flows in large part from the Tasmanian Government's authorisation of restrictive practices and other deprivation of liberty matters under Tasmanian law, such as secure aged residential care for people with acute dementia. While the Commonwealth plays an overarching regulatory and funding role for the national aged care and disability support schemes, the analysis finds that deprivation of liberty circumstances remain subject to Tasmanian law – notably through decisions made by the Tasmanian Civil and Administrative Tribunal (TASCAT) Protective Division and certain departmental Secretaries.

This clarifies that the Tasmanian NPM's mandate includes community-based health and social care. However, it is relevant to reiterate that jurisdiction is limited to those places where deprivation of liberty is or may be occurring. In view of that, due to the expansive service sector landscape and wide range of services that do not give rise to deprivation of liberty, the Tasmanian NPM will need to evaluate its authority on a place-by-place basis. Completing this evaluation requires understanding Tasmania's aged residential care and disability support landscape in detail and developing a system to accurately map places of deprivation of liberty. These matters are explored at Stage 2.

A key recommendation arising from this primary analysis is to reform section 5(3) of the *OPCAT Implementation Act 2021*, to provide clarity for avoidance of doubt that 'place of detention' includes an aged residential care facility, disability support residence or similar place.

1.1 Jurisdiction and control

The limitation imposed on the Tasmanian NPM to only visit places 'subject to the jurisdiction and control of Tasmania'[26] reflects Australia's multiple-NPM framework, whereby each state and territory and the Commonwealth have agreed to implement OPCAT separately. As a combined entity, the Australian NPM will need to regularly visit *all* places of deprivation of liberty falling within the scope of OPCAT Article 4.[27] In practical terms, this means that if a place in Tasmania falls within the scope of OPCAT Article 4 as a place of deprivation of liberty, then the Tasmanian NPM and/or the Commonwealth NPM must have jurisdiction to visit it.

With this overarching framework in mind, this first step in determining the scope of the Tasmanian NPM's mandate within the health and social care sector is about understanding its responsibility, and that of the Commonwealth NPM. By

[26] OPCAT Implementation Act (Tas), s 5(2).

[27] *See* Appendix 2 for a detailed overview of the scope of OPCAT Article 4.

extension, this involves considering the roles played by Tasmanian Government and the Commonwealth Government in the sector's service design and delivery, and importantly who authorises deprivation of liberty.

Across many sectors, particularly those related to policing, justice, the military, or immigration, identifying which NPM has responsibility over a place of deprivation of liberty is a straightforward exercise, because jurisdiction and control is clearly delineated between the Commonwealth and states/territories. This is discussed broadly in the 2023 Report.[28] This same level of certainty does not exist across community-based health and social care settings, where responsibility is shared by the Commonwealth, states and territories, who work together to provide a broadly consistent model of care and support around the country. This shared operating model includes coordinated legislation,[29] regulation, accreditation, resourcing, and operational oversight across both levels of government. The complexity of this operating model for health and social care means that further analysis is required to determine which NPM body is responsible.

Tasmania's health and social care landscape is comprised of a diverse mix of large and small service providers operating in specialised and general-purpose settings, including residential housing. Some of these services are provided directly by the Tasmanian government, such as aged residential care services attached to health centres. And some places are Tasmanian government owned, but privately operated, such as disability support services provided to residents in houses owned by Homes Tasmania.

However, for the most part service providers and places in Tasmania are private. Consistent with Australia's shift away from large group homes and related facilities, many services are now provided in smaller residential premises. These places may be privately owned or leased by a service provider, or by the service user(s) themselves. Across the sector, service providers may also receive funding or subsidies from the Commonwealth and/or Tasmanian Governments, in addition to any direct contributions from service users.

National regulation of the disability support and aged care sectors is Commonwealth led, through the NDIS Commission and the Aged Care Quality and Safeguarding Commission, respectively. However, under this framework Tasmania maintains responsibility for the authorisation of restrictive practices,

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[28] 2023 Report, Part 2.

[29] For example, disability support and aged care services in Tasmania operate subject to the *Disability Services Act 2011* (Tas) and *Health Service Establishments Act 2006* (Tas).

guardianship, and related approvals that relate to deprivation of liberty.[30] This is clearly evidenced by the fact that the NDIS Commission's restrictive practices framework for disability support service providers is different to the one legislated and operating in Tasmania.[31] Under this Tasmanian framework, recognition of restrictive practices differs from the NDIS Commission's, and authorisation to use restricted practices is provided by TASCAT or a Department. This is discussed in further detail below at Part 2.

This mix of Commonwealth and State regulatory oversight and approvals indicates that although the Commonwealth government exercises an overarching administrative and regulatory coordination function, acts that deprive a person of liberty remain subject to Tasmanian law and authorisation. In addition, some social care and support services continue to be regulated by the Tasmanian Government, such as out of home care for children and young people, select aged care facilities, and inpatient care, all of which may also include the use of restrictive or like practices.

Having regard to this shared responsibility framework for health and social care but noting that the Tasmanian Government is principally responsible for authorising deprivation of liberty, the 2023 Report recommended that the Tasmanian NPM and the Commonwealth NPM engage cooperatively in relation to the exercise of NPM functions and responsibilities across the sector.[32]

Specifically, it outlined that the Tasmanian NPM lead the NPM's core visit function across places of deprivation of liberty in Tasmania, while the Commonwealth NPM, acknowledging its role as the Australian NPM Coordinator, would assist to coordinate and facilitate all jurisdictions' activities across the sector. This notably would include by facilitating engagement and information sharing with Commonwealth Agencies including the NDIS Commission and Aged Care Commission, as well as promoting capacity building.

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[30] Such as under the *Guardianship and Administration Act 1995* (Tas), *Mental Health Act 2013* (Tas), and subject to the *Disability Services Act 2011* (Tas) and *Health Service Establishments Act 2006* (Tas).

[31] Tasmania's restrictive practices is currently subject to legislative and regulatory reform, but at the time of this report's publication the relevant reforms had not been implemented. *See*: *Disability Inclusion and Safeguarding Bill 2024* at Parliament of Tasmania: <https://www.parliament.tas.gov.au/bills/bills2024/disability-inclusion-and-safeguarding-bill-2024-29-of-2024> (accessed 1 September 2024).

[32] 2023 Report, Part 2.2.2, page 51 – 58.

Some additional practical considerations outlined in the 2023 Report also favouring this approach included:

- the significant number and geographic distribution of places of deprivation of liberty around Tasmania that will need to be visited regularly (discussed further at Part 4);
- that most information related to deprivation of liberty would be predominantly sourced from Tasmanian authorities and service providers, which the Tasmanian NPM could request under the *OPCAT Implementation Act 2021*;
- the Tasmanian NPM would be best placed to engage with Tasmanian service providers, stakeholders, representatives, as well as people and advocates for people deprived of their liberty; and
- that the Commonwealth Ombudsman has no physical presence in Tasmania or resourcing to exercise this oversight function.

Against these considerations and satisfied that the Tasmanian NPM has requisite authority under Australia's NPM framework and the *OPCAT Implementation Act 2021* to exercise its mandate in the health and social care sector, project analysis turned to identifying the deprivation of liberty circumstances that arise.

Before proceeding, however, it is useful to first discuss what is meant by deprivation of liberty within the context of health and social care, building on discussion in the 2023 Report.[33]

1.2 Deprivation of liberty and the NPM

As outlined in the 2023 Report, central to the NPM mandate are the definitions of 'deprivation of liberty' and 'places of detention', at Article 4 of OPCAT, which apply to the Tasmanian NPM under section 5 of *OPCAT Implementation Act 2021*. Following release of the 2023 Report, the SPT has endorsed its General Comment on OPCAT Article 4, which provides authoritative guidance on how this article is to be interpreted and applied.[34] With respect to deprivation of liberty in health and social care and the role of NPM's, paragraphs 56 – 57 are pertinent:

[33] 2023 Report, Part 2.

[34] This document sets out a detailed explanation of Article 4, its application by the SPT and NPM, and approach to people in positions of vulnerability in the community. Appendix 2.

The Subcommittee is mindful of the various settings in which persons in situations of vulnerability, including children and adolescents, older persons, LGBTIQ+ persons, individuals with physical and psychosocial disabilities, Indigenous Peoples and people who use drugs, may be confined, unable to leave at will. Aside from such places as prisons and remand centres, there are specific settings where people are or may be deprived of their liberty, including but not limited to schools and institutions that engage in the care of children, military camps, social care facilities, institutions for persons with disabilities or for persons with drug or alcohol use disorders, drug use treatment centres, orphanages, children's homes, institutions for the educational supervision of children, psychiatric hospitals, mental health centres, shelters, hostels and migration detention centres. Moreover, in the case of children, there are settings in which they are or may be deprived of their liberty for reasons related to their, or their parents', migration status, regardless of the name and reason given to the child's deprivation of liberty, or the name of the facility or location where the child is deprived of liberty. All such places fall under article 4 of the Optional Protocol and therefore under the mandate of the Subcommittee and national preventive mechanisms.

The Subcommittee notes that many persons with disabilities are presumed to be unable to live independently, or that support to live independently is not available or is tied to specific living arrangements. Although there may be no legal or administrative order confining such persons to a certain facility, the lack of support compels them to remain in living situations that deprive them of their liberty and may subject them to harmful practices. This form of disability-specific deprivation of liberty can occur in family homes and in institutional arrangements, including social care institutions, psychiatric institutions, long-stay hospitals, nursing homes, secure dementia wards, special boarding schools, child welfare institutions, group homes, rehabilitation centres, forensic psychiatric settings, albinism hostels, leprosy colonies, religious communities, family-type homes for children and prayer camps.

Therefore, when considering whether a particular place, facility or setting is a place of deprivation of liberty within the meaning of article 4 of the Optional Protocol, it is important that national preventive mechanisms and the Subcommittee ascertain the presence of reasonable accommodation arrangements and support for persons with disabilities. If reasonable accommodation and support are unavailable, the place, facility or setting should be considered a place of deprivation of liberty.[35]

[35] Appendix 2.

During preparation of the 2023 Report, detailed community feedback was sought on the scope and application of OPCAT Article 4 within Tasmania. Through multiple rounds of stakeholder and subject matter expert consultation, responses identified that deprivation of liberty circumstances were a regular occurrence across the health and social care sector and emphasised that the Tasmanian NPM prioritise visits to these settings. Places mentioned included:

- disability group homes and other specialised support residences;
- aged residential care homes, including within hospital/medical centres, nursing homes, and dementia units; and
- other community-based care residences where restrictive practices may be used (whether approved or not).[36]

In this report, references to 'health and social care' include these places mentioned, as well as related transport.[37]

Stakeholders elaborated that within these places service users might be deprived of their liberty by being secluded or confined to a room, area, or premises; require permission or support to leave a premises; have physical or mechanical restraints applied, such as a service user being placed on/in an object from which they cannot freely remove themselves; or by being under a chemical restraint, such as a sedative.

When considering the use of these practices, stakeholders also flagged that service users may have substitute decision-makers legally appointed by others, such as guardians and administrators appointed by the Tasmanian Civil and Administrative Tribunal (TASCAT). These appointments, and the decisions made by appointees, may or may not be consistent with the will and preferences of the service user.

A result of these examples described above is that the service user is likely to be deprived of their liberty as defined under OPCAT Article 4. It is important to note that any assessment of whether a situation gives rise to deprivation of liberty requires understanding its impact on the person receiving care or support. The Tasmanian NPM is focused on the potential or actual outcome to the person

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[36] For instance, where people with disability receive supported independent living services in their home, which may include being deprived of their liberty.

[37] Additional health and social care settings, such as mental health facilities and hospitals, were examined under the 2023 Report. Also see the Tasmanian NPM's Expectations on the treatment of people deprived of their liberty under mental health law, available to download at www.npm.tas.gov.au.

having regard to all circumstances, rather than deferring to any considerations of a stated object or purpose of a place, practice, framework, or the intentions of other people involved such as a service provider.

For example, a locked door may signal deprivation of liberty. However, this will not be made out if the person receiving care or support is willing and able to operate that lock and can freely exit at will without obstacle. By contrast, if in that same scenario the person is unable to operate the lock or is unwilling to do so, such as because of coercion, then deprivation of liberty is likely established. Given this individualised nature of deprivation of liberty across the sector, occasions will likely arise where the Tasmanian NPM is unable to make a definitive evaluation until it has visited in-person and met the person receiving care or support.

It is relevant to emphasise that the Tasmanian NPM's jurisdiction is not limited to only visiting places where deprivation of liberty has been authorised by legislation. As part of its mandate, it may need to visit places if information is received that indicates that unauthorised deprivation of liberty is occurring. It is critical that the Tasmanian NPM not be prevented from visiting these places.

Across the aged residential care and disability support sectors, service provision is often tailored to the service user, privately delivered, and occurs within residential or shared properties in the community. These premises may be owned or leased by the Tasmanian Government, a service provider, the individual service user, or a third party. This dispersed and fragmented service delivery landscape is in distinct contrast to other places that the Tasmanian NPM is expected to visit, which are typically centralised, government-operated, and officially designated facilities that are designed to be closed, such as secure mental health facilities and custody centres. It also raises a challenge for the Tasmanian NPM when identifying health and social care places that may require visiting.

Given the breadth of health and social care settings potentially within the Tasmanian NPM's jurisdiction, stakeholder feedback received through initial consultation rounds in 2023 was advantageous in drawing attention to high level indicators of deprivation of liberty. However, further in-depth analysis was required to reliably identify specific places within the service system where this deprivation of liberty may be occurring. This task was essential to accurately evaluate the operational and resourcing requirements necessary for the Tasmanian NPM to effectively fulfil its statutory functions, and to minimise the likelihood of visiting places beyond its mandate.

Prior to undertaking a visit, the Tasmanian NPM must be satisfied that deprivation of liberty may be occurring. The importance of this arises from the fact that within

the health and social care sector, most services provided will not give rise to deprivation of liberty. It is also good practice to prevent unnecessary resource expenditure and maintain stakeholder goodwill. Simply being a place where aged residential care or disability support services are provided does not give rise to a likelihood of deprivation of liberty. This includes with respect to the use of restrictive practices, given not all practices result in deprivation of liberty as defined under OPCAT.

For the Tasmanian NPM to exercise its jurisdiction appropriately it must be able to request and receive information that will allow it to identify potential places of deprivation of liberty across the respective service sectors. Due to the many sources of information that may contribute to identifying deprivation of liberty and accurately assessing risk, this will require ongoing proactive engagement by office staff with service providers and users, regulators, and stakeholders.

For this project, information gathering was crucial to developing a comprehensive understanding of how and where deprivation of liberty may be occurring within Tasmanian health and social care settings, which in turn would inform evaluation of the office's projected resource and organisational design requirements. To complete this work, the Office of the Tasmanian NPM and Elm Consulting interrogated relevant data held by the Australian Bureau of Statistics (ABS), and engaged proactively with Commonwealth and Tasmanian regulators, service providers, and representative bodies.

These engagement activities included awareness raising with assistance from National Disability Services (NDS) and the Aged & Community Care Providers Association (ACCPA),[38] numerous service provider meetings and surveys,[39] and acquiring data in relation to the use of specialised disability accommodation, supported independent living, and restrictive practices in Tasmania from the NDIS Commission and the Office of the Senior Practitioner. Further detail on the project team's methodological approach is provided at Stage 2.

During this stakeholder engagement it became apparent that there was merit to amending the *OPCAT Implementation Act 2021*, to improve clarity. As noted above, section 5(2) of the Act provides an expansive definition of place of detention, in line with OPCAT Article 4. However, subsection 5(3) provides limited illustrative guidance in relation to community-based health and social care, beyond noting that the Tasmanian NPM's jurisdiction includes "a hospital or other similar

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[38] The Director, Office of the Tasmanian NPM, also presented on the implementation project at the NDS Tasmania 2024 state conference.

[39] Survey templates are included at Appendix 4.

place". While aged residential care and disability support includes the provision of medical and related therapeutic services, the settings in which services are delivered are not always comparable to hospitals.

Feedback from private service providers raised that it would be considerably more efficient if the Tasmanian NPM could point to a plainly worded provision stating that its jurisdiction includes aged residential care and disability support residences or similar. This would provide certainty to administrators that the Tasmanian NPM and its staff are authorised to enter, request information, and speak to residents. Equally so, it would clarify to stakeholders and the public that these places are subject to the Tasmanian NPM's mandate. This is rational feedback. An amendment to subsection 5(3) of the Act to include aged residential care and disability support residences is likely to considerably assist the Tasmanian NPM in fulfilling its functions, and is recommended accordingly.

Recommendation 9: That the *OPCAT Implementation Act 2021*, section 5(3) be amended to include reference to aged residential care facilities and disability support residences, or similar.

Part 2: When does deprivation of liberty occur?

Having broadly outlined the scope of the Tasmanian NPM's mandate, this next part progresses to explore Tasmania's aged residential care and disability support sector landscape and the main circumstances in which deprivation of liberty occurs. It begins by developing an overall picture of the landscape through information arising from the most recent Australian Bureau of Statistics (ABS) Census, followed by an analysis of each respective service sector and identification of areas of focus for the Tasmanian NPM.

2.1 Overall sector snapshot: the ABS Census

A useful starting point for understanding each service system is the most recent ABS Census, which took place in 2021. Its results provide helpful reference information about service user populations, evolving trends, and potential areas of focus for the Tasmanian NPM.

Beginning with a bird's eye view of people living in non-private dwellings, the Census counted 10,460 people in Tasmania usually residing as a guest, patient, inmate or other resident, which is approximately 2% of the total state population (Table 6).[40] Breaking down this figure by age it demonstrates that the likelihood of a Tasmanian person residing in a non-private facility increases as people get older, peaking at 66% of all persons aged 100 years or more.[41] This aligns with current aged care policy, which prioritises entry into residential aged care for people who need more care than can be provided in their own homes.

[40] This data is not limited to people with disability or people in aged care.

[41] ABS Tablebuilder 2021 Census of Population and Housing, counting persons, place of usual residence STATE (UR) by RLNP Residential Status in a Non-Private Dwelling and AGE10P Age in Ten Year Groups Counting: Person Records

Table 6: *Persons in non-private dwelling by age group (Tasmania)*

Census 2021 Persons usually resident in a non-private dwelling as guest, patient, inmate or other resident		
Age Group	**Count**	**Per cent of total count**
0-9 years	92	0.2%
10-19 years	669	1.1%
20-29 years	1,229	1.8%
30-39 years	895	1.2%
40-49 years	747	1.2%
50-59 years	804	1.1%
60-69 years	933	1.3%
70-79 years	1,427	2.6%
80-89 years	2,178	9.6%
90-99 years	1,420	29.9%
100 years and over	66	66.0%
Total	10,460	

Relevantly, among the settings considered in Table 6, the 2021 Census provides that at that time Tasmania had 16 hostels for people with disability, 61 nursing homes, and 23 other facilities providing accommodation for the retired or aged (not self-contained housing).[42]

Delving further into the data in Table 6, the Census identified that the likelihood of people living in residential facilities with a level of disability that requires assistance with core needs of mobility, communication or self-care also increased with age. Table 7 provides a breakdown of this information by age group. Notably, it

[42] ABS Tablebuilder 2021 Census of Population and Housing, counting dwellings, place of enumeration STATE (EN) by NPDD Type of Non-Private Dwelling Counting: Dwelling Records

identified that being in a residential facility and having a disability both increase the likelihood of experiencing restrictive practices through physical and pharmacological interventions.

Table 7: *Persons with core need for assistance in residential facility (Tasmania)*

Census 2021 Persons usually resident in a non-private dwelling as guest, patient, inmate or other resident with need for assistance with core activities (mobility, communication, self-care)		
Age Group	**Count**	**Per cent**
0-9 years	4	4%
10-19 years	20	3%
20-29 years	32	3%
30-39 years	37	4%
40-49 years	80	11%
50-59 years	126	16%
60-69 years	296	32%
70-79 years	858	60%
80-89 years	1,797	83%
90-99 years	1,252	88%
100 years and over	58	89%
Total	4,560	

Following the 2021 Census, the number of individuals residing in non-private dwellings has continued to steadily rise. As Tasmania's population ages and the complexity of healthcare needs grows, the demand for residential facilities to accommodate these individuals has correspondingly increased.

The implementation of the aged care and disability support service reforms, and particularly the NDIS, have enabled new entrants to operate in the sector, bringing

new service offerings which provide greater choice and flexibility to consumers and participants. This is notably the case with regard to choice of residence and service provider(s). Government and aged care and disability support service providers face an ongoing challenge of adapting to this evolving landscape, to ensure that high quality supports and care services are available to meet the diverse needs of all individuals. The progression of recommendations arising from the NDIS Review, Disability Royal Commission, and Aged Care Royal Commission is essential to responding effectively to this challenge. This of course includes effective OPCAT implementation to ensure that as service demand increases, service delivery continues to meet Australia's human rights obligations and ill-treatment is effectively prevented.

Building on the Census data, the project team engaged with service providers and regulators to develop a more detailed understanding of the types of services provided and their geographic distribution across the state. The data presented in Table 1, reproduced below, indicates a near-even distribution of organisations in the south (52.7%) and combined across the north and northwest regions (47.3%). However, in contrast to the southern region which has a more geographically concentrated population around greater Hobart, services across the north and northwest are more dispersed, particularly beyond the greater Launceston area. This broadly reflects the population distribution and Tasmania's unique status as Australia's most decentralised state, with about two thirds of the population living beyond the capital city area (about 309,000 people).

Table 1: *Aged residential care and disability support services by region*

Region	Aged care organisations	Disability services organisations	Total
North and North-West	37	170	207
South	32	199	231
Grand total	69	369	438

Expanding on this initial analysis, sections 2.2 and 2.3 below are designed to provide further primary information about each service sector, and in doing so identify core areas of focus for the Tasmanian NPM related to deprivation of liberty.

In identifying these areas of focus, it is pertinent to reiterate that the Tasmanian NPM is not intended to be a regulatory or accreditation body. Following SPT guidance, it should also aim to avoid repeating the activities of such existing bodies. With this in mind, an added aim during this initial stage of the project was identifying ways that the Tasmanian NPM could add value to improve service delivery quality and in turn reduce the likelihood of torture and ill-treatment occurring, while complementing the work of regulators.

Productive meetings were held with Office of the Senior Practitioner, the NDIS Commission, and the Office of the Independent Regulator, to understand how these bodies operated and where the Tasmanian NPM could complement their roles while fulfilling its own. These discussions identified that the Tasmanian NPM will contribute the most value to the Tasmanian people and existing regulatory landscape where it works cooperatively to dynamically enhance the visibility of service provider quality. This included by prioritising monitoring on the basis of risk informed by proactive information sharing with regulators, and the delivery of advice and educative resources to service providers, service users and the wider public.

2.2 Disability support and the National Disability Insurance Scheme

Disability support encompasses the provision of tools and services that empower individuals with additional needs to achieve greater independence and pursue their goals. Australia's Disability Strategy 2021–2031 envisions an inclusive society in which people with disabilities can fully participate as equal members, aligning with Australia's commitments under the United Nations Convention on the Rights of Persons with Disabilities in protecting, promoting and realising the human rights of people with disabilities.[43]

The National Standards for Disability Services intend to promote person-centred approaches based on principles of human rights and quality management.[44] These standards detail an emphasis on placing people with disability at the forefront of planning and service delivery, aiming to maximise their control over their lives. The

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[43] Department of Social Services, 'Disability and Australia's Disability Strategy 2021 – 2031' <https://www.dss.gov.au/disability-and-australias-disability-strategy-2021-2031> (accessed 1 August 2024).

[44] Department of Social Services, 'National Standards for Disability Services' <https://www.dss.gov.au/our-responsibilities/disability-and-carers/standards-and-quality-assurance/national-standards-for-disability-services> (accessed 1 August 2024).

aim is to ensure that individuals, supported by their networks including families, friends and advocates, actively shape service arrangements according to their strengths, needs and goals. These standards also emphasise the right of people with disability to participate in decisions affecting their lives. The framework integrates these principles to safeguard and promote the wellbeing and interests of individuals with disabilities across service delivery and decision-making processes.

The National Disability Insurance Scheme (NDIS), jointly funded and operated by the Australian, state and territory governments, supports people with disability, their families and carers. It aims to foster independence, facilitate social and economic participation, and provide necessary supports, including early intervention. The NDIS is designed to promote a unified national approach to accessing, planning and funding disability supports, emphasising high-quality and innovative services integral to Australia's disability support framework.[45]

2.2.1 Primary focus of the Tasmanian NPM

A significant range of services is available to people with disability under the NDIS to address their specific support needs. As outlined under Part 1, delivery of many services is unlikely to give rise to deprivation of liberty. In consultation with stakeholders, the Tasmanian NPM identified three interconnected types of service delivery where deprivation of liberty was evaluated as most likely to arise:

1. in specialised disability accommodation (SDA);
2. when providing certain supported independent living (SIL) services; and
3. when using restrictive practices.

Each type of service delivery is briefly elaborated on below.

SDA and SIL services

SDA is housing designed for individuals with extreme functional impairment or very high support needs. It features accessible elements that enhance independent living and facilitate safer delivery of additional supports. Eligible participants meet stringent criteria, ensuring accommodation is tailored to their needs. Restrictive practices occur in SDA residences.

SIL are discrete services that enable people with disability to live independently in shared or individual homes. Support services are customised to the service user and designed to facilitate for daily tasks. SIL aims to enhance autonomy, foster social inclusion, and encourage active community engagement within the NDIS

[45] National Disability Insurance Scheme (NDIS), “About the NDIS.” <https://www.ndis.gov.au/understanding/what-ndis> (accessed 1 October 2024).

framework. Similar to SDAs, during delivery of certain SIL services restrictive practices may be used, or a person's deprivation of liberty may be incidental to delivery of the service. SIL services may be provided within a SDA residence.

In Tasmania, NDIS insights reveal a disparity between the general prevalence of primary disabilities among participants[46] and those receiving SDA/SIL support.[47] Autism is the most common disability overall, followed by intellectual disability, then psychosocial disability and developmental delay.

However, the regions vary in the types of disabilities most frequently supported through SDA/SIL services. Intellectual disability is the most common across regions, while the prevalence of other disabilities like autism, acquired brain injury, and psychosocial disabilities varies, influencing service demands regionally. North Tasmania and North West show similar disability profiles, dominated by intellectual disabilities and autism. By contrast, the South West and South East of the state exhibit a broader range of prevalent disabilities, including higher instances of psychosocial disabilities in the South West, which aligns with the national trend of these participants residing more frequently in non-private dwellings.

With respect to children and young people, NDIS data indicates that there is minimal provision of SDA/SIL support for children aged 0-14 in Tasmania, and only a marginal amount of support for young people aged 15-18.[48] The number of individuals receiving SDA/SIL servicessignificantly increase from age 19 onwards. This information provides that disability among children in Australia manifests predominantly as intellectual and sensory and speech conditions, with psychosocial and physical disabilities also being significant. Physical conditions are often reported as the primary disability affecting children, indicating a higher

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[46] NDIS. (n.d.). *Participant Dashboards* <https://dataresearch.ndis.gov.au/reports-and-analyses/participant-dashboards> (accessed 10 October 2024).
[47] NDIS. (n.d.). *Market Monitoring: TAS, ACT, and Other Territories* <https://dataresearch.ndis.gov.au/reports-and-analyses/market-monitoring/market-monitoring-tas-act-and-other-territories> (accessed 10 October 2024).
[48] As discussed at Part 2.3, this does not include services provided in the child or young person's family home.

visibility and possibly a greater impact on daily functioning compared to other disability types.[49]

Restrictive Practices

Restrictive practices are any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability, with the purpose of protecting the person or others from harm. Certain restrictive practices are expressly intended to deprive a person of their liberty.

The NDIS Commission regulates and monitors five categories of regulated restrictive practices:

1. *Environmental restraint:* restricting a person's free access to all parts of their environment, including items or activities.

2. *Mechanical restraint:* using of a device to prevent, restrict or subdue a person's movement for the purpose of influencing thier behaviour.

3. *Seclusion:* sole confinement of a person with disability in a room or a physical space at any hour of the day or night where voluntary exit is prevented, or not facilitated, or it is implied that voluntary exit is not permitted.

4. *Physical restraint:* using physical force on a person to prevent, restrict or subdue the movement of their body, or part of their body, for the purpose of influencing their behaviour.

5. *Chemical restraint:* medication or chemical substance used to influence a person's behaviour. However, it does not include medication prescribed by a medical practitioner for or to enable treatment of a diagnosed mental disorder, a physical illness, or a physical condition.

Under the NDIS, any approved restrictive practices must be included in a service user's approved behaviour support plan (BSP), which is approved by the NDIS Commission. Any use of unauthorised restrictive practices must also be reported. The use of restrictive practices in disability support services is regulated by

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[49] ABS. *Disability, Ageing and Carers Australia: Summary of Findings*; AIHW (2004). *Children with disabilities in Australia* <https://www.aihw.gov.au/getmedia/a792fd34-61db-4f62-91f8-9aa8e41f8207/cda.pdf?v=20230605172251&inline=true>; (accessed 1 October 2024).AIHW. (2006). *Disability updates: Children with disabilities* <https://www.aihw.gov.au/getmedia/0e07be54-bece-4d6c-bc9e-42981ee2bebc/bulletin42.pdf?v=20230605163954&inline=true>

Tasmanian law: the *Disability Services Act 2011*.[50] Before any restrictive practices can be approved by the NDIS Commission, they must first be authorised under this framework. Depending on the nature of the restrictive practice, the framework provides that authorisation may be granted by either the Secretary of the Department of Premier and Cabinet or TASCAT, with the Senior Practitioner providing input on applications and oversight.

However, it is relevant to highlight that the NDIS Commission and Tasmanian restrictive practices frameworks are not the same. Notably, where the Tasmanian framework does not address a type of restrictive practice, the NDIS Commission deems it approved. This is currently the case for chemical restraints, although it is observed that at the time of this report's preparation law reform was underway to introduce this type of restrictive practice into Tasmanian law. There are also gaps in oversight, where neither the NDIS Commission nor the Tasmanian framework applies. This is discussed below in further detail, in relation to children and young people.

Irrespective of these differences and gaps between the applicable frameworks and their legal characterisation, any use of a restrictive practice—authorised or not—that causes deprivation of liberty will fall under the Tasmanian NPM's jurisdiction.

It is relevant to note that the Disability Royal Commission considered the use restrictive practices within the context of disability support services. It found that they were most often used as a means of behaviour control, resulting in a direct failure of care providers to understand and respond appropriately to behaviours of concern as a means of communication by the person with disability.[51] Commission recommendations 6.35 to 6.40 call for legislative reform to reduce, restrict, and to work towards the elimination of restrictive practices. This is consistent with Australia's obligations under the CRPD, which are addressed in detail in the draft expectations discussed at Part 6.

Against this analysis, the project team sought to understand the prevalence of deprivation of liberty within Tasmania's disability services landscape. Information

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[50] Comprehensive reform to the existing system is currently progressing through the Tasmanian Parliament, under the *Disability Inclusion and Safeguarding Bill 2024*. For more information about Tasmania's current framework *see*: Department of Premier and Cabinet, *Chemical Restraint Frequently Asked Questions* <https://www.dpac.tas.gov.au/divisions/cpp/community-and-disability-services/office-of-the-senior-practitioner/chemical_restraint_frequently_asked_questions> (accessed 3 August 2024).

[51] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, Final Report, Executive Summary, 'Our vision for an inclusive Australia and Recommendations', page 82.

about restrictive practices, SDA and SIL services, and respite was obtained from the NDIS Commission, Homes Tasmania, and the Senior Practitioner. Table 8 provides an overview of settings identified, regional location, and the number of approved restrictive practices, SIL and SDA services, and respite beds present therein.[52]

Table 8: *Disability services specific data*

Region	Number of settings	Use of restrictive practices	SIL	SDA	SIL & SDA	Respite beds
North	75	28	10	1	6	2
North-West	95	23	50	16	2	1
South	199	48	142	22	8	5

Note that this data includes support provided to NDIS participants in aged residential care.

With respect to children and young people and the use of restrictive practices, information provided by the NDIS Commission and Office of the Senior Practitioner indicates that, as of 5 August 2024, there were 46 with approved restrictive practices residing in 43 different settings. 23 of these children and young people are in the South, and 20 in the North and North-West regions of the State. All of the restrictive practices identified are physical in nature and likely involve deprivation of liberty, including locked gates and exits, and the use of restraints including belts and harnesses. However, as discussed below at Part 2.3, this data *does not* include children and young people living in out of home care.

SDA services were identified as carrying a high risk of deprivation of liberty. However, whether an SDA gives rise to deprivation of liberty will depend upon the nature of the service provided and its effect on the service user. Similarly, across the spectrum of restrictive practices that may be approved not all are unlikely to result in deprivation of liberty within the context of OPCAT Article 4. This includes practices such as:

[52] Note that a setting may provide multiple services that may give rise to deprivation of liberty, e.g. an approved restrictive practices in addition to SIL.

- restricting access to objects that are not required for a person to freely leave or make related arrangements;
- using mechanical devices to prevent injury but which do not restrict freedom of movement, e.g. a helmet; and
- momentarily guiding or redirecting a person away from potential harm/injury.

By contrast, practices more likely to give rise to deprivation of liberty include:

- locked doors and gates or refusing to allow a person to leave;
- refusing to provide a participant access to their funds or items necessary to freely exit, e.g. a phone to arrange transport;
- the use of bodysuits or wheelchair restraints;
- the use of pharmacological products that cause a person to be unable to freely leave at will, e.g. sedatives;
- refusing to provide a person access to prescribed medication that they need to facilitate exit and participation in the community;
- the use of mechanical or other restraints during transportation that are not required for safe transportation or when the vehicle is not moving.

Nevertheless, it is important to highlight that just because a restrictive practice does not give rise to deprivation of liberty does not mean the Tasmanian NPM will not examine its use. Depending on the type of practice that gives rise to deprivation of liberty, other restrictive practices being used within the same environment may consequently be examined for compliance with relevant human rights obligations in accordance with the Tasmanian NPM's published expectations. For instance, if a person is unable to freely leave an SDA residence because of locked doors, that person's treatment within the residence will then be examined in full, including any other restrictions in use. The matters that will be considered during a visit are discussed at Part 6 and elaborated on in the draft expectations provided at Appendix 9.

These insights have informed recommendations for segmenting populations, risk analysis in relation to torture and ill-treatment, and the Office of the Tasmanian NPM's resource needs, which are discussed at Parts 3 – 4.

2.3 Children and young people in out of home care

Before progressing to consider the aged residential care sector, it is relevant to briefly address deprivation of liberty of children and young people in out of home care (OOHC), administered by the Department for Education, Children and Young People (DECYP). It is noted that the project team was unable to determine the scope of the Tasmanian NPM's jurisdiction to visit OOHC settings, and accordingly this has not been included in the implementation assessment at Stage 3 of the report. This section provides background information on why this information was sought and the Department's response.

The 2023 Report included stakeholder feedback identifying that children and young people may be deprived of their liberty in OOHC and educational settings, and that restrictive practices were being applied.[53] Stakeholders observed that restrictive practices were used on children or young people in OOHC and education settings and expressed heightened concern about the potential for misuse of restrictive practices on children and young people in these places.

To complete this stage of the implementation project accurately, the project team sought information to obtain a detailed picture of the use of restrictive practices across Tasmania. This included seeking information about relevant policies and current authorised restrictive practices from relevant bodies and service providers. In Tasmania, DECYP is responsible for the delivery of public education and out of home care services. It predominantly contracts delivery of OOHC services to nongovernment service providers.

As outlined in the previous section, Tasmania's restrictive practices framework in the *Disability Services Act 2011* sets out a process for the authorisation and oversight of restrictive practices to be used in the delivery of services to people with disability participating in and paid for by the NDIS (either directly or indirectly). It includes involvement of the Senior Practitioner and Department of Premier and Cabinet, TASCAT, and the NDIS Commission. If the criteria are not met, the framework does not apply.

Information provided by the Office of the Senior Practitioner explained that this framework was not applicable to many children and young people with disability living in out of home care and in public education because their support was paid directly by DECYP (i.e. it is not paid for by the NDIS). The framework was also not applicable for some children and young people because they do not have a disability but are experiencing significant trauma and pain. In these situations, the

[53] 2023 Report, Part 2.2.1.

feedback provided was that DECYP is responsible for approving a service provider's use of restrictive practices. For the project team, this created a gap in data that was unobtainable from the NDIS Commission or the Senior Practitioner, and which therefore needed to be sought from DECYP.

Accordingly, to complete this component of the implementation project, the Tasmanian NPM requested information from DECYP about its restrictive practices framework, policies and current approvals. This is the same information that was requested from the NDIS Commission, and which it shared in detail. The framework's application was also discussed with OOHC staff. A copy of the formal response received from DECYP is included at Appendix 8.

Relevantly, the response provided that an OOHC policy was currently unavailable and specific data could not be provided. It mentions that restrictive practices in OOHC can include locking of doors, which is an indicator of deprivation of liberty. It is noted that DECYP currently publishes a restrictive practices framework for education settings on its website, which similarly provides for seclusion and containment restrictive practices that may deprive a child or young person of their liberty.[54] Given that DECYP was unable to provide a restrictive practices policy for OOHC and related data, in the absence of conducting physical visits the project team was unable to consider these places under this component of the project. As such, OOHC has not been factored into the implementation assessment provided at Stage 3 of the report.

It is important to highlight that the project team found interactions with DECYP staff valuable, and all indications were that staff are acting with the best interests of children and young people front of mind. Nonetheless, it goes without saying that having documented policies accompanied by detailed record keeping on the use of restrictive practices is essential to preventing torture and ill-treatment. This is particularly important to ensure quality of care is consistent, meets contemporary child centred and safe practices, and prevents abuse.

Consistent with established NPM practice, all expectations materials prepared by this office emphasise that deprivation of liberty and interventions need to be properly recorded, and underpinned by a policy that reflects relevant human rights obligations.[55] This is included in the draft expectations at Appendix 8. The

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[54] Department of Education, Children and Young People, Guiding resources for safeguarding children and young people, available at: https://www.decyp.tas.gov.au/safe-children/safeguarding-children/policy-and-document-library/

[55] Available at www.npm.tas.gov.au.

existence of appropriate policies and recordkeeping is also critically important for the Tasmanian NPM to function efficiently.

Recalling that the Commission of Inquiry expressed serious concern about the wellbeing of children and young people in the out of home care and education systems, it is encouraging that DECYP is currently developing an appropriate restrictive practices policy. It is essential that this forthcoming policy and its application does not fall below the quality and safeguarding standards applicable to children or young people participating in the NDIS. Noting that the forthcoming Commission for Children is expected to exercise an oversight function across the OOHC system, good record keeping will be essential for this Commission to also perform effectively.

Once staffed and operational the Office of the Tasmanian NPM will revisit consideration of deprivation of liberty in OOHC in coordination with the Commission for Children and Young People.

2.4 Aged residential care

Aged residential care in Tasmania encompasses the provision of essential services and support tailored for older individuals, facilitating their wellbeing and quality of life as they age. This includes a broad spectrum of care options, ranging from in-home support under individual Home Care packages[56] to care in group residential facilities, ensuring older adults receive necessary assistance with daily activities, healthcare needs and social engagement.

Tasmania's aged population is the oldest in Australia. It is marked by prevalent mobility and cognitive impairments, with nearly half of those in permanent residential care diagnosed with dementia.[57] According to the ABS,[58] long-term health conditions that increased with age were all forms of dementia, including Alzheimer's disease and other specific dementia types, such as dementia with Lewy bodies and frontotemporal dementia. Additionally, the prevalence of

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[56] For more information *see*: My Aged Care, Home Care Packages, <https://www.myagedcare.gov.au/help-at-home/home-care-packages> (accessed 1 August 2024).
[57] AIHW. (n.d.). *My aged care region* <https://www.gen-agedcaredata.gov.au/my-aged-care-region> (accessed 1 November 2024).
[58] ABS. (2024). *Disability, Ageing and Carers Australia: Summary of Findings* <https://www.abs.gov.au/statistics/health/disability/disability-ageing-and-carers-australia-summary-findings/latest-release> (accessed 1 November 2024).

intellectual disability, psychosocial disability, and head injury, stroke or acquired brain injury (ABI) increases considerably from age 65 to 74.[59]

The typical age of entering residential aged care is high, with most individuals admitted in their mid-80s. This late stage of life transition is often precipitated by significant health declines or the incapacity to live independently, highlighting the intensifying care needs that accompany aging. While residents in group care settings are typically older people, younger people may also receive care if no other suitable accommodation to meet their needs is available, e.g. a person with early onset dementia.[60]

The necessity of residential care often becomes apparent through repeated respite care use before transitioning permanently when health deteriorates substantially. Most exits from permanent care are due to death, indicating prolonged stays averaging around two years. Additionally, older adults increasingly suffer from multiple long-term health conditions like arthritis, back problems and hypertension, complicating their care requirements as they age.

Aged residential care services are provided by both government[61] and private sector entities. Funding for services may be wholly government provided (public), accompanied by a service user co-payment (i.e. with a government subsidy), or paid for in full by the service user (private).

The Commonwealth is primary regulator and funder of aged care providers nationally, under the *Aged Care Act 1997* (Cth). This framework operates in Tasmania by authorisation of the Tasmanian Parliament, under the *Health Service Establishments Act 2006* (Tas). The legislation incorporates Commonwealth law and establishes a state government framework for the licencing of service providers,[62] which relevantly includes obligations that service providers adhere to

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[59] AIHW. (n.d.) *People with disability in Australia* <https://www.aihw.gov.au/reports/disability/people-with-disability-in-australia/contents/people-with-disability/prevalence-of-disability#dis_type> (accessed 1 November 2024).

[60] The Australian Government's *Younger People in Residential Aged Care Strategy 2020-2025* aims to reduce the number of younger people entering residential aged care, and move these people into supported and age-appropriate accommodation. *See*: Department of Social Services, Younger People in Residential Aged Care <https://www.dss.gov.au/disability-and-carers/programmes-services/for-people-with-disability/younger-people-with-disability-in-residential-aged-care-initiative> (accessed 1 August 2024).

[61] Beaconsfield District Health Service, Campbell Town Health and Community Service, Flinders Island Multi-Purpose Centre, King Island District Hospital and Health Centre, Lyell House (West Cost District Hospital), Midlands Multi-Purpose Health Centre - Residential Aged Care.

[62] *Health Service Establishments Act 2006* (Tas), Part 2.

relevant quality of care principles and accreditation standards, and establishes a complaints mechanism.

Regulatory oversight of Australia's aged care sector is principally the responsibility of the national Aged Care Quality and Safety Commission (ACQSC). The ACQSC is an end-to-end regulator whose functions include complaint resolution, accreditation and monitoring of services, investigations, and assessing compliance with the accreditation Aged Care Quality Standards and other obligations. Reports of monitoring and related activities are published on the ACQSC website.[63]

Alongside this overarching framework, service providers are required to adhere to additional relevant Tasmanian regulatory frameworks. These may relate to guardianship, restrictive practices, substituted decision making, the operations of types of residences (e.g. retirement villages), and other legal orders made by Tribunals related to operations or treatment of service users.

As noted at Part 2.2, service users within the aged residential care sector include people with disability, who may concurrently be participants in the NDIS. Aged residential care service providers who provide care to NDIS participants are required to be simultaneously registered with the NDIS Commission, and are consequently also subject to NDIS Commission oversight (discussed further at part 1.3).[64]

2.4.1 Primary focus of the Tasmanian NPM

As an entity focused on the prevention of torture and ill-treatment in places of deprivation of liberty, the Tasmanian NPM will not visit all aged care settings in Tasmania. Broad oversight remains the responsibility of the ACQSC, which in line with SPT guidance the Tasmanian NPM will aim to complement and not duplicate.

The Tasmanian NPM's focus will be on identifying and visiting group aged residential care settings in Tasmania where it has identified that deprivation of liberty is or may be occurring. Where deprivation of liberty is only occurring within a specific area within a setting, such as a closed ward, then the Tasmanian NPM will focus on that ward. This practice is consistent with other large settings that the

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[63] *See*: Aged Care Quality and Safety Commission, 'Find a report' <https://www.agedcarequality.gov.au/service-and-reports> (accessed 1 August 2024).
[64] Also *see*: Aged Care Quality and Safety Commission, 'Younger people and NDIS participants in aged care' <https://www.agedcarequality.gov.au/older-australians/younger-people-and-ndis-participants-aged-care> (accessed 1 August 2024).

Tasmanian NPM will visit, such as closed hospital units rather than an entire hospital.

Following SPT guidance, the Tasmanian NPM will also be mindful of the principle of proportionality when determining its priorities and the focus of its work, and will take into account the ethical principle of 'do no harm' in the planning of each visit.[65] Part 4 provides detail on a risk-based model that has been developed to assist the office with prioritisation process. An overarching aim of the office will be to engage cooperatively to enhance the service providers' ability to deliver quality services that align with relevant human rights obligations and best practice.

Deprivation of liberty within aged residential care settings can take many forms. Within many group residential settings, it is common for services to include the use of closed wards or gardens to provide care for people with advanced dementia. Where specific wards do not exist, these service users may be provided with a secure bed, and permitted to freely move around all or an area within a facility but will be restricted from exiting. In these circumstances, exit restrictions may be extended to other residents who in turn need permission to leave, which can also constitute deprivation of liberty.

As noted above, some aged residential care residents may also be NDIS participants, who may accordingly be subject to approved restrictive practices depriving them of their liberty. There are also likely to be service users who are not NDIS participants but still require support to perform daily activities. Where this service is denied or unavailable, the service user may similarly be de facto deprived of their liberty. For instance, service users may be additionally subject to chemical or mechanical restraint, or substituted decision-making.

Against this analysis, the project team interviewed and surveyed Tasmanian aged residential care service providers to understand deprivation of liberty and its potential prevalence within Tasmania's aged residential care sector. Table 9 provides a breakdown of settings identified, regional location, and any approved restrictive practices, secure dementia or respite beds and gardens therein.[66]

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[65] United Nations Subcommittee, 'Ninth annual report of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment', UN Doc CAT/C/57/4 (22 March 2016), page 19.

[66] Note that a setting may contain multiple different deprivation of liberty services, e.g. approved restrictive practices, secure dementia beds, and a secure garden.

Table 9: *Aged residential care specific data*

Region	Group care settings	Approved restrictive practices	Secure dementia beds	Secure gardens in residential care settings	Respite beds
North	20	17	5	16	17
North West	17	10	7	14	17
South	32	25	12	30	27

Stage 2: Analysis and application

Stage 1 provides a broad overview of the Tasmanian NPM's mandate in community-based health and social care. Its findings reveal a large, complex, and geographically spread-out service delivery landscape that is continuously changing to meet the needs of service users. And, in the course of service delivery, it identifies many different circumstances that can result in deprivation of liberty.

This landscape creates a unique challenge in the design of an appropriate operating model for the Tasmanian NPM. The large number of aged residential care and disability support places and service users identified under Stage 1 is greater than the combined total of all other deprivation of liberty settings at which the Tasmanian NPM will exercise its functions.[67] It will be impossible to visit and examine every identified place of deprivation of liberty with consistent regularity. Nor is it expected to. Following SPT guidance, it is essential that the Tasmanian NPM exercises its functions and uses resources in a manner consistent with the proportionality principle.

Stage 2 is accordingly focused on determining where, and how, the Tasmanian NPM should prioritise its work across the aged residential care and disability support sectors. It aims to provide a nuanced understanding of the sector, building on the results of Stage 1 to analyse service user populations, service delivery risk factors related to deprivation of liberty, and cross-cutting themes between aged residential care and disability support services. This information will enable the creation of an evidence-based, systematic risk assessment framework, which the Tasmanian NPM can use to identify service users and populations most at risk of torture or ill-treatment, and sustainably manage capabilities to deliver positive impact for the Tasmanian community.

The stage proceeds in two parts: first, in-depth consultation, information gathering, and analysis to determine where the Tasmanian NPM should exercise its functions; followed by design of the risk framework, and its application to data obtained from regulators and service providers. The results arising from this application of the risk assessment framework will guide Stage 3 of the project, which focuses on developing an appropriate organisational design, resource estimate, and draft expectations.

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[67] *See* Table 8 and Table 9. As identified in the 2023 Report, these other deprivation of liberty settings include police and court cells, custody centres, youth detention, and closed mental health facilities.

Part 3: How should the Tasmanian NPM exercise its functions?

3.1 Introduction

Answering this question requires developing a comprehensive appreciation of the varying risks of torture and ill-treatment that a person deprived of their liberty may be exposed to while receiving care or support specific to their needs.

This section of the report applies contemporary service design methods to map service delivery and service users through common characteristics, and their journeys within and between the two service sectors. It does this through detailed segmentation analysis and detailed journey mapping. The outcomes of this analysis will then form a baseline assessment in the creation of a data-driven approach to prioritising visits and the exercise of other functions, examined in the next section.

Before progressing to discuss these outcomes, it is useful to first provide an overview of the proportionality principle and the service design methodologies applied.

3.1.1 Developing a proportionate response

The SPT has said in its guidance that NPMs need to be mindful of the proportionality principle when determining priorities and the focus of its work. This reflects that OPCAT defers to NPM bodies' discretion in identifying places of deprivation of liberty, deciding the regularity of visits and form of examinations, and in the exercise of other functions. Different places of deprivation of liberty and treatment circumstances will benefit from different NPM responses, notably to prevent harm and maximise impact.

No specific approach has been established within the context of OPCAT that sets out how the proportionality principle is to be applied. While other treaty bodies have developed methods to approaching proportionality within the context of their

respective treaty, there is no requirement and appears to be little benefit in transposing these concepts to OPCAT and the NPM framework.[68]

Mindful of the context in which the SPT guidance was provided, its reference to the proportionality principle is interpreted to mean that the NPM should comport itself in a way that is suitable and necessary to achieve its mandate of preventing torture and ill-treatment, without imposing an undue burden on individuals likely to be impacted by the exercise of its functions. This is practical guidance that necessitates the weighing and balancing of multiple competing factors and overarching strategic priorities.

As a recommended integrity body focused on upholding human rights, the end alone cannot justify the means.[69] When evaluating how to the exercise its functions the Tasmanian NPM will need to assess the potential impact of proposed activities and their contribution to the prevention of torture and ill-treatment. Given it will be unable to exercise its functions over all places of deprivation of liberty and in relation to all relevant issues within a particular year, it will additionally need to weigh potential opportunity costs and plan its activities accordingly.

Alongside these considerations, planning will also need to factor in staff safety and wellbeing considerations. Inherent in the mandate of the Tasmanian NPM is a high risk of personnel being exposed to matters that may be distressing, traumatising, or which may give rise to vicarious trauma. For monitoring staff, frequent travel and long periods away from home can also impact welfare. Relevant planning factors include assessing the minimum number of staff required to attend each visit (at least two), their consecutive and accumulated days out of office/away from home, providing adequate recovery time between visits, and to complete reporting and fulfil other duties.

Flowing from these considerations the Tasmanian NPM will need to be confident that the office's annual workplan and resultant budget is economical, efficient, and

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[68] These doctrines are generally applied within the context of dispute settlement. For example, the 'margin of appreciation' doctrine created by the European Court of Human Rights, or the approach taken by the European Court of Justice in relation to Article 5(4) of the Treaty on European Union. *See* Council of Europe, the Margin of Appreciation, available at: <https://www.coe.int/t/dghl/cooperation/lisbonnetwork/themis/echr/paper2_en.asp>; and European Union, EUR-lex: Principle of Proportionality, available at: <https://www.coe.int/t/dghl/cooperation/lisbonnetwork/themis/echr/paper2_en.asp> (accessed 1 September 2024). Similar doctrines have also been developed for the World Trade Organization's dispute settlement process, and within the realm of investor state arbitration.

[69] As outlined in the 2023 Report, poorly prepared or planned visits may do more harm than good. *See* 2023 Report, Part 4.

effective. The 2023 Report identified that NPMs around the world employ a variety of visit and methodological approaches to the exercise of their functions and the regularity prioritisation of visits.[70] There was no dominant or preferred approach, with NPMs shaping their response to meet local circumstances. Through consultation and information analysis, the project team evaluated that the most appropriate approach to exercising the Tasmanian NPM's functions in health and social care would be to develop and follow a comprehensive risk model that prioritises visits according to their evaluated likelihood of torture or ill-treatment.[71]

The outcome of a risk-based approach will be that places identified as being in the higher risk categories are prioritised for visits and in-depth examination, while the exercise of other functions will similarly target the highest risk populations or issues. And, correspondingly, the Tasmanian NPM should be resourced to exercise its functions in this way.

In practice, this approach means that although the Tasmanian NPM will endeavour to visit all identified places of deprivation of liberty without extensive delay, regularity will vary depending on risk and lower rated places may not receive a second or subsequent visit for a longer period or until new information is received indicating that circumstances may have changed since the last visit. Desktop monitoring and information sharing by relevant authorities will be essential to regularly monitoring places not visited in person.

Once a place has been selected for visiting, the Tasmanian NPM will need to then evaluate the most appropriate type of examination to conduct.[72] This will include analysing:

- information available related to deprivation of liberty circumstances and treatment;
- the characteristics of the place and other environmental matters;
- results of any recent activities by other regulatory or accreditation bodies;[73]
- results of visits to other places operated by the same service provider;
- application of the do no harm principle;
- minimising the likelihood of reprisal to information providers; and

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[70] 2023 Report, Part 2.2.2.

[71] 2023 Report, Part 2.2.2.

[72] For an overview of the different types of visits NPMs conduct, *see* 2023 Report, Part 5.2.2. The 2023 Report identifies a broad range of types of visits, approaches to regularity, and how functions are exercised, noting that there is no preferred or optimal approach among NPM bodies worldwide.

[73] Such as the NDIS Commission, ACQSC, and Senior Practitioner.

- attendant impact on relevant authorities.

3.1.2 Methodological approach

Stage 1 identifies that considerable overlap exists between aged residential care and disability support service providers, service users, and the deprivation of liberty circumstances that may occur in the course of service delivery. Having regard to this interconnectivity between the sectors, the project team used contemporary service design approaches to acquire a detailed understanding of:

- commonalities across service delivery methods and between different service users;
- how people typically transition into, through, and out of different places; and
- attendant risks that may relate to deprivation of liberty and torture or ill-treatment.

The insights arising from this analysis contribute to the development of a risk framework that allows the Tasmanian NPM to systematically prioritise the exercise of functions, and accurately estimate the resourcing needed to operate effectively (discussed at Stage 3).

Service design is the process of organising and optimising services to ensure they effectively meet users' needs while being efficient for service providers. It involves analysing each stage of the user's journey to identify opportunities for improvement, ensuring that every interaction is cohesive and streamlined. The goal is to create an experience that is not only functional but also engaging, so that users can navigate the service with ease and satisfaction.

The two service design approaches applied to the project were a segmentation analysis and journey mapping. These methods were essential in supporting the development of a robust risk framework.

Segmentation analysis is the process of dividing a diverse group of people into smaller, more manageable groups based on shared characteristics, such as demographics (age, gender), geographic location, attitudes, behaviours, or a combination of these factors. Segmentation allowed the project team to categorise users based on their care needs and associated risks, enabling the development of a more nuanced understanding of where risks might arise.

A journey map is a visual tool that outlines the steps and experiences a user goes through while interacting with a service or product. It helps to understand the user's journey, highlighting key stages, interactions, and potential challenges within the service delivery process. It usually takes the form of a horizontal timeline that progresses from left to right, representing the user's journey from start to

finish. Journey mapping helped visualise the user experience, identifying critical points where potential risks were most likely to surface.

The focus of this segmentation analysis and journey mapping project was on care needs, which often go beyond traditional aged-based categorisations. Background information and methodological approaches are outlined below and a brief summary of results is provided below. The complete segmentation analysis results and journey maps are provided at Appendix 5 and Appendix 6.

Segmentation analysis

The main objective of the segmentation analysis is to categorise consumers and participants in residential group living arrangements in aged care and disability settings in Tasmania, based on their specific care needs, environments and associated risks. By developing an understanding of these segments and mapping their journeys through care settings, the Tasmanian NPM will be more appropriately positioned to identify potential risks and appropriately prioritise and exercise its functions.

The methodology involved aligning consumer care needs—such as severe mobility impairments, complex medical needs, or dementia—with the services provided by facilities. This led to a segmentation strategy that categorised individuals based on the type and impact of their disabilities, while also considering demographic and cultural contexts.

By focusing on care needs, the segmentation analysis was able to highlight the risk profiles of different groups and identify specific places where these groups are located. This helped in understanding the diverse needs of people receiving aged residential care and disability support, and the identification of potential risks. As detailed at Part 4.2, the segmentation analysis underpinned the risk assessment process, which will support decision-making on where to focus monitoring efforts and helping allocate resources efficiently to areas with the highest risk of torture or ill-treatment.

The segmentation analysis covered all of Tasmania, focusing on individuals in aged residential care and receiving disability support in circumstances where they are or may be deprived of their liberty. The segmentation analysis did not include in-home independent living.

The process was informed by a comprehensive desktop review, surveys, ecosystem analysis and service provider interviews. The desktop review provided an understanding of existing research, reports, statistics, and theoretical foundations from key national databases. Surveys gathered direct input from

stakeholders, ensuring that the segments accurately reflect real-world needs and preferences. Ecosystem analysis offered insights into the broader context of these care settings, while interviews with service providers supplied practical perspectives on observed challenges and needs. Following this, mapping was undertaken to organise and categorise the data.

Journey mapping

The journey mapping process adopted for this project follows a macro-to-micro progression. It begins with a high-level overview of the entire service delivery framework, providing a broad strategic view of the overall consumer experience and identifying key stages and common challenges across all segments. These challenges were identified through interviews with stakeholders and service providers, offering valuable insights into the real-world issues faced by consumers. From this macro level the process narrows down to develop individualised journey maps for specific service user groups that focus on specific information in greater detail. These in-depth journey maps provide a more comprehensive analysis of the unique needs and risks associated with each service user group.

The journey map draws on information arising from the segmentation analysis, as well as wider information related to identified primary demographic groups. This includes information about care requirements, common service user needs and the characteristics of places designed to address them, prevalence of certain needs within age groups, typical entry points into care, and the specific care needs associated with each segment. By integrating these elements into the journey mapping process, the analysis aims to provide a broad understanding that aligns with real-world scenarios, data trends, and reflects challenges faced by service user groups. Insights arising from segmentation analysis and journey mapping processes are provided below.

3.2 Segmentation analysis – summary of outcomes

Readers are encouraged to read this part together with Appendix 5.

The aged residential care and disability support landscape encompasses a broad spectrum of service user needs that vary significantly across age groups. Data from the ABS, NDIS, and the Australian Institute of Health and Welfare (AIHW) underscored the dynamic and variable nature of care and support needs among different demographic groups, and revealed significant overlap in the needs of aged residential care and disability support service users.

These insights favoured a segmentation approach that considered both sectors and populations collectively, rather than separately. As a consequence, the methodology focused on aligning specific consumer care needs with the services

provided, which went beyond a traditional age-based categorisation approach. The analysis assessed people based on type of service, impact, and demographic characteristics, while also considering age-specific and cultural contexts.

Seven segments were identified overall, each of which addresses distinct risks and care requirements, from social isolation and communication barriers to complex medical management and cultural sensitivities. A basic overview of each segment and baseline risk rating is provided below, with detailed results included at Appendix 5.

1. **Physical Disability:** This segment focuses on individuals with physical disabilities, including mobility impairments and other physical limitations that impact daily living. Identified potential risks include increased dependency on care, physical injury due to inadequate support or adaptive technologies, and misuse of mechanical aids. This segment has a moderate baseline risk rating.

2. **Sensory Impairments:** This segment encompasses individuals with impairments in hearing, vision, or other sensory functions that can affect communication, mobility, and social integration. Identified risks include social isolation, communication barriers, and challenges in navigating environments. This segment has a moderate baseline risk rating.

3. **Dementia:** This segment includes older people as well as early-onset cases with dementia, particularly in its advanced stages, which are characterised by memory loss, cognitive decline and difficulty with everyday activities. Identified risks include increased risk of wandering, injury and exploitation, and challenges in communication and personal care. This segment has a very high baseline risk rating.

4. **Complex Medical Needs:** This segment is designed to capture people with multiple chronic conditions or severe medical issues requiring ongoing, complex medical management and frequent healthcare interventions. Identified risks include complications due to polypharmacy, coordination of multiple treatments and potential for hospital readmissions. This segment has a high baseline risk rating.

5. **Psychosocial Disability:** This segment includes individuals dealing with disabilities which can affect their ability to function, engage socially, and manage daily stress and relationships. Identified risks include social isolation, inappropriate care, and the potential for both under and overtreatment, including misuse of physical restraints. This segment has a high baseline risk rating.

6. **Developmental Disability:** This segment is intended to include people with intellectual disabilities, autism, and cerebral palsy, arising during early development and affecting lifelong functionality. Identified risks include social isolation, educational barriers and increased vulnerability to neglect and abuse. This segment has a high baseline risk rating.

7. **Diverse Needs:** This segment addresses the unique cultural, linguistic and diverse backgrounds of individuals and communities, ensuring care delivery is respectful and responsive to their varied cultural identities and lifestyle preferences. Identified risks include cultural insensitivity, miscommunication and inadequate care that does not respect cultural preferences. This segment has a moderate baseline risk rating.

Across these segments, three primary demographic groups were identified: people in aged care, disability services participants, and children and young people. The connection between segmentation and primary groups clarifies the applicability of a data-driven approach and guides the identification and management of potential risks in care delivery across facilities and services.

Primary group 1: people in aged care

This group predominantly aligns with the Dementia, Complex Medical Needs and Physical Disability segments. Tasmania's aged population faces mobility and cognitive impairments, with a notable incidence of dementia. Care strategies are designed to manage these conditions effectively, addressing the segment-specific risks such as wandering and injury.

Among the states and territories, Tasmania's population and in particular its aged population is the oldest in Australia. It is marked by prevalent mobility and cognitive impairments, with nearly half of those in permanent residential care diagnosed with dementia.[74] According to the ABS,[75] the long-term health conditions that increased with age were all forms of dementia, including Alzheimer's disease and other specific dementia types, such as dementia with Lewy bodies and frontotemporal dementia. Additionally, the prevalence of

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[74] AIHW. (n.d.). *My aged care region* <https://www.gen-agedcaredata.gov.au/my-aged-care-region> (accessed 10 October 2024).
[75] ABS. (2024), *Disability, Ageing and Carers Australia: Summary of Findings* <https://www.abs.gov.au/statistics/health/disability/disability-ageing-and-carers-australia-summary-findings/latest-release> (accessed 10 October 2024).

intellectual disability, psychosocial disability, and head injury, stroke or acquired brain injury (ABI) increases considerably from age 65 to 74.[76]

The typical age of entering residential aged care is also high, with most individuals admitted in their mid-80s. This late stage of life transition is often precipitated by significant health declines or the incapacity to live independently, highlighting the intensifying care needs that accompany aging.[77]

The necessity of residential care often becomes apparent through repeated respite care use before transitioning permanently when health deteriorates substantially — illustrated by the fact that most exits from such care are due to death, indicating prolonged stays averaging around two years.[78] Additionally, older adults increasingly suffer from multiple long-term health conditions like arthritis, back problems and hypertension, complicating their care requirements as they age.[79]

Primary group 2: disability services participants

In Tasmania, NDIS data reveals a disparity between the general prevalence of primary disabilities among participants[80] and those receiving SDA/SIL support.[81] Autism is the most common disability overall, followed by intellectual disability, then psychosocial disability and developmental delay.

However, the regions vary in the types of disabilities most frequently supported through SDA/SIL provisions. Intellectual disability is the most common across the board, while the prevalence of other disabilities like autism, acquired brain injury, and psychosocial disabilities varies, influencing service demands regionally. North Tasmania and the North-West show similar disability profiles, dominated by intellectual disabilities and autism. In contrast, the South-West and South-East of the state exhibit a broader range of prevalent disabilities, including higher instances of psychosocial disabilities in the South West, which aligns with the

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[76] AIHW. (n.d.) *People with disability in Australia*. <https://www.aihw.gov.au/reports/disability/people-with-disability-in-australia/contents/people-with-disability/prevalence-of-disability#dis_type> (accessed 10 October 2024).
[77] ABS. *Disability, Ageing and Carers Australia: Summary of Findings*.
[78] AIHW. *My aged care region*.
[79] ABS. *Disability, Ageing and Carers Australia: Summary of Findings*.
[80] NDIS. (n.d.). *Participant Dashboards*, <https://dataresearch.ndis.gov.au/reports-and-analyses/participant-dashboards> (accessed 10 October 2024).
[81] NDIS. (n.d.). *Market Monitoring: TAS, ACT, and Other Territories* <https://dataresearch.ndis.gov.au/reports-and-analyses/market-monitoring/market-monitoring-tas-act-and-other-territories> (accessed 10 October 2024)

national trend of these participants residing more frequently in non-private dwellings.[82]

Finally, data indicates there is minimal provision of SDA/SIL support for children aged 0-14 within Tasmania, and only a marginal amount of support for those aged 15-18. The number of individuals receiving SDA/SIL services sees a significant increase from age 19 onwards.

Primary group 3: children and young people

Disability among children in Australia manifests predominantly as intellectual and sensory and speech conditions, followed by a significant prevalence of psychosocial and physical disabilities.[83] Physical conditions are often reported as the primary disability affecting children, indicating a higher visibility and possibly a greater impact on daily functioning compared to other disability types.[84]

The landscape of disability services for children is characterised by a preference for in-home and community-based support, emphasising the importance of family and home settings in the management and support of young individuals with disabilities. Families are more likely to access respite care, with children with intellectual and psychosocial disabilities accessing respite services more frequently. In contrast, children with sensory and physical disabilities are significantly more likely to use community support services compared to their peers, underscoring the varied and specialised needs across different disability groups.[85]

For children transitioning into adolescence, particularly those aged 15 to 18, there is a notable increase in engagement with SDA/SIL services.[86] This change is likely

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[82] NDIS. (n.d.). *Market Monitoring: TAS, ACT, and Other Territories* <https://dataresearch.ndis.gov.au/reports-and-analyses/market-monitoring/market-monitoring-tas-act-and-other-territories> (accessed 10 October 2024)

[83] AIHW. *Children with disability* <https://www.aihw.gov.au/reports/children-youth/australias-children/contents/health/children-disabilities> (accessed 1 November 2024).

[84] ABS. *Disability, Ageing and Carers Australia: Summary of Findings*; AIHW (2004). *Children with disabilities in Australia* <https://www.aihw.gov.au/getmedia/a792fd34-61db-4f62-91f8-9aa8e41f8207/cda.pdf?v=20230605172251&inline=true> (accessed 1 November 2024); AIHW. (2006). *Disability updates: Children with disabilities* <https://www.aihw.gov.au/getmedia/0e07be54-bece-4d6c-bc9e-42981ee2bebc/bulletin42.pdf?v=20230605163954&inline=true> (accessed 1 November 2024).

[85] ABS. Disability, Ageing and Carers Australia: Summary of Findings.

[86] NDIS. *Market Monitoring: TAS, ACT, and Other Territories*.

influenced by transition planning that prepares them for adult services, which are more focused on independent living and social participation relevant to adult life stages such as employment and higher education.

3.3 Journey mapping – summary of outcomes

Readers are encouraged to read this part together with Appendix 6.

The journey mapping process integrates the results of the segmentation analysis and progresses to consider the individual characteristics and needs of each segment in depth. This includes consideration of care requirements, common circumstances, the settings most likely to address the segment populations' care or support needs, and movement between and through settings. By integrating these elements, the analysis aims to provide a well-rounded understanding that aligns with real-world scenarios and data trends, and which identifies risk factors and insights relevant to the Tasmanian NPM. This mapping process helps to ensure that the Tasmanian NPM's visit planning and related assessments accurately consider the conditions of treatment and challenges faced by these groups when receiving care and support.

The journey mapping process follows a macro-to-micro progression in three stages:

1. a high-level journey map, providing an overview of the service delivery framework as a whole;
2. detailed mapping of each individual segment to offer an in-depth analysis of the needs and risks associated with each group; and
3. mapping of flows within and between different care or support settings.

Further information is provided below. The process was informed through detailed interviews with stakeholders and service providers, who provided valuable, detailed insights into the real-world challenges faced by service users. Further detail was obtained through survey responses from service providers. A survey example is provided at Appendix 4.

Information about each stage in the mapping process is provided below, with the complete maps provided at Appendix 6.

High-level journey map

The high-level journey map is a strategic tool designed to illustrate the overall experiences of users within aged care and disability services. The purpose of this map is to offer a top-down view of the service delivery framework and highlight areas where potential issues may arise, and where the service user experience

could be enhanced to prevent torture or ill-treatment. It serves as a foundational tool for understanding the broader dynamics of care provision and to identify opportunities for improvement.

The map aims to provide an overview of how services are experienced and delivered by breaking down the consumer journey into four components:

1. consumer activities;
2. internal processes;
3. key stakeholders; and
4. identified challenges.

It is important to note that the information reflected in this journey map is derived from interviews and literature reviews conducted within the scope and timeline of this project. As such, it may not be exhaustive but aims to provide a comprehensive understanding based on the data available and may be refined over time through in-person visits.

Individual segment maps

The detailed journey map refines the consumer experience by organising it into specific stages: assessment and admission, daily life and care, and exit and transition.

This map is centred around the three identified primary consumer groups, each with its own subsegments (e.g., dementia, psychosocial disabilities, complex medical needs). For each stage, the map details entry points, care needs, and exit points specific to each group, providing a clear picture of the consumer journey.

In addition, dedicated pages for each of the seven identified segments (e.g., physical disabilities, sensory impairments, complex medical needs, dementia) offer an in-depth analysis of the care needs and risks associated with these groups across the three journey stages. These pages highlight the specific vulnerabilities and requirements of each segment, ensuring that their unique characteristics are thoroughly understood and appropriately addressed. By focusing on these needs and risks, the detailed journey map and segment-specific pages support the development of tailored care plans and interventions that align with the real-world experiences of consumers in aged care and disability settings.

Journeys within and between settings

In Tasmania, individuals in aged care residential and disability support settings often experience prolonged periods where they are unable to leave at will. These settings, ranging from secure dementia units to SDA and SIL residential services, present unique environments that require continuous oversight to ensure the

safety, dignity, and wellbeing of residents. As individuals transition between different care settings, such as moving from a disability support to an group aged residential care facility as their needs evolve, their journey often involves navigating varying levels of restriction and care.

Mapping these journeys provides a comprehensive understanding of how individuals transition between different environments. The analysis focuses on the typical entry points, key stages of care, and eventual exit points within these environments, helping to identify and mitigate risks. Understanding the interconnected nature of these settings allows for more consistent oversight and the development of person-centred, culturally sensitive care strategies that uphold the principles of autonomy, dignity, and respect throughout an individual's experience of deprivation of liberty.

Part 4: Where should the Tasmanian NPM prioritise its resources?

4.1 Introduction

Drawing on the results of the service design analysis, this section of Stage 2 focuses on creating a comprehensive risk assessment framework and toolkit that the Tasmanian NPM can use to systematically categorise places of deprivation of liberty according to identified risk of torture or ill-treatment, and guide the prioritisation work accordingly.[87] It provides a description of how the assessment process operates, and the different risk ratings generated.

The primary objective of aged residential care and disability support services is to provide a safe, efficient, and high-quality care environment that respects and preserves the dignity, respect, and autonomy of service users. When participating in the sector, service providers are required to operate within a structured environment that prioritises the safety and rights of residents.

The risk assessment framework for the Tasmanian NPM in aged residential care and disability services has been designed to meet the requirements of Article 4 of OPCAT and the *OPCAT Implementation Act 2021*. It focuses on aged residential care and disability support settings, however it can be adapted to other community-based care environments where deprivation of liberty is identified. Its purpose is to enhance risk visibility, prioritise areas for intervention, support informed decision-making, and ensure that the Tasmanian NPM is best positioned to exercise its functions effectively to prevent torture and ill-treatment.

Accompanying this framework is an interactive assessment toolkit, built in Microsoft Excel, which assesses 41 risk variables to produce individualised risk ratings for every identified aged residential care and disability support setting in Tasmania where a person may be deprived of their liberty.[88] Input fields in the model can be revised by Office staff as new information becomes available, such as in response to information sharing or the outcomes of visits, thereby ensuring that risk ratings remain current. Noting that this is a constantly evolving service

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[87] This approach directly responds to stakeholder feedback that the Tasmanian NPM needed to implement a visit scheduling framework that prioritises visits according to risk. *See* 3.1.1 above and 2023 Report, Part 2.2.2.

[88] Comprised of 17 variables for disability support settings, and 24 variables for aged residential care settings.

delivery landscape, it has been designed so that places can be easily added or removed over time.

4.2 The risk assessment process

The risk assessment framework follows three main steps:

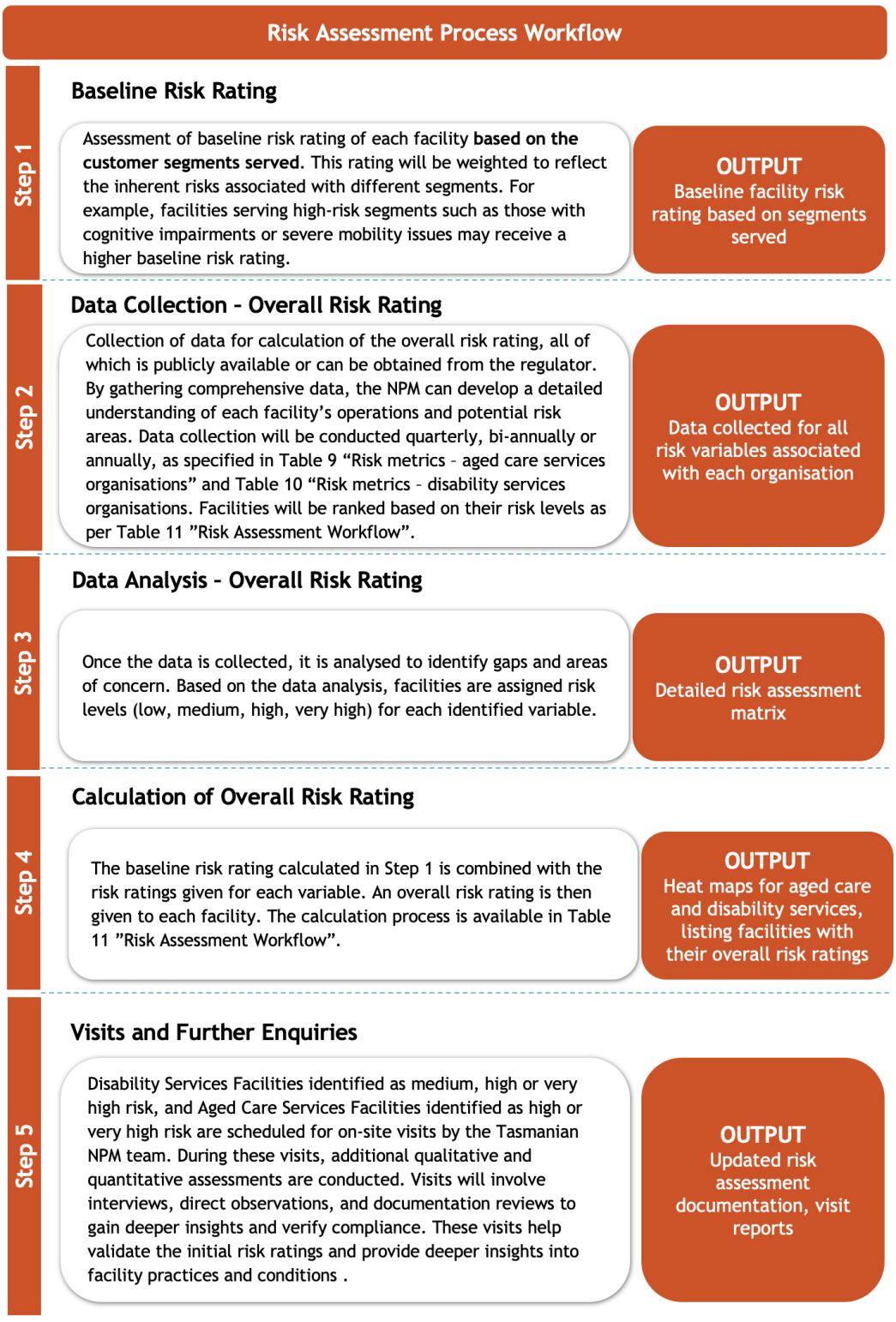
1. Service level baseline risk rating. This step applies the segmentation analysis and journey mapping outcomes (detailed in the previous section). At the conclusion of the baseline risk assessment process either a low, moderate, or high, or very high-risk rating is generated for each category of service delivered. Service providers delivering are automatically assigned a baseline risk rating corresponding with the service(s) delivered.

2. Service provider individualised 'overall' risk rating. Following the baseline assessment, each service provider is individually assessed for risk, incorporating additional information about the specific setting, service(s) provided, and people deprived of their liberty, to provide a more accurate individual risk rating. This risk profile may vary from the baseline risk rating depending on information provided.

3. Regular refinement of the overall rating. Through visits and examinations, and information provided by third parties, the Tasmanian NPM will continue to regularly monitor and update the risk ratings of all service providers. The intention is for service providers that demonstrate quality of treatment consistent with expectations, or which demonstrate improvement by responding positively to recommendations, will receive low or reduced risk ratings. While service providers whose quality of treatment does not meet expectations or does not respond to recommendations may see their risk rating increase to a higher priority level.

Table 10 provides a detailed overview of the risk assessment process.

Table 10: *Risk assessment process*



Each step in the risk assessment process is discussed below. A detailed risk assessment workflow is included at Appendix 7.

4.3 Baseline risk assessment

The segmentation of service users, outlined in the previous section, has enabled the Tasmanian NPM to tailor the way it approaches monitoring and the exercise of its other functions, in order to ensure that the unique challenges faced by different population groups are adequately addressed.

Integrating customer segmentation into the risk assessment process enables a more focused and accurate analysis, augmenting the Tasmanian NPM's capacity to evaluate and identify priorities, tailor approaches in the delivery of its functions, and support decision making. Overall, it aims to improve the effectiveness of the office by ensure that responses meet unique needs and risks of specific segments and reduce the risk of torture and ill-treatment.

In practice, using the risk model will involve the Tasmanian NPM identifying the customer segment or segments present in each aged residential care and disability support setting in Tasmania. This may be based on specific data provided to the office, or publicly available information such as the types of services provided. An initial baseline risk rating will then be assigned to each service provider based on the segments served (refer to Step 1 of Table 10) and their related journeys.

Table 2, reproduced below, indicates the baseline risk rating for each service based on the customer segments served. It is important to recall that the baseline risk rating does not represent torture or ill-treatment actually occurring, but rather its evaluated potential to occur if a service provider's treatment of service users and related processes fall below expectations.

Table 2: *Baseline risk rating by service provided*

	Service	Customer segments served	Service risk rating
Disability services	**Supported Independent living**	Physical Disability, Sensory Impairments, Psychosocial Disability, Developmental Disability, Diverse Needs	High
	Specialist Disability Accommodation	As above plus Complex Medical Needs	High
	Respite	As above	High
Aged care services	**Residential Aged Care**	Physical Disability, Complex Medical Needs, Diverse Needs	High
	Respite	As above	High
	Secure Dementia Unit	As above plus Dementia	Very High
	Secure Garden	As above	Very High
	Supported Independent Living	Physical Disability, Sensory Impairments, Diverse Needs	Moderate

4.4 Individualised overall risk ratings

4.4.1 Methodology

Readers are encouraged to read this part together with the detailed risk assessment workflow included at Appendix 7.

Following baseline evaluation, the risk assessment process proceeds to integrate additional qualitative and quantitative data to evaluate the safety and quality of care in specific environments and produce comprehensive risk weightings for each identified setting. In other words, once a baseline risk rating is applied to a place, further information is gathered to improve its accuracy, which may cause the overall rating to increase or decrease.

The three steps in this process are data collection and analysis, application of relevant risk indicators, and determination of an overall rating. The application process includes evaluating each information category against to its relevance to

OPCAT,[89] calculating weighted scores for each place, and prioritising the exercise of functions based on overall scores. This sequenced approach is designed to ensure that a thorough evaluation occurs for each setting identified. Aged residential care and disability services are evaluated separately, recognising the distinct challenges and risk factors associated with each sector. A detailed risk assessment workflow is provided at Appendix 7.

4.4.2 Risk indicators

Risk indicators play a crucial role in the Tasmanian NPM by providing a structured framework to evaluate and monitor the quality of care and service delivery in aged care and disability services. The indicators have been formulated to align with the Tasmanian NPM's purpose detailed at section 3(a) of the *OPCAT Implementation Act 2021* – to fulfil the mandate set out in Part IV of OPCAT. That is, the prevention of torture and other cruel, inhuman or degrading treatment or punishment. The indicators have also been designed to align with the Aged Care Quality Standards and the National Standards for Disability Services.

Each risk variable has been given a weighting based on an assessment of its general relevance to Article 4 of OPCAT. This includes the SPT General Comment,[90] and the requirement that visits are to be undertaken with a view to strengthening, if necessary, the protection of persons against torture and other cruel, inhuman or degrading treatment or punishment. Both quantitative and qualitative data will be collected throughout the assessment process. Some variables contribute to defining the overall risk, which aim to help the Tasmanian NPM prioritise facilities for visits, while other variables are assessed during on-site visits or through direct contact with the facility. By systematically assessing these indicators, the Tasmanian NPM can identify places that present significant risks and develop a proportionate visit response.

The Tasmanian NPM will review the variables for both disability services and aged care services annually to ensure that they continue to reflect and align with the ongoing sector reforms. In particular, reforms responding to the Royal Commissions into both sectors, as well as arising from the Commission of Inquiry, which are multiyear reform projects. Regular reviews will ensure that the indicators remain relevant and effective in identifying risks and an accurate overall rating.

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[89] Notably, article 4 and the relevant SPT General Comment. *See* Appendix 2 for further information.

[90] *See* Appendix 2.

Risk Indicators for Aged Care Organisations

The risk indicators for aged care services are essential for systematically evaluating the quality of care and service delivery within aged care facilities. These indicators are closely aligned with the Aged Care Quality Standards, ensuring that facilities operate within a robust framework designed to protect customers' rights and promote high standards of care. This approach not only ensures compliance with OPCAT obligations but also reinforces the commitment to protecting the rights and dignity of older Australians.

Table 11 below provides an overview of the risk categories and risk indicators for aged care organisations, with further detail provided at Appendix 7.

Table 11: *Risk indicators for aged care*

Risk Category	Risk Variables
Physical Restraints and Confinement Practices Monitoring the frequency and justification for the use of physical restraints and other restrictive practices is critical for understanding how such practices are being used, and if they are being used appropriately or represent a potential violation of customers' rights, directly relating to the obligations under Article 4 of OPCAT.	**Level of Restrictive Practices:** Evaluates the use of restrictive practices, examining their frequency, duration, and the justification provided by the facility. **Reportable Incidents:** Tracks incidents that must be reported under regulatory standards, analysing their causes and how effectively they are resolved.
Access and Quality of Healthcare and Services The availability and timeliness of healthcare services are key indicators of a facility's commitment to customer wellbeing. This category helps the NPM determine if facilities are meeting their obligations to provide comprehensive and prompt care, thereby reducing the risk of neglect. These indicators are aligned with both sector-specific standards and the broader human rights framework mandated by OPCAT.	**Availability of Specialised Services:** Assesses the access to necessary specialised services, such as geriatric care and palliative care. **Timeliness of Access:** Monitors the speed at which residents receive needed healthcare services. **Transition and Continuity of Care:** Evaluates how customer care transition is supported through their journey. **Behavioural and Psychological Support:** Assesses the adequacy of support for customers with behavioural issues, including the frequency of psychological interventions.
Resident Autonomy and Decision-Making This category measures how well facilities support customer autonomy and decision-making, which are crucial for upholding the rights of individuals under the NPM's mandate. This aligns with the principles of informed consent and respect for autonomy as enshrined in human rights legislation and standards.	**Resident Experience Rating:** Measures resident satisfaction with the care and services they receive. **Supported Decision-Making:** Measures the availability and effectiveness of support systems that aid residents in making informed decisions about their care.
Environmental Factors and Living Conditions This category examines the physical conditions of the facility, ensuring that they meet the necessary standards for cleanliness, safety, and accessibility. Such an environment is crucial for the protection of residents' rights and is a key focus of the NPM's monitoring activities.	**Secure Dementia Beds:** Evaluates the presence and adequacy of secure facilities for residents with dementia. **Secure Garden:** Assesses the availability of safe outdoor spaces for residents. **Falls or Injuries:** Monitors the incidence and severity of falls or injuries within the facility, along with the effectiveness of preventive measures. **Living Conditions:** Reviews the overall quality of living spaces, including their safety, cleanliness, and adequacy. **Physical Environment and Accessibility:** Assesses the facility's physical environment and its compliance with accessibility standards.
Access to Family and External Support This category assesses how well facilities facilitate these connections, which are critical for the holistic care of residents. The ease and frequency of visits and communications also serve as indicators of the facility's commitment to upholding residents' social rights and overall wellbeing.	**Frequency of Visits:** Tracks how often residents receive visits from family and friends. **Communication Channels:** Evaluates the availability and effectiveness of communication methods between residents and their external support networks. **Language Support Services:** evaluates to which level these services are available and used by customers.
People and Governance This category assesses staffing levels, qualifications, and the overall governance structure of the facility to ensure it is equipped to meet customers' needs. Proper governance and staffing practices are aligned with regulatory standards and are crucial for preventing rights violations.	**Level of Staffing:** Measures the average amount of direct care time residents receive, including care provided by Registered Nurses and Carers. **Training and Competency:** Evaluates staff qualifications, training levels, and their adequacy. **Cultural Competency Training:** Evaluates staff training levels in cultural competency and their adequacy
Rights Awareness and Compliance This category measures the effectiveness of the facility's policies and procedures in safeguarding customers' rights. Compliance with these standards is directly linked to the obligations under Article 4 of OPCAT.	**Compliance with Standards:** Monitors adherence to the standards set by the Aged Care Quality and Safety Commission. **Staff Knowledge of Customer Rights:** Evaluates how well staff is trained and informed about customer rights and the accessibility of rights-related information. **Customer Knowledge of Their Rights:** Evaluates how well customers are informed about their rights and the accessibility of rights-related information.

Risk Indicators for Disability Services Organisations

The risk indicators for disability services organisations follow a similar structure to aged residential care, tailored to the specific needs and challenges faced by individuals with disabilities receiving support. These indicators are designed to assess the quality of care and the protection of rights within disability service settings. These indicators have been developed to align with the NDIS Practice Standards, the Quality and Safeguarding Framework for the NDIS; and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which is a guiding framework for disability services and rights in Australia, ensuring compliance with best practices.

Table 12 provides an overview of the risk categories and risk indicators for disability services organisations, with further detail provided at Appendix 7.

Table 12: *Risk indicators for disability services*

Risk Category	Risk Variables
Physical Restraints and Confinement Practices This category evaluates the use, frequency, and types of physical restraints and other confinement practices, as well as the justification for their use. It is critical for understanding the extent to which restrictive practices are employed and the potential impact on the rights of individuals with disabilities.	**Restrictive Practices:** Monitors the presence and frequency of restrictive practices within the organisation, including the types and reasons for their application. **Incident Management:** Tracks the number, type, and resolution time of incidents occurring within the organisation.
Access and Quality of Healthcare and Services This category assesses the availability, accessibility, and quality of healthcare and support services provided to individuals with disabilities. Ensuring timely and appropriate care is vital for protecting the health and rights of service users.	**Support Plan Reviews:** Evaluates the accuracy and frequency of support plan reviews to ensure they reflect the current needs of participants. **Behaviour Support:** Measures the number of behaviour support plans in place and the frequency of interventions. **Transition and Continuity of Care:** Examines the regularity of health assessments, including annual reviews and ongoing monitoring of customers' health status. **Quality and Risk Management:** Assesses the effectiveness of quality practices and improvement initiatives within the organisation.
Infrastructure, Environmental Factors, and Living Conditions This category examines the physical environment and living conditions within disability service facilities. Safe, clean, and accessible living conditions are fundamental to the well-being of residents and the provision of high-quality care.	**Living Conditions:** Evaluates the cleanliness, safety, and adequacy of living spaces.
Access to Family and External Support This category assesses the extent to which individuals in disability services have access to family and external support networks.	**Feedback and Complaints Management:** Evaluates satisfaction with the handling of complaints and the evidence of learning from feedback. **Communication Accessibility:** assesses the availability and use of communication aids and frequency of interpreter and other communication support services **Engagement with Cultural and Community Representatives:** assesses the frequency and effectiveness of cultural and community engagement activities
People and Governance This category assesses the management and governance practices within disability services. It includes evaluating staff qualifications, training, staff-to-participant ratios, and the effectiveness of management structures, all of which are critical for providing high-quality care.	**Human Resource Management:** Ensures that staff are qualified and adequately trained in areas such as disability care, mental health, and rights awareness. This is essential for maintaining high standards of care and ensuring that staff can meet the complex needs of individuals with disabilities. **Rights and Responsibilities:** Measures the presence and effectiveness of policies that safeguard the rights of individuals with disabilities. This includes assessing staff and participant satisfaction with respect and dignity within the facility, ensuring that rights are respected and upheld. **Staff Ethical Training:** Evaluates staff training levels in ethical standards and their adequacy **Cultural Competency Training:** Evaluates staff training levels in cultural competency and their adequacy
Rights Awareness and Compliance This category measures the effectiveness of the organisation's policies and procedures in safeguarding customers' rights. Compliance with these standards is directly linked to the obligations under Article 4 of OPCAT.	**Compliance with Standards:** Monitors adherence to the standards set by NDIS Practice Standards **Staff Knowledge of Customer Rights:** Evaluates how well staff is trained and informed about customer rights and the accessibility of rights-related information. **Customer Knowledge of Their Rights:** Evaluates how well customers are informed about their rights and the accessibility of rights-related information.

Once all available information associated with the risk variables is collected and assessed, an overall risk rating is generated for the place or facility. The characteristics and indicators of each risk rating category are as follows:

Low Risk

Low-risk facilities demonstrate a strong commitment to customer care and rights, with minimal reliance on restrictive practices and a high degree of customer autonomy. These facilities consistently provide timely access to healthcare, maintain optimal living conditions, and exhibit robust external support networks. Their operations are characterised by well-trained staff, adequate resources, and high compliance with legal and ethical standards. These facilities may present the following:

- Minimal use of restrictive practices, with documented justification;
- Consistent, timely and regular access to healthcare and specialised services, ensuring customer needs are promptly addressed;
- High levels of customer autonomy, with customers actively involved in decision-making processes that affect their care and daily lives;
- Optimal living condition and an absence of incidents of abuse or neglect;
- Regular family visits and strong external support networks that enhance customers' quality of life and social connections;
- Adequate staffing ratios and well-trained and qualified staff capable of meeting residents' needs effectively;
- High awareness of rights among staff and residents, with strong compliance and proactive measures to prevent violations; and
- Facilities with minimal incidents, high participant satisfaction, well-qualified staff, and effective management practices that ensure continuous improvement.

Moderate Risk

Moderate-risk facilities may occasionally resort to restrictive practices, with some gaps in customer autonomy and healthcare access. These facilities generally meet minimum standards but may have areas that require improvements. These environments are not always responsive to customers' needs and may exhibit occasional lapses in care or resident rights awareness. These facilities may present the following:

- Occasional use of restrictive practices, with some documentation gaps;
- Moderate delays or inconsistencies in accessing healthcare services;
- Customer autonomy is somewhat supported, but decision-making processes are not always consistent or clear;
- Living conditions are generally acceptable, though occasional concerns about cleanliness, safety or comfort may arise;
- Family visits occur, but external support networks are not consistently strong or active;
- Staffing ratios and training are adequate but may lack the flexibility to handle unexpected challenges;
- Awareness of rights among staff and customers is present but not consistently reinforced; and
- Facilities with moderate incidents and complaints, some areas needing targeted improvements, and a workforce that may need further development.

High Risk

High-risk facilities use restrictive practices more frequently, potentially limiting resident autonomy and increasing barriers to healthcare access. Living conditions may be sub-standard, with incidents of abuse or neglect. These facilities have lower staffing ratios and training, with limited awareness of customers' rights and significant legal non-compliance. These facilities may present the following:

- More regular use of restrictive practices with inadequate justification or proper documentation;
- Significant delays or barriers in accessing health care, with potential negative outcomes for customers;
- Limited customer autonomy and involvement in decision making;
- Living conditions may be poor, with some concerns regarding safety, hygiene, and comfort;
- External support networks are weak, with irregular family visits and limited community engagement;
- Staffing ratios are low, and staff may be inadequately trained, leading to a reactive rather than proactive approach to care; and
- Poor awareness of rights among staff and residents, with recurring compliance issues.

Very High Risk

Very high-risk ratings are likely to exhibit significant deficiencies across service delivery areas that pose an immediate risk to resident safety and wellbeing. These deficiencies will be principally identified through in-person examinations, including by NPM staff, regulators, and other external authorities. Places given a very high-risk rating are likely experiencing ongoing systemic issues, including chronic understaffing, persistent non-compliance with legal standards, and a high incidence of severe incidents such as abuse, neglect, and medical emergencies. External support in these settings is minimal, and there is a significant failure in the management and oversight of the facility. Relevant indicators include:

- Evidence of use of restrictive practices with little to no justification, often in violation of residents' rights;
- Chronic and severe delays or complete lack of access to healthcare and specialised services, endangering residents' health;
- Customer autonomy and involvement in decision making is limited;
- Living conditions may be poor, with incidents of abuse, neglect, or harm;
- External support networks may be limited or non-existent, with customers feeling isolated from family and community;
- Critically low staffing ratios, with unqualified or inadequately trained staff, leading to significant care deficits and risks;
- Presence of non-compliance and potential for regulatory action; and
- Facilities with systemic failures, high turnover, frequent and severe incidents, representing a significant threat to resident safety and wellbeing.

4.5 Results

This section provides a description of results arising from application of the Risk Assessment Framework to information collected by the project team about aged residential care and disability support settings in Tasmania.[91] It ties together outcomes arising from the detailed research and analysis discussed in the previous sections to accurately identify places where people are or may be

[91] As noted earlier in the report, relevant information was provided by the NDIS Commission, Office of the Senior Practitioner, Homes Tasmania, and service providers directly. Public reports and compliance notices issued by the Aged Care Quality and Safety Commission and NDIS Commission were also cross checked.

deprived of their liberty, the people residing in these places, and calculate individualised risk ratings for each place.

It is important to emphasise that these results present an assessment of risk and do not constitute findings of mistreatment. Any place assessed as medium or high risk has been evaluated as having an elevated likelihood of torture and ill-treatment occurring, with increasing severity if expectations are not met. The NPM mandate is to prevent this from happening through proactive examinations, and by providing cooperation, advice, and education.

Data provided identifies 438 (112 North West, 95 North, and 231 South) aged residential care and disability support settings in Tasmanian where people may be deprived of their liberty. Applying the risk assessment framework, 280 settings were evaluated as low risk, 136 were medium risk, and 22 high risk.

No very high-risk ratings have been produced at this time because this rating will predominantly materialise by inputting insights arising from in-person visits and additional information collected from individual settings. All ratings are accordingly subject to change following the commencement of NPM activities and as new information becomes available.

Tables 3 and 4, reproduced below, provide a breakdown of setting risk ratings by region for aged residential care settings, and disability support settings respectively.

Table 3: *Aged residential care setting risk assessment ratings, by region.*

Region	**Low risk**	**Medium risk**	**High risk**
North West	1	9	7
North	1	13	6
South	1	23	8

Table 4: *Disability support setting risk assessment ratings, by region.*

Region	Low risk	Medium risk	High risk
North West	71	24	0
North	56	19	0
South	150	48	1

Consistent with the principle of proportionality approach outlined at Part 3.1, the Risk Assessment Framework identifies 158 settings for priority visiting and further examination by the Tasmanian NPM, evenly spread between the North and North West, and the South of the state. Priority has been assigned to places that received a risk rating greater than low, indicating that there is a heightened risk of torture or ill-treatment and highly vulnerable service users receiving care and support.

Against these results, it is recommended that the Office of the Tasmanian NPM be appropriately resourced to properly visit and examine priority settings. Low rated settings may be visited by NPM staff as capacity arises but specific funding to carry out these visits will not be specifically requested. Overall preference will be for desktop monitoring of these low-priority settings.

Recommendation 9: That the Tasmanian NPM be appropriately resourced to exercise its functions over places of deprivation of liberty assessed as having a heightened risk of torture or ill-treatment.

Having completed the research and risk analysis components, the report now progresses to Stage 3: designing an optimal organisational model for the Tasmanian NPM fulfil its mandate in the health and social care sector, in addition to the exercise of its functions identified in the 2023 Report, related budget modelling, and expectations development.

Stage 3: Implementation assessment and budget

This final stage of the report focuses on developing an operating model for the Tasmanian NPM to fulfil its functions in the health and social care sector, applying the results of Stages 1 and 2. It provides a revised organisational design for the office to incorporate health and social care, an assessment of staffing requirements and budget, and new draft expectations on the treatment of people deprived of their liberty.

The organisational design process followed in this section mirrors that described in the 2023 Report.[92] It is chiefly concerned with guaranteeing that the Tasmanian NPM's design is best suited to Tasmania, is fully independent, and enables the office to effectively respond to identified priority places of deprivation of liberty and have tangible impact. Operating effectively, this impact will include enhanced accountability of service providers, improved treatment of vulnerable people receiving care and support, augmented policy development, and greater societal awareness of human rights.

Importantly, the 2023 Report's eight recommendations remain unchanged, with the results of this report augmenting these outcomes by making four additional recommendations. To incorporate the large number of priority settings identified and their geographic spread, this report provides an updated organisational design, office layout, and budget estimate. Critically, this revised approach is designed to enable the office to operate in compliance with recommendations 8.2, 11.7, 11.11, and 11.16 of the Disability Royal Commission, which specifically address NPM implementation. It will allow the office to visit and examine prioritised health and social care settings. Notably, as a key recommendation the report recommends colocation with the Office of the Disability Commissioner, in addition to the previously recommended Commission for Children and Young People.[93]

Colocation is a valuable tool for effectively avoiding siloing of expertise by promoting agile workforce collaboration and information sharing. It supports joint activities to improve the quality of each respective office's service delivery. Having regard to the diversity of populations present in health and social care places to be visited by the Tasmanian NPM, and the complementary mandates of the Disability

[92] 2023 Report, Part 5.

[93] 2023 Report, Recommendation 5, pg 15.

Commissioner alongside the Commission for Children and Young People, substantial efficiencies are likely to arise from colocation.

Finally, following the approach outlined in the 2023 Report,[94] the draft expectations have been expert led and developed in active codesign with representative and advocacy organisations of persons with disability, older persons, and group residential aged care and disability support services. These expectations are included at Appendix 9, and available for consultation feedback until **March 2025**. The finalised expectations will be published on the Tasmanian NPM website in accordance with section 9(1)(i) of the *OPCAT Implementation Act 2021*.

Part 5: What is the most appropriate NPM operating model for Tasmania?

5.1 Introduction

This part of the report follows on from the extensive analysis and planning provided in the 2023 report, in relation to the Tasmanian NPM's organisational design, operational and budget requirements.[95] The foremost outcome being a recommendation that the Tasmanian NPM be established as a new specialised entity. This new entity would be responsible for fulfilling the functions set out in the *OPCAT Implementation Act 2021*, *Custodial Inspector Act 2016*, and lead the exercise of overlapping inspection and oversight jurisdictions of the forthcoming Commission for Children and Young People and Disability Commissioner. Effectively establishing a single, specialist and accountable independent oversight body for Tasmania.

Building on these results, this part of the report focuses on designing an optimal operating model for the Tasmanian NPM to fulfil its functions within the health and social care sector. To satisfactorily fulfil all functions across the North, North-West, and South regions, a detailed calculation has been conducted to determine the office's required Full-Time Equivalent (FTE) staffing. This calculation ensures

[94] 2023 Report, Part 4.

[95] 2023 Report, Part 5. This includes a description of the design process and outcomes, recommended governance model, strategic plan, stakeholder engagement strategy, and risk management plan. These outcomes have been observed in the development of this part of the report.

adequate coverage of all facilities, with a focus on prioritising places with higher risk ratings, identified at Part 4.5.

Further analysis is subsequently completed to incorporate these findings into the governance model outcomes in the 2023 Report,[96] to ensure that the Office of the Tasmanian NPM remains agile, efficient, and economical. The revised operating model is supplemented by an updated office design, resource estimate, and two overarching recommendations necessary for the Tasmanian NPM effectively prevent torture and ill-treatment.

This prominently includes recommending that a second Tasmanian NPM office be established in the state's north. In alignment with 2023 Report recommendations, this northern office should be shared with the forthcoming Commission for Children and Young People, and the Disability Commissioner. There is a considerable volume of work that all offices will be required to complete across Tasmania's northern regions, and the creation of a northern office has been assessed as being more economical and effective than the current model of offices being exclusively situated in Hobart.

Overall, in concluding the implementation project, this Part finds that the Tasmanian NPM will require 24 full time staff and annual resourcing of $4.29 million per annum if it is to fulfil all oversight functions to an appropriate baseline standard.[97]

A detailed budget estimate is provided at Appendix 3.

5.2 Office staffing and location (health and social care operations)

The Tasmanian NPM will exercise four overarching functions across the health and social care sector: visiting, advisory, cooperation, and education. These are elaborated at section 9 of the *OPCAT Implementation Act 2021*, and are the same functions exercised in relation to settings identified in the 2023 Report. For the office to be effective, and to minimise risk, delivery of each function will need to be carried out by relevantly qualified staff, necessitating a diverse and multidisciplinary office.[98]

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[96] 2023 Report, Part 5.3.3, page 132.

[97] Including functions under the *OPCAT Implementation Act 2021*, *Custodial Inspector Act 2016*, and to lead the exercise of overlapping oversight functions held by the Commission for Children and Young People and Disability Commissioner.

[98] These matters are discussed in the 2023 Report. *See* Part 5.

This first section is focused on developing a reliable baseline staffing estimate to satisfactorily fulfil these functions each year, and an office model that will enable economical and efficient operations. The results of this analysis will inform development of an updated organisational design and governance. Each component is considered in turn.

5.2.1 Functions and staffing

Among the NPM functions, conducting visits is the most resource intensive. This is reflected in NPM practice worldwide.[99] As outlined at OPCAT Article 19(a) and section 9(1)(a) of the *OPCAT Implementation Act 2021*, the visit function involves regularly examining the treatment of the people deprived of their liberty with a view to strengthening, if necessary, their protection against torture and other cruel, inhuman or degrading treatment or punishment.[100] In practice, when conducting examinations Tasmanian NPM staff will apply the expectations discussed at Part 6.

Core staff capabilities needed to fulfil this function will include investigations training or experience, and report writing experience. In addition, the recruitment of monitoring staff with relevant subject matter knowledge or experience, i.e. within the health and social care sector, will reduce the need for expert consultants to join visits and contribute to the accumulation of corporate knowledge. This approach is reflected in the governance and budget assumptions outlined in the next section.

The remaining three functions (advice, cooperation, and education) will not require frequent travel and work will be predominantly desktop-based; focusing on the development of comprehensive advice, reporting, and related public-facing materials, followed by targeted stakeholder engagement. These activities will often flow from the results of examinations and as issues are identified, or from

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[99] For instance, as noted in the 2023 Report (pg. 57): "the Office of the New Zealand Ombudsman, which exercises a similar jurisdiction over correctional facilities and residential aged care settings with high level dementia care throughout New Zealand, advised the project team that it maintains a dedicated OPCAT visiting staff complement of over 30 multidisciplinary inspectors based out of Wellington, with a smaller new office in Auckland. These staff are further supported by a large office-based staff complement of legal, policy, report writing, and administration experts. For these visiting staff to effectively fulfil the NPM functions, its annual travel budget alone, not including staff wages, and other related and administrative expenses, exceeded two million New Zealand Dollars."

[100] Appendix 2 provides further explanation of the requirements of this function, and the places that the NPM will be expected to visit.

proposed government legislation and policy.[101] It is essential to the Tasmanian NPM's long-term success that it develops good relationships with service providers and community stakeholders statewide through effective stakeholder engagement activities. The core capabilities required to fulfil these functions are different to visit staff. It includes legal or policy development experience, human rights knowledge, and community engagement experience. One FTE position has been estimated to fulfil these non-visit functions. Noting that the 2023 Report already recommends the recruitment of a one FTE policy officer and a one FTE community liaison officer to fulfil these non-visit functions,[102] the project team considered these positions adequate for the office and accordingly has not recommended additional FTE in this report.

Having regard to how each function will be fulfilled, most of the Tasmanian NPM's staffing and financial needs to fulfil its mandate in health and social care will arise from conducting visits and reporting on examinations. If the Tasmanian NPM is to achieve its mandate to a satisfactory standard and have impact—raising quality of treatment in priority settings where issues are identified and preventing abuse—it will require an office staff complement capable of fulfilling its visiting function economically and effectively.

The primary considerations in developing an accurate staff and resource estimate to fulfil the visit function satisfactorily include:

1. number of places to be visited;
2. types of visits to be conducted;
3. the days required to complete a visit;
4. staffing requirements for each visit; and
5. regularity of visits.

The first consideration is addressed at Part 4, identifying 66 priority aged residential care and 92 priority disability support settings (i.e. with a medium or high-risk rating), evenly distributed between Tasmania's South, and North and North-West regions.

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[101] Among the non-visit functions, the NPM is required by Article 19(c) of OPCAT to 'submit proposals and observations concerning existing or draft legislation'. This is reflected at section 9(1)(j) of the *OPCAT Implementation Act 2021*.

[102] 2023 Report, Part 5.3.3.

With respect to the remaining considerations, the 2023 Report describes the different types of visits conducted by NPMs.[103] In order from least to most comprehensive and resource intensive these are:

- drop-in or follow-up visits;
- thematic examinations; and
- omnibus (in-depth) examinations.

Included in the 2023 Report's description are insights arising from direct engagement with the New Zealand Ombudsman, who relevantly exercises NPM jurisdiction over health and social care settings described in this report.[104] This enabled the project team to accurately understand the capability, logistical, and resourcing requirements of different visit types in relation to health and social care.

At a high level, the resource requirements of each visit type correlate to their ability to achieve long-term impact. The less-formal 'drop-in' or post-examination follow-up visits are the least resource intensive, taking up to half a day to complete and are conducted in pairs. They are a valuable tool for quickly raising awareness about the Tasmanian NPM, gathering high level or discrete information, and developing a general awareness of a place to plan future thematic or in-depth visits. However, they are ineffective at examining treatment of people deprived of their liberty: information obtained is limited, very little or no analysis is conducted, and few or no specific interviews take place.

By contrast, thematic and omnibus examinations can achieve substantial impact if properly planned and executed. They are therefore complemented by insights arising from drop-in or follow-up visits. These in-depth visits typically require a larger staff contingent with multidisciplinary skills, may also involve the engagement of subject matter experts, and can take up to a week depending on the size of the place and issues examined.[105]

All visits will follow the same basic three-stage structure:

1. planning and preparations, including desktop information gathering;
2. physical visit, examination if planned, and debrief; and

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[103] 2023 Report, Part 5.2.2.

[104] This included the Director of the Office of the Tasmanian NPM joining Ombudsman staff on a series of visits in 2023.

[105] Similar in nature to existing thematic inspections and reporting completed by the Custodial Inspector. *See* www.custodialinspector.tas.gov.au to view inspection reports published by the Custodial Inspector in response to thematic visits.

3. report preparation and publication.

The more in-depth the visit and examination, the longer its duration and staffing requirements. The visit function will only be effective if the Tasmanian NPM is resourced to conduct all visit types as it deems necessary to prevent torture or ill-treatment.

Given the large number of identified priority settings, the aim will be to develop an agile management approach that enables the Tasmanian NPM to economically maximise impact by striking an appropriate balance between less formal and in-depth visits, and effectively manage competing priorities.[106] To accurately estimate capability requirements, the project team considered information provided by stakeholders and service providers about the physical characteristics of each priority setting and identified resident service user segments.

Adopting a conservative approach, Table 13 provides a summary of overall assumptions made by the project team about the average duration of each visit type:

Table 13: *Duration assumptions for different types of visits*

Category	Total days	Assumptions
Ad-hoc and Follow-up visits	2	• 1 day planning and preparation • 1 day visit
Thematic visits	4	• 2 days planning and preparation • 2 days examination
In-depth visits	5	• 2 days planning and preparation • 3 days examination

Turning to staffing requirements for each visit, the project team followed this conservative approach and assumed that all visits would require two people, to meet the bare minimum requirement to maintain staff safety; and one person to complete visit planning and preparations. In practice, thematic and in-depth examinations will typically require more than two staff, however the expectation is

[106] For instance, resourcing the Tasmanian NPM to only conduct drop-in visits would enable it maximise visibility, but it would be unlikely to prevent torture and ill-treatment because these visits provide limited substantive feedback in relation to treatment and key issues that need to be addressed. On the other hand, if the Tasmanian NPM was only resourced to conduct limited in-depth visits it would have greater concentrated impact for places visited, long-term sector improvements would be unlikely to materialise because most service providers would not be visited, limiting the office's ability to fulfil its cooperative and educative functions.

that an agile visit program will be developed enabling additional staff to be rostered onto these visits as needed without incurring any significant resource impost.

The project team also assumed that 80% of ad-hoc visits would lead to a thematic visit, and only 20% would result in a subsequent in-depth visit. In-depth visits would typically be reserved for larger settings (notably aged care residences with closed dementia units), in circumstances where multiple or significant treatment issues are identified meriting an enhanced examination response. This approach ensures adequate coverage of all facilities, with a focus on prioritising and examining those with higher risk ratings.

Following these assumptions, it is estimated approximately 1712 business days are required to fulfil the visit function to a baseline level regularity. These hours are calculated as 823 for the North and North West regions, and 889 for the South, translating into a requirement of eight full-time staff, split between the regions. Table 14 provides a detailed breakdown of assumptions, and Table 15 provides a forward estimate.

Table 14: *Calculation of number of visits per annum*

	Total prioritised facilities - Thematic Visits	In-Depth Visits	Follow-Up Visits	Ad-hoc visits	Total Follow-up + Ad hoc days	Total Visit Days Estimated
North & North-West	78	16	63	10	55	259
South	80	16	64	12	57	284
Grand Total	158	32	127	22	112	543

*Table 14 continued	Total Visit Preparation Days Estimated	Total business days to cover visits	Total business days to cover Visit preparation days	Total business days required to cover Visiting Activities	Total business days required to cover Other Activities	Total business days
North & North-West	168	518	168	686	137	**823**
South	173	568	173	741	148	**889**
Grand Total	341	1086	341	1426	285	**1712**

***Table 15**: Visit staff calculation 2026 – 2028.*

	2026	2027	2028
Start Date	1/07/2025	1/07/2026	1/07/2027
End Date	30/06/2026	30/06/2027	30/06/2028
Number of holidays (est)	13	13	13
Net work days per FTE	261	261	262
Number of FTE required to cover visiting activities N/NW	4	4	4
Number of FTE required to cover visiting activities South	4	4	4

Critically, these assumptions and staffing estimates do not include commute time to the place being visited, or time required to prepare post-examination reports for publication. The assumptions only capture preparatory time and physical time on-site. Of the four FTE estimated for each regional area, the expectation is that two FTE will focus on disability support and restrictive practices, and two FTE will focus on aged residential care. This is because travel time will vary, and reporting requirements can vary considerably, taking days to months, depending on factors including the type of visit, theme(s) examined, information obtained, if any follow-up visits or information is requested, and departmental feedback.

Given this variability, only one FTE has been included in the governance framework to specifically assist the office with report preparations and quality assurance, thereby ensuring visit staff time is most efficiently optimised. This approach is similar to that of the New Zealand Ombudsman, which maintains separate visit and reporting staff within its OPCAT team.

5.2.2 Office location

Recommendation 5 in the 2023 Report recommends that the Tasmanian NPM and Commission for Children and Young People be collocated in a purpose designed office setting. This recommendation, while remaining current, is silent on office location. Of course, a Hobart office is assumed, however further consideration is merited given the additional staff identified as necessary on the previous page.

The function and staffing analysis identifies that a large portion of the Office's annual expenses will be spent on visit related activities, notably travel costs and allowances. This is an area where efficient planning can result in noticeable budget and productivity improvements. It necessitates the consideration of an operating model that minimises travel time and costs, and facilitates staff wellbeing by reducing time spent by staff away from their homes.

At present, the common approach for independent Tasmanian bodies is to be based in Hobart, providing good proximity to government departments, parliament, and related government services. This single-hub operating model poses a challenge for the Tasmanian NPM, however, given that about half of all visits will be to locations in the North and North-West, notably in rural and remote areas.

For staff safety and to minimise overtime accrual, any travel from Hobart to the North and North-West regions will typically require staying overnight prior to and/or following a visit. Due to unavailability of flights from Hobart to King Island and Flinders Island, visits to these locations will often require multiple-day commutes. The accumulated costs and associated with staff travelling to these regions is likely to be noticeable and creates a productivity risk. Managing staff wellbeing and retention may also prove challenging, given that extended periods away from home and accumulated flex or overtime are likely to occur, which may also impact on recruitment or retention.

It is not entirely uncommon for Tasmanian government entities to maintain a secondary presence in the state's north, notably in Launceston, if beneficial to do so or required. This approach has been assessed as more cost effective and productive for the Office of the Tasmanian NPM than basing its entire team in Hobart. Given that over 100 priority settings have been identified across the northern communities for regular visits and examination,[107] budget estimates indicated that a net productivity gain would arise from establishing a second office in Launceston. This northern office would also accommodate staff whose duties include examining closed facilities in the North and North-West, such as custodial centres, police and court cells, and mental health wards.

Cost-benefit analysis indicated that the benefits flowing from establishing a northern presence would exceed any administrative expenses associated with maintaining a physical office. This includes:

- enhanced productivity and reduced travel costs due to smaller commute times.
- improved awareness of cultural and practice matters unique to the North and North-West regions, particularly with respect to the North-West and islands which are less accessible from Hobart.
- greater opportunities for regular cooperation with northern service providers and community engagement initiatives.

[107] This is on top of places identified in the 2023 report, i.e. secure mental health facilities, police and court cells, youth detention, and adult custody centres.

- The ability to recruit skilled staff based in and around Launceston with locally obtained experience.
- Positioning multiple staff in Launceston will create a smaller office requirement in Hobart, providing greater flexibility in securing appropriate commercial space noting the current low vacancy rate within the central business district.

Alongside these considerations, it is relevant to highlight that visit staff based in Launceston and performing year-round, regular visits across the regions will contribute a financial uplift to local service providers, particularly during low tourism periods (notably winter).

In consideration of these factors, it is recommended that the Tasmanian NPM establish a second Launceston office with a focus on optimisation of visit and community engagement activities in the state's North and North-West. Having regard to recommendation 5 of the 2023 Report, and noting that both the Commission for Children and Young People and Disability Commissioner will similarly undertake activities in the northern regions, this recommendation is extended to providing suitable shared offices for all collocated bodies.

Recommendation 11: The Tasmanian NPM establish an office in Launceston to support the delivery of functions in the North and North-West regions. And that this office space be made available for use by staff of the Commission for Children and Young People, and Disability Commissioner.

It is recommended that four health and social care visit function staff be positioned in each the Hobart and Launceston offices. This reflects that there is a proportionately even distribution of priority disability support and aged residential care settings in the Southern, and North and North-West regions. The research and support staff member may be situated in either office, however Hobart has been initially proposed, as detailed below in relation to overall staff distribution.

5.3 Office governance and staff distribution

The creation of a second office in Launceston provides a valuable opportunity to improve productivity in the delivery of all statutory functions exercised by the Office of the Tasmanian NPM and Custodial Inspector, notably across the state's northern regions. These gains will occur through the strategic positioning of key staff at the Launceston office, so that they can proactively engage with local stakeholders, service providers, and readily visit northern settings.

This section addresses two key questions that arise from the findings and recommendations in this report, in relation to overall organisational design:

1. What is the most appropriate governance model for the Office of the Tasmanian NPM and Custodial Inspector?
2. What is the optimal distribution of staff between the recommended Hobart and Launceston offices?

5.3.1 Governance model

The 2023 Report provides a recommended governance model and strategy for the implementation of the new combined Office of the Tasmanian NPM and Custodial Inspector, including the exercise of overlapping Commission for Children and Young People functions and colocation with that office. The model was designed to enable the Tasmanian NPM and Custodial Inspector, as well as the Commission for Children and Young People, to exercise their oversight functions to an acceptable baseline standard across all deprivation of liberty settings, except in the health and social care sector which is the subject of this report.[108]

This section is accordingly focused on updating this governance model to incorporate the results of the health and social care sector implementation analysis contained in this report, and to ensure that Tasmanian NPM can operate as productively as possible. A revised governance model and organisational design is proposed, with office staffing requirements and budget modelling addressed in the next sections.

The intention of the 2023 Report was to enable the Tasmanian NPM and Custodial Inspector to commence activities before this final component of the project was complete, promoting an iterative implementation approach. However, currently the Tasmanian NPM has been unable to commence any operations due to not being resourced to recruit staff. While regrettable, it provides a valuable opportunity to reassess the governance model, with a view to improving agility and further reducing costs.

In particular, the recommended creation of a second northern office presents a valuable opportunity to enhance productivity, increase impact, and improve overall value to Tasmanians. Recommendation 5 in the 2023 Report remains current and is emphasised. The Office of the Tasmanian NPM and Custodial Inspector be collocated with the Office of the Commission for Children and Young People, as well as the forthcoming Office of the Disability Commissioner.

Noting that nine FTE have been assessed as necessary to fulfil the Tasmanian NPM's functions within disability support and aged residential care settings to a baseline standard, the project team evaluated that a more robust governance

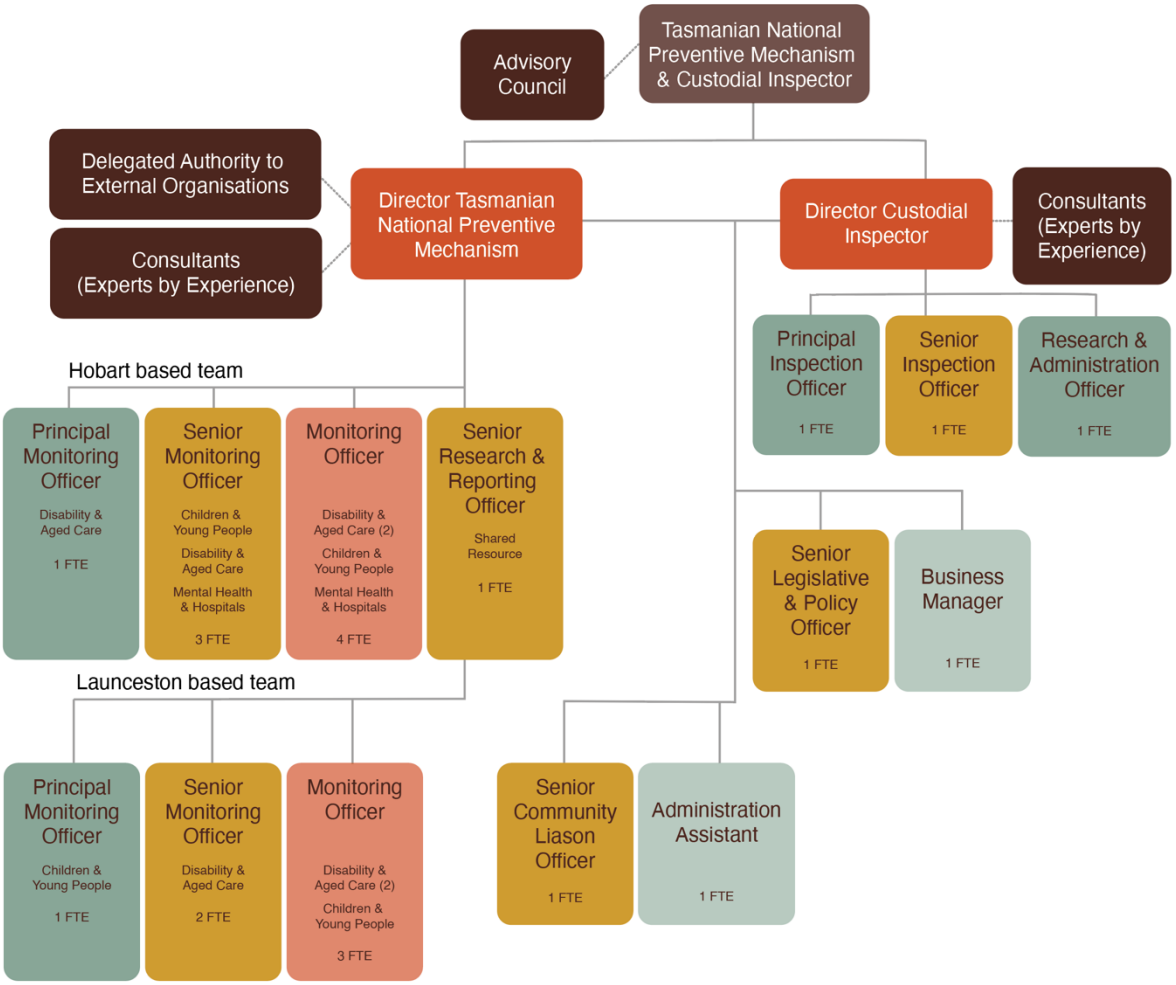
[108] 2023 Report, Part 5.3.3.

approach would be to divide the visit and examination function into four thematic workstreams (including Custodial Inspector inspections). This approach ensures that an appropriate multidisciplinary office is created, with each stream guided by a principal officer possessing relevant subject matter experience, followed by additional subordinate staff commensurate with the number of priority settings identified. Division of staff between Hobart and Launceston is discussed in the next sections.

A total of 24 FTE has been assessed as necessary to fulfil the Tasmanian NPM and Custodial Inspector, as well as overlapping Commission for Children and Young People and Disability Commissioner, oversight functions to a satisfactory baseline standard, exercising jurisdiction over about 200 combined prescribed places of detention and identified priority aged residential care and disability support settings in Tasmania where people are or may be deprived of their liberty. Noting that the Custodial Inspector currently inspects five custodial centres and one youth detention centre with a staff of 4 FTE, this new operating model represents a 400% increase in staff to oversee 3300% more places, spread across four jurisdictions, presenting significant value for money to achieve long-term impact.

Figure 2, reproduced below, provides a visual representation of the recommended revised governance model.

Figure 2: *Revised governance model for the Office of the Tasmanian NPM and Custodial Inspector*



The revised governance model proposes four visit function thematic streams:

1. Children and young people (4 FTE);
2. Custodial Inspector (existing jurisdiction, 3 FTE);
3. Disability support and aged residential care (8 FTE); and
4. Mental health and Hospitals (2 FTE).

Following Recommendation 1 in the 2023 Report, the person appointed as Tasmanian NPM and Custodial Inspector will continue to play a direct and full-time role in the exercise of the Tasmanian NPM functions. Each statutory jurisdiction (*OPCAT Implementation Act 2021*, *Custodial Inspector Act 2016*) will be managed by an office Director, which are existing roles.

For each respective thematic stream, a principal staff will be responsible for exercising leadership duties, reporting to the Office Director. These staff will support the Director with overall coordination and planning of office visit and

examination activities, reporting, and be responsible for leading visits in circumstances where the Office Director or Tasmanian NPM is not in attendance. Each thematic stream will comprise a senior officer and junior staff with supporting duties. The total number of staff within each stream will be commensurate to the number of priority places it is required to regularly visit.

Non-visit functions will be exercised by a smaller team of three senior staff, each of whom will be responsible for a specific function (advisory, cooperation, and education).[109] The Tasmanian NPM's Advisory Council—recommendation 6 in the 2023 Report—was established in June 2024.

This governance model is reliant on the adoption of an agile and multidisciplinary approach to planning visits and examinations across all streams, whereby respective Directors will join and call on staff across streams to assist where necessary to meet capability requirements to carry out an in-depth visit. The person appointed as Tasmanian NPM and Custodial Inspector will also be expected to play a significant role in participating in visits and engaging constructively with administrators and government. The Commissioner for Children and Young People, and the Disability Commissioner, may also be delegated authority to attend visits where significant issues or risks are identified.

The composition of each thematic visit stream is discussed below.

Children and Young People

Over 100 places will be regularly visited and examined by this thematic stream, including places overlapping jurisdictions shared by the Tasmanian NPM, Custodial Inspector, Commission for Children and Young People, and Disability Commissioner. As outlined in the 2023 Report, this will include leading examinations of youth justice settings, including Ashley Youth Detention Centre, consistent with Commission of Inquiry recommendations.[110]

Staff in this stream will have carriage of the Tasmanian NPM's expectations on the treatment of children and young people deprived of their liberty.[111] This will include supporting staff in other thematic streams by providing subject matter expertise on visits and examinations of settings where children and young people are or may be deprived of their liberty alongside adults. These places include police and court cells, adult custody centres, education settings, mental health facilities and hospitals, and disability support residences.

As of August 2024, information provided by the Office of the Senior Practitioner indicates that approximately 21% of individuals supported by the NDIS with

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[109] The Office of the Custodial Inspector will retain its existing Research and Administration Officer.
[110] A precise number of settings was incalculable due to an inability to obtain data about restrictive practices from the Department for Education Children and Young People. *See* Part 2.3.
[111] Available at www.npm.tas.gov.au.

approved restrictive practices are children and young people. As outlined at Part 2.3, this data does not include children and young people deprived of their liberty in out of home care or schools subject to restrictive practices, which will also fall within the Tasmanian NPM's purview (and hence staff under this thematic stream).

Four full-time equivalent (FTE) positions are recommended:

- 1 FTE Principal Monitoring Officer (Band 7);
- 1 FTE Senior Monitoring Officer (Band 6); and
- 2 FTE Monitoring Officer (Band 5).

Despite the significant number of places that will be visited regularly by this stream, a four FTE baseline staff requirement was assessed as satisfactory for this stream to function because many of these activities will occur in a supporting capacity, working alongside other thematic stream staff. Only inspections of youth detention centres will be conducted solely by staff from this stream.[112] This agile approach to staffing visits relies on other thematic streams being appropriately resourced and staffed.

Consistent with recommendation 3 in the 2023 Report, positions under the children and young people stream will be staff of the Commission for Children and Young People.[113]

Custodial Inspector (existing jurisdiction)

Following recommendation 2 in the 2023 Report,[114] the Custodial Inspector will continue to operate pursuant to the *Custodial Inspector Act 2016* and conduct inspections of Tasmania's five adult custody centres. In addition, the Custodial Inspector will commence visiting police and court cells around the state, which number about 12. The Custodial Inspector will have carriage of the Tasmanian NPM's expectations on the treatment of people deprived of their liberty in adult custody centres, and in police and court cells.[115] Between 2023 and 2024 the Office of the Custodial Inspector and Office of the Tasmanian NPM completed familiarisation visits to police and court cells around Tasmania to prepare for this new jurisdiction to commence operations.

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[112] This is consistent with Commission of Inquiry recommendations that the Custodial Inspector transfer responsibility for youth detention inspections to the Commission for Children and Young People.

[113] Delegated authority under section 11 of the *OPCAT Implementation Act 2021*. Or alternatively, staff of the Commission for Children and Young People may be made available to the Tasmanian NPM under section 12 of the *OPCAT Implementation Act 2021*.

[114] That the person appointed as Tasmanian NPM concurrently serve as Custodial Inspector, which is also to be separated from the Ombudsman, and offices combined following the recommended governance model.

[115] Available at www.npm.tas.gov.au.

Upon commencement of the Commission for Children and Young People, the Custodial Inspector will transfer responsibility for oversight of youth detention, which as noted above is recommended be led by the children and young people stream. Staff from this stream will be expected to accompany Custodial Inspector on visits to adult custody centres and police and court cells in circumstances where children or young people are deprived of their liberty, to ensure relevant expectations are being met.

Given that at the same time oversight of youth detention will be transferred to the Commission for Children the office will take on added responsibility for visits to police and court cells, it is recommended that no changes be made to current Office of the Custodial Inspector staffing levels (4 FTE). This is unchanged from the 2023 Report.[116] That is: 1 FTE Band 8 (Director), 1 FTE Band 7 (Principal Inspection Officer), 1 FTE Band 6 (Senior Inspection Officer), and 1 FTE Band 5 (Research and Administration Officer).

Disability support and aged residential care

Based on the findings and recommendations of this report,[117] this stream will be responsible for all visits and examinations to 158 priority aged residential care and disability support settings with a heightened risk of torture or ill-treatment. This comprises 66 aged residential care and 92 disability support residences, distributed almost evenly between the South, and the North and North-West regions. It will exercise jurisdiction overlapping with the Disability Commissioner, notably in examining the application of restrictive practices.

Staff in this stream will have carriage of the Tasmanian NPM's expectations on the treatment of people deprived of their liberty in health and social care, discussed at Part 6 in this report.

In circumstances where a person deprived of their liberty in a disability support residence is a child or young person, staff from the children and young people stream will join examinations. As noted earlier in the report, this number of priority places will likely change from time to time, however it is seen as more likely to increase than decrease as Tasmania's population continues to age, and as further detail is provided about restrictive practices occurring within the out of home care and education systems.

Eight FTE have been calculated as necessary to fulfil the visiting function in relation to health and social care to an acceptable baseline standard. In practical terms, it is expected that four FTE will focus on aged residential care, and four

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[116] 2023 Report, pg. 132.

[117] *See* Part 4 of this report.

FTE will focus on disability support, spread equally between offices. Combining staff into a single stream reflects the outcomes of the segmentation and journey mapping analysis, which demonstrates considerable overlap between the two service sectors and service users. This approach will enable the stream to operate with necessary agility and conduct simultaneous visits across the regions, while adhering to the minimum two staff per visit safety requirement.

The eight FTE are comprised of:

- 1 FTE Principal Monitoring Officer (Band 7);
- 3 FTE Senior Monitoring Officer (Band 6); and
- 4 FTE Monitoring Officer (Band 5).

Consistent with recommendation 3 in the 2023 Report, the Tasmanian NPM and the Disability Commissioner may coordinate to make staff available to fulfil this function, or for staff to exercise functions on delegated authority.

Mental health and hospitals

This thematic stream will be responsible for visiting and examining five closed mental health settings and hospitals around Tasmania. Staff in this stream will have carriage of the Tasmanian NPM's expectations on the treatment of people deprived of their liberty under mental health law. Similar to other streams, in circumstances where a person subject to an assessment order, treatment orders or similar is a child or young person, staff from the children and young people stream may join examinations.

Given the smaller number of fixed settings to be visited and examined, two FTE was assessed as necessary to fulfil the visit function to a satisfactory baseline standard. In contrast to other streams, a Senior Monitoring Officer position was assessed as adequate to lead the stream, rather than a Principal officer, because of the comparatively smaller number of settings around the state requiring regular visiting compared with other streams. This is unchanged from the proposal in the 2023 Report.[118] It is comprised of:

- 1 FTE Senior Monitoring Officer (Band 7); and
- 1 FTE Monitoring Officer (Band 6).

Following the agile visit planning approach mentioned above, it is expected that this stream will actively draw from any available capacity in other streams, as well as the Office Director and Tasmanian NPM, in circumstances where an in-depth visit is necessary and requires additional staff.

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[118] 2023 Report, pg. 132.

5.3.2 Hobart and Launceston staff distribution:

With the recommended revised governance model detailed, this section proceeds to outline the division of labour between the Hobart and Launceston offices.

Overall, the Hobart office will serve as the Tasmanian NPM's head office, housing core administrative and corporate staff, a share of the office's substantive functions staff (visits, education, advisory, and cooperation), as well as the existing Office of the Custodial Inspector. This aligns with other government bodies that maintain multiple offices across the state, with the Hobart office serving as head office. **16 FTE** are recommended in total.

Consequently, the Launceston office will service as a secondary office, comprised of core staff of the Office of the Tasmanian NPM, while providing additional temporary space for mental health stream and Office of the Custodial Inspector staff when visiting to inspect settings in the state's North and North-West. Subject to agreement between the Tasmanian NPM, Commission for Children and Young People, and the Disability Commissioner, the office will also include space for visiting staff from each respective office, providing a northern base for all staff exercising functions across the northern regions. **8 FTE** are recommended in total.

An overview of the office's composition is provided below. Figure 2, above, provides a visual representation.

Hobart office:

The recommended corporate and administrative positions to be located in Hobart are:

- Tasmanian NPM and Custodial Inspector (head of office).
- Director, Office of the Tasmanian NPM (1 FTE).
- Director, Office of the Custodial Inspector (1 FTE).
- Business Manager (1 FTE). This position will be responsible for managing office finances, office administration, recruitment and human resources, budgeting, and liaison with the Department of Finance. This is a whole of office position i.e., both the Office of the Tasmanian NPM and Office of the Custodial Inspector.
- Senior Legislative and Policy Officer (1 FTE). This position will focus on the advisory function. It will be responsible for oversight of advice and policy materials in response to government policy consultations, preparation of the Annual Report, final quality assurance of reporting, and submissions to

external bodies including United Nations representative bodies including the SPT.[119] This is a whole of office position.

- Senior Research and Reporting Officer (1 FTE). This position is a shared resource that will support Office of the Tasmanian NPM staff with desktop research and information requests,[120] report preparations, and the development of preparatory materials, such as visit workbooks. This position mirrors the Custodial Inspector's Research and Administration Officer role.
- Research and Administration Officer (1 FTE), Office of the Custodial Inspector (existing position).

The recommended visiting and examination staff positions are:

- Principal Monitoring Officer, disability support and aged residential care stream (1 FTE). The positioning of this stream's Principal in the South aligns with most key stakeholders, regulators, and larger service providers having their head office in Hobart.
- Principal Inspection Officer, Office of the Custodial Inspector (1 FTE). The positioning of this existing officer and all Custodial Inspector positions in the South reflects that Tasmania's major custody centres are all located within greater Hobart, and only smaller facilities located in the northern regions.
- Senior Inspection Officer, Office of the Custodial Inspector (1FTE), existing position.
- Senior Monitoring Officer (3 FTE), comprised of:
    - Children and young people stream (1 FTE).
    - Disability support and aged residential care stream (1 FTE).
    - Mental health and hospitals stream (1 FTE).
- Monitoring Officer (4 FTE), to provide supporting duties and ensure that all southern visits can be conducted with at least two staff, comprised of:
    - Children and Young People stream (1 FTE).
    - Disability support and aged residential care stream (2 FTE).
    - Mental health and hospitals stream (1 FTE).

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[119] *OPCAT Implementation Act 2021*, section 9(1) (i), (j), (k), (l); and sections 18, 24.

[120] *OPCAT Implementation Act 2021*, section 9(1)(b), (g); section 16.

Launceston office:

The recommended corporate and administrative positions are:

- Administration Assistant (1 FTE), who will provide administrative assistance to Launceston Office staff, and who will support and report to the Business Manager in relation to whole of office matters.

- Senior Community and Liaison Officer (1 FTE), who will lead delivery of the education and cooperation functions with a focus on engagement with stakeholders and communities in the northern regions.[121] This is a whole of office position.

The recommended visiting and examination staff positions are:

- Principal Monitoring Officer, children and young people stream (1 FTE). The positioning of this stream leader in Launceston aligns with the current location of Tasmania's sole youth detention facility, Ashley Youth Detention Centre, being located in Deloraine. This will enable regular visits by the Principal Monitoring Officer to the facility, accompanied by a Monitoring Officer. Additionally, the Principal will be responsible for coordinating stream activities across other deprivation of liberty places that include children and young people, notably in out of home care and disability support settings.[122]

- Senior Monitoring Officer, disability support and aged residential care stream (2 FTE). Under the leadership of the Hobart-based Principal Monitoring Officer, these two staff will be responsible for planning and leading drop-in visits and less complex thematic examinations of priority settings across the North and North-West regions. More complex thematic or omnibus examinations will require Hobart-based staff to travel to Launceston to provide assist.

- Monitoring Officer (3 FTE), comprised of:

    - Disability support and aged residential care stream (2 FTE). These junior positions will exercise supporting duties to the senior monitoring officers, particularly with respect to planning drop-in visits

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[121] *OPCAT Implementation Act 2021*, section 9(1)(h), (i).

[122] This location may be reconsidered following planned relocation of Tasmania's youth detention facility to greater Hobart in the coming years. The 2023 Report recommends (recommendation 3) that the Commission for Children and Young People share for oversight of Ashley Youth Detention Centre with the Tasmanian NPM, with monitoring staff of the Commission acting on delegated authority of the Tasmanian NPM to conduct these visits and examinations. *See* Part 5.2.4.4, pages 107 – 122.

and providing assistance with thematic examinations. This will enable agile visit practices, as the senior officers would be able to pair up with junior officers to conduct simultaneous visits.

- Children and young people stream (1 FTE). Because a minimum of two staff will be required for every visit, this this junior position will primarily ensure that the Principal Monitoring Officer has the necessary support to conduct regular visits to Ashley Youth Detention Centre, and exercise supporting duties in relation to other activities.

5.5 Resourcing and budget modelling

Following budget modelling completed in the 2023 Report,[123] further analysis has completed to update figures to reflect the results and findings contained in this report, notably the additional FTE required to fulfil the Tasmanian NPM's functions in relation to disability support and aged residential care, and the creation of the Launceston office.

This budget is a critical component of the Tasmanian NPM and Custodial Inspector's strategy to enhance custodial oversight and ensure the safety and dignity of individuals in aged care and disability support services across Tasmania. Methodologies used in this analysis follow those described in the 2023 report.

It is recalled that, where an existing body is appointed to act as an NPM, OPCAT requires all NPM functions be resourced separately and operate independent to any non-NPM functions exercised by that body. This is to preserve the NPM's independent financial and operational autonomy. The current Tasmanian Budget reflects this requirement, with OPCAT resourcing for the Tasmanian NPM expressed as a separate line item under the Office of the Ombudsman. Following the report's recommendations, upholding this separate resourcing requirement will be essential with respect to the Commission for Children and Young People, noting that the Commission will exercise many functions unrelated to the NPM.

For that reason, it is recommended that the four FTE proposed under the children and young people thematic stream be resourced out of the Office of the Tasmanian NPM budget, to maintain the overall integrity of Tasmania's NPM framework. Under the proposed governance model, the Commission for Children and Young People will be responsible for the recruitment and administration of these thematic staff, as Commission employees. Accordingly, the budget

[123] 2023 Report, Part 5.5.

estimates provided in this report include NPM-related resourcing for the Commission for Children and Young People.

In developing this budget, several variables were considered, ensuring alignment with the overarching vision, purpose, and values of the Tasmanian NPM.[124] These variables form the foundation of the budget, guiding the allocation of resources and the prioritisation of initiatives. It includes the revised organisational design and governance model, key staff capability requirements, and proper application of the risk assessment methodology discussed in Part 4.

Table 5, reproduced below, provides the total operational expenses of the Office. Further detail and assumptions underpinning these estimated figures are provided at Appendix 3.

Table 5: *Total estimated operational expenses for the Tasmanian NPM*

	FY25–26	FY26–27	FY27–28	FY28-29
Total operational expenses	$4,286,164.90	4,260,307.41	$4,283,526.34	$4,306,784.66

It is important to note that the government will be the sole source of funding for the Office of the Tasmanian NPM and Custodial Inspector budget. Meeting this commitment will underscore the government's dedication to ensuring robust oversight of care and detention settings, and align with the Commission of Inquiry and Disability Royal Commission recommendations that it has accepted.

The important mandate to be exercised by the Tasmanian NPM and Custodial Inspector, including overlapping Commission for Children and Young People and Disability Commissioner jurisdictions, merits enhanced oversight by Parliament. Noting that the Custodial Inspector is currently a defined integrity entity under the *Integrity Commission Act 2009*, and that the Tasmanian NPM's powers and functions exceed those of the Custodial Inspector, it is recommended that the Tasmanian NPM be added to the list of integrity entities.[125] This will enable thorough scrutiny of the Office of the Tasmanian NPM and Custodial Inspector in full by the Joint Standing Committee on Integrity.

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[124] 2023 Report, Part 5.4.

[125] *Integrity Commission Act 2009*, section 4.

In addition, it is recommended that the *Integrity Commission Act 2009* be amended to extend the functions of the Joint Standing Committee on Integrity to include scrutiny and approval of integrity entity budgets. This reflects that integrity entities exist to serve the Tasmanian people through the Tasmanian Parliament, to ensure that decisions made by government and related practices are ethical, free from misconduct, and lawful.

Providing this crucial layer of independent scrutiny is dependent on each entity being appropriately resourced. In recent years, particularly in response to identified serious misconduct and abuse, additional oversight obligations have been placed on integrity bodies without corresponding increases in resourcing. Furthermore, despite assurances in Parliament and resourcing this office to complete this vital implementation analysis, the 2024 – 2025 Tasmanian Budget regrettably only funded the Office of the Tasmanian NPM $300,000 of the $2.8 million requested in response to the 2023 Report, to commence operations. This has left the Office of the Tasmanian NPM unable to exercise any functions beyond the completion of this report, providing no capability to prevent torture or ill-treatment.

It is recommended that the Parliament play a greater role in ensuring that integrity entities are properly resourced to fulfil their functions. It is observed that similar processes exist in other jurisdictions.[126]

Recommendation 12: That the *Integrity Commission Act 2009* be amended to include the Tasmanian NPM as a defined integrity entity, and to extend the functions of the Joint Standing Committee on Integrity to include scrutiny and approval of integrity entity budgets.

[126] For instance, the New Zealand Ombudsman is a defined Officer of Parliament, reporting to the Parliament's Governance and Administration Committee, with a select committee—Officers of Parliament Committee—chaired by the Speaker of the House and responsible for approving and recommending the budgets for the officers, among other functions. *See* New Zealand Parliament, Who are the Officers of Parliament? <https://www.parliament.nz/mi/visit-and-learn/how-parliament-works/fact-sheets/who-are-the-officers-of-parliament/> (accessed 1 November 2024).

Part 6: Expectations development

6.1 Introduction

As outlined in the 2023 Report,[127] the development of expectations for the treatment of people deprived of their liberty is essential to the Tasmanian NPM's effective operations. Around the world, NPMs use these documents to help people understand the matters that will be considered when exercising their functions, and to support operational staff by setting out the visit process and criteria against which the treatment of people deprived of their liberty will be examined. This is reflected at section 9(1)(j) of the *OPCAT Implementation Act 2021*, which provides that it is a function of the Tasmanian NPM to develop and publish guidelines and standards.

Central to this implementation project has been the development of expectations materials for each thematic area of deprivation of liberty that the Tasmanian NPM will visit and examine. The expectations released under the 2023 Report and now finalised address:[128]

- children and young people;
- adult custody centres;
- police and court custody; and
- mental health

The 2023 Report further identified that expectations on the treatment of people deprived of their liberty in health and social care remained in development, alongside related implementation planning. To lead the development of these expectations, the Tasmanian NPM engaged subject matter expert, Dr Yvette Maker, at the University of Tasmania.[129]

The draft expectations are now included at Appendix 9, and available for consultation feedback until the end of **March 2025**.

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[127] 2023 Report, Part 4 (pg. 76).

[128] Available on the Tasmanian NPM website: www.npm.tas.gov.au.

[129] Yvette has a background in law and social policy and her work focuses on the disability- and gender-related dimensions of law, policy, and practice. This includes providing research support to the Chair of the United Nations Committee on the Rights of Persons with Disabilities and the Office of the High Commissioner for Human Rights on topics including sexual and reproductive rights, the right to education and the right to liberty and security of the person.

Recommendation 11.11 of the Disability Royal Commission includes that NPM bodies implement their functions in a disability-inclusive way involving people with disability in the inspection of places of detention. This is, of course, a process that needs to commence by involving people with disability in the development of the expectations that will underpin NPM visits and examinations.

In compliance with this recommendation, the Office of the Tasmanian NPM and Dr Maker have drawn up these expectations in codesign with representative and advocacy organisations of persons with disability, older persons, and group residential aged care and disability support services. Further detail about the methodological approach applied is provided below.

Preparation of the expectations also involved in-person familiarisation visits to Tasmanian operated aged care settings, including the Roy Fagan Centre, King Island District Hospital and Health Centre, and the Flinders Island Multi-Purpose Centre. In addition, to understand the service delivery landscape in Tasmania, the Office of the Tasmanian NPM engaged with the Interim Disability Commissioner Tasmania, the National Disability Insurance Scheme (NDIS) Quality and Safeguards Commission, the National Disability Insurance Agency (NDIA), Office of the Senior Practitioner, and many private sector Aged Care and Disability Services providers.

6.2 Methodological approach

The methodological approach adopted was designed to ensure that the draft expectations are rights-based, effective and legitimate. The first step involved identifying and reviewing relevant literature, including available guidance on human rights and OPCAT monitoring from United Nations bodies and mandates and other international, national, and local bodies. This included expectations and indicators developed for other settings and in other jurisdictions, as well as recent Royal Commission reports and papers. The documents identified and utilised in the development of the expectations are listed in Annex 1 of Appendix 8.

The drafting process followed co-design principles to ensure that the document addressed rights issues and risks for people who use aged residential care, disability support and related services in Tasmania, and was grounded in the perspectives of advocacy and representative organisations of persons with disabilities and older persons. The Tasmanian NPM invited Tasmanian organisations to participate in two co-design workshops and provide written feedback on an initial draft of the expectations.

Participants included representatives from:

- TasCOSS
- Speak Out Association of Tasmania
- Association for Children with Disability (Tas)
- Council on the Ageing Tasmania
- Disability Voices Tasmania
- Dementia Support Australia
- Advocacy Tasmania

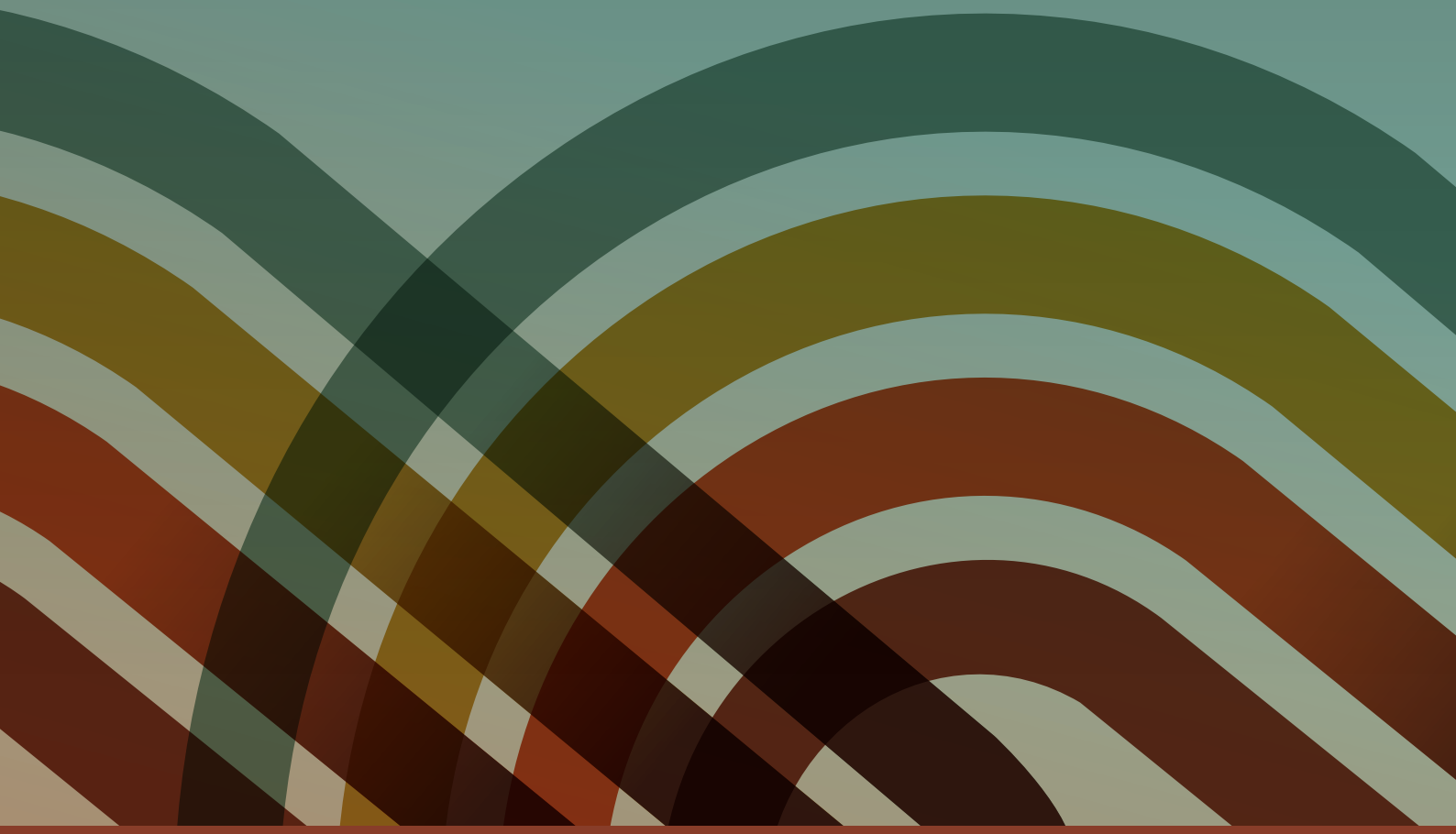
Also participating in these meetings was Interim Disability Commissioner, Mary Mallett and her office.

The co-design workshops were held in-person and online in June and August 2024.[130] In the first workshop, which took place prior to the commencement of drafting, participants were briefed on the purpose and scope of expectations documents and invited to provide initial information and views on the appropriate scope and content of the health and social care expectations. Based on this input, the reviewed literature, and information gathered during the Office's civil society consultations in 2023, Dr Maker prepared an initial draft of the expectations in June and July 2024.

Co-design participants were subsequently invited to provide feedback on the initial draft in a second workshop, and to provide written comments after the workshop via email. In August 2024, Dr Maker revised the initial draft to incorporate this feedback. When matters raised by co-design participants were not included in the draft—either because they were beyond the scope of the Office of the Tasmanian NPM's functions or because Dr. Maker and the Office deemed them more appropriate for other Tasmanian NPM documentation, such as visit workbooks—this was explained to the participants.

[130] Participants were remunerated for their time and expertise.

Tasmanian NPM
National Preventive Mechanism



Preventing torture and ill-treatment in Tasmania

Supplementary report to the Tasmanian Government focusing on health and social care and update on the implementation of the Tasmanian National Preventive Mechanism under the *OPCAT Implementation Act 2021*

2024 Annual Report - APPENDICES

Appendix 1: Civil Society Advisory Council Charter

Tasmanian NPM
National Preventive Mechanism

GPO Box 960, Hobart
Tasmania, 7000

P (03) 6166 4566
enquiries@npm.tas.gov.au

www.npm.tas.gov.au

Tasmanian NPM
Civil Society Advisory Council

Charter, July 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.

Contents

A. Background

1. The Advisory Council

The Tasmanian National Preventive Mechanism (NPM) Advisory Council ("the Advisory Council") is established by the Tasmanian NPM, Richard Connock.

2. The Tasmanian NPM

The Tasmanian NPM is an independent statutory body established in accordance with the *OPCAT Implementation Act 202*1 (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 policies and practices. 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).

3. Role of the Advisory Council

Recognising the importance of proactive, continuous civil society engagement in the delivery of the Tasmanian NPM's functions, and to give effect to Recommendation 6 in the *Preventing torture and ill-treatment in Tasmania* report, the Tasmanian NPM is establishing the Advisory Council.

The role of the Advisory Council will be to informally report to and advise the Tasmanian NPM in relation to its activities, and assist in promoting wider civil society engagement through the dissemination of information to stakeholder populations.

Advisory Council meetings will also provide a confidential forum to obtain feedback on emerging issues in deprivation of liberty settings, and to discuss performance and strategic planning.

In its formative years of operationalisation, the Advisory Council will also provide feedback on implementation activities and informally assist with awareness raising.

B. Charter

1. Functions

The Council shall:

1. Assist in monitoring the implementation of Tasmanian NPM framework.

2. Informally advise the Tasmanian NPM on matters critical to the success of the National Preventive Mechanism.

3. Provide confidential feedback in relation to strategy planning, policy development, and outcomes of examinations.

4. Present solutions to issues raised in meetings.

5. Ensure that the perspectives of people deprived of their liberty within the Tasmanian community and overrepresented populations in deprivation of liberty settings are reflected in advice provided to Government.

6. When relevant to do so, consult and work in partnership with International, National and State stakeholders.

7. Provide feedback on the Tasmanian NPM Annual Report prior to its submission to the Australian NPM Coordinator.

The Advisory Council is not a board of Directors, and does not approve direction or budget.

2. Chair and External Representation

The Advisory Council is chaired by the Director, Office of the Tasmanian NPM.

The Tasmanian NPM, and Principal Inspection Officer, Office of the Custodial Inspector (or a nominated Office representative) shall attend meetings.

Where relevant, Tasmanian Agency representatives, independent statutory bodies, experts, and other Australian NPM members may be invited to attend Advisory Council meetings and provide feedback in relation to Tasmanian NPM activities, or provide briefings on related matters.

Preference will be given to briefing requests from relevant regulatory and human rights bodies, including the:

- Office of the Independent Regulator Tasmania
- Commission(er) for Children and Young People Tasmania
- Disability Commissioner Tasmania
- Equal Opportunity Tasmania
- The Australian Human Rights Commission
- The NDIS Quality and Safety Commission
- The Aged Care Quality and Safety Commission
- The Subcommittee on Prevention of Torture
- The Association for Prevention of Torture

3. Membership

The Advisory Council shall consist of seven (7) independent members.

Each person appointed to the Advisory Council will serve for a fixed term period of two (2) years, commencing in June 2024.

Preference will be given to a composition of members that that holds combined experience or expertise across the following areas:

1. Children and young people;
2. People with disability;
3. Aboriginal and Torres Strait Islander peoples;
4. Health and social services;
5. Lived experience of deprivation of liberty;
6. Custodial settings; and
7. Expertise in human rights law.

All Advisory Council members are appointed as individuals and do not represent a particular organisation and/or its views.

All Advisory Council members are required to be engaged as independent consultants, following usual Tasmanian Government consultancy contracting processes. Nothing in this Charter shall override or replace a contractual term contained in any agreement signed between an Advisory Council member and the Tasmanian NPM.

As far as possible the membership will be regionally balanced and reflect the gender and cultural diversity of the Tasmanian community.

An Advisory Council member may vacate their position at any time, by providing notice in writing. The Tasmanian NPM may terminate an Advisory Council member's

position if they breach a term of their appointment, or if they fail to attend two (2) consecutive meetings.

Vacancies on the Advisory Council will be widely advertised and interested people will be invited to apply and participate in a selection process. In the event of a casual vacancy, applicants who were deemed suitable in the most recent selection process may be appointed during the following 12-month period without undergoing a further selection process.

Where a member has been appointed from a prior selection process to fill a casual vacancy that member will serve until the end of the departing member's term whereupon they may be offered a further additional two-year term.

The Tasmanian NPM may elect to leave a vacancy open if the vacancy arises within a year of scheduled membership rotation.

4. Secretariat

The Office of the Tasmanian NPM will provide secretariat services, including preparing meeting materials and facilitating member attendance at meetings.

The Secretariat is responsible for:

- supporting the Chair and Community Chair,
- liaison with Council members;
- organising meetings and collating meeting papers; and
- assisting in the compilation of reports and submissions.

Where an Advisory Council member(s) intends to submit additional materials for discussion at a future meeting, the Director, Office of the Tasmanian NPM may agree for that Advisory Council member to coordinate the preparation of this specific matter. Any papers must be provided to the Secretariat at least three (3) weeks before the scheduled meeting at which they are intended to be discussed. Papers received by the Secretariat within three weeks of a meeting may be held over to the next meeting by discretion of the Secretariat.

The Office of the Tasmanian NPM shall not incur any cost associated with an Advisory Council Member(s) preparing additional materials for discussion at a meeting, unless agreed in writing by the Tasmanian NPM.

5. Expectation of Members

Members are expected to give priority to attendance at normal meetings of the Council and cannot be represented by proxy members.

Membership will expire automatically if a member is absent for more than three (3) consecutive meetings. In this event, members will be notified in writing by the Chair.

Members may be asked to attend Advisory Council meetings or provide feedback out of session.

Members are required to:

- Actively participate in all meetings and share information advice and expertise in relation to issues of importance to people deprived of their liberties.
- Act in a professional, respectful and collaborative manner when discussing and resolving issues.
- Maintain the confidentiality of the Advisory Council deliberations and, on occasion, of sensitive information shared with the Advisory Council.

On occasion, Council members may be provided with confidential material. Members will be able to seek advice from the Secretariat where they have queries about confidential information and the circumstances in which it may be shared beyond the Council.

Advisory Council members will not attribute any comments or matter discussed at a meeting to an Advisory Council member(s), the Tasmanian NPM, or an external representative without their written consent.

Any member with a conflict of interest regarding a particular issue or agenda item must declare that interest prior to the commencement of related discussions.

6. Work Program

A work program for the Advisory Council will be determined annually by the Chair in consultation with members.

Any incoming correspondence for the Advisory Council will go to the Chair and be distributed to community members as soon as possible.

Advisory Council members may decide to prepare submissions on policy issues relevant to the NPM Framework and strategies, and may also submit meeting papers

for discussion on behalf of community members. Such papers are to be distributed to the Secretariat in the manner detailed at section B.4.

Following each meeting a communiqué will be published on the Tasmanian NPM website.

Where an Advisory Council member raise issues with the Secretariat out-of-session, this may be referred to the Chair for advice and a response.

7. Specialist Working groups

In consultation with the Advisory Council, the Chair may establish additional specialist working groups, comprised of at least three Advisory Council members, to assist it in undertaking its work program.

Working groups will be responsible for progressing all aspects of the assigned work and for reporting on progress to the Advisory Council. The Advisory Council will determine the membership and work program of the working groups.

Working group membership may include additional Office of the Tasmanian NPM staff participation, or the participation of third parties (e.g. subject matter experts).

Any working group established is immediately dissolved upon satisfaction of its work program. The Chair may also dissolve a working group after notifying the Advisory Council of its intention to do so.

8. Administrative Arrangements

The Advisory Council will aim to meet three times annually, and at least twice per financial year.

Wherever possible, video-conferencing facilities will be made available for meetings to minimise travel. Advisory Council members are encouraged to attend at least one meeting per year in person.

A quorum for meetings will be half the membership plus one.

The Tasmanian NPM may determine administrative arrangements on matters related to the operation of the Advisory Council, including:

- Policy in relation to reimbursement of reasonable out-of-pocket expenses of members;
- Guidelines for members in relation to conduct and participation;

- The process to support the Chair in the appointment of members; and
- Arrangements to assist the effective operation of the Council.

Administrative support for other specialist working groups will be determined by the Chair on a case-by-case basis.

9. Guide for Reimbursement of Costs

Travel

- Where a Council Member is based interstate, any airfares associated with attending a meeting are to be agreed in writing by the Chair prior to booking. Where possible, preference is to be given to same-day interstate travel within ordinary business hours.
- Taxi vouchers are available for members who have no alternate means of transport to attend local meetings.
- Members who are government employees are expected, whenever possible, to use a government vehicle to attend meetings.
- Where a person intends to use their own vehicle, travel allowance and mileage reimbursements are based on the current State Government per kilometre travel allowance rates.
- If the above options do not meet the travel needs of a member, please contact NPM office to make alternate arrangements.

Meal allowance

Lunch will be provided for members attending face-to-face meetings between 11am and 1pm. Advisory Council members are required to inform the Secretariat of their intention to attend a meeting in person, and any dietary requirements, at least two (2) weeks prior to a scheduled meeting.

Other Costs

Any other costs not captured by this Charter that relate to Civil Society Advisory Council membership are to be raised with the Secretariat as soon as practicable and before they are incurred. The Tasmanian NPM is not liable to pay any costs not approved in writing.

10. Personal support

Inherent in the mandate of the Tasmanian NPM is a high risk of personnel being exposed to matters that may be distressing, traumatising, or which may give rise to

vicarious trauma. The Tasmanian NPM acknowledges that this risk extends to Civil Society Advisory Council members, such as when asked to review or discuss Tasmanian NPM activities.

The Tasmanian NPM will endeavour to provide Civil Society Advisory Council members with appropriate forewarning when matters identified as potentially distressing are proposed for discussion, and structure meetings to provide wellbeing breaks.

Civil Society Advisory Council members may choose to withdraw from a discussion at any time. Safe spaces information will be included in all Civil Society Advisory Council meeting materials circulated to members.

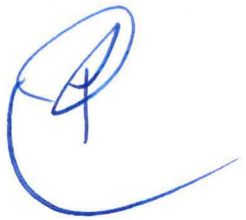
Through the Department of Justice, Civil Society Advisory Council members will have access to Wellbeing Support services, including access to psychologist/counsellors for debriefing purposes.

Civil Society Advisory Council members can contact Wellbeing Support services directly at wellbeing.support@justice.tas.gov.au or by phone: (03) 6165-6718.

On request, the Tasmanian NPM will consider in person Wellbeing Support attendance at meetings, and may also be able to arrange personal or family support if this is required to assist a member to attend meetings.

Date accepted: 22 July 2024

Signed:



Richard Connock
Tasmanian National Preventive Mechanism

Appendix 2: Subcommittee on Prevention of Torture General Comment No. 1

United Nations CAT/OP/GC/1

Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Distr.: General
4 July 2024

Original: English

Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

General comment No. 1 (2024) on article 4 of the Optional Protocol (places of deprivation of liberty)*

I. Introduction

1. The Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment was established as a result of the conviction of the international community that further measures were necessary to achieve the purposes of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and that States had the primary responsibility for implementing effective measures to prevent acts of torture and other cruel, inhuman or degrading treatment or punishment in any territory under their jurisdiction.[1] To effectively fulfil the legal obligations relating to torture prevention contained in the Optional Protocol, States parties are obliged to maintain, designate or establish national preventive mechanisms and allow regular visits by those mechanisms and by the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment[2] to places where people are deprived of liberty.[3]

2. Article 4 (1) of the Optional Protocol reinforces the fundamental purpose of the Optional Protocol as a whole by defining the places that the Subcommittee and national preventive mechanisms have the mandate to visit as any place under a State party's jurisdiction or control[4] where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence. This broad definition includes not only places dedicated to the detention or custody of persons but also places where the public authority instigates or consents or acquiesces to the deprivation of liberty.

3. Article 4 (2) of the Optional Protocol defines the term "deprivation of liberty" as "any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority". This definition specifically acknowledges that deprivation of liberty may occur in both public and private settings.

* Adopted by the Subcommittee at its fifty-third session (3–7 June 2024).

[1] Optional Protocol, preamble.

[2] Ibid., art. 1.

[3] The Optional Protocol contains references to both places where people are deprived of their liberty and places where people are or may be deprived of their liberty, which are defined in article 4. Article 4 also contains a definition of the term "deprivation of liberty". Furthermore, the Optional Protocol contains, as a short form, the term "places of detention". For purposes of consistency, the term places of deprivation of liberty" and not "places of detention" will be used throughout the present general comment.

[4] See paragraphs 29 to 39 below for an explanation of the use of the phrase "jurisdiction or control" in the present general comment.

4. The preventive objective of the Optional Protocol is manifest in its *travaux préparatoires* and the wording of the preamble.[5] The understanding and practical application of article 4 by the Subcommittee[6] and national preventive mechanisms leave no doubt that paragraphs 1 and 2 of that article should be read together. This means that the definition of places of deprivation of liberty must be understood broadly to encompass both public and private settings and situations in which there is State instigation of, or consent or acquiescence to, the deprivation of liberty.

5. However, in practice, some national preventive mechanisms have, at different times, faced difficulties or restrictions in conducting visits to some places of deprivation of liberty. In exceptional cases, these difficulties have stemmed from the national legislation; for example, when it is specified in legislation that national preventive mechanisms can only visit places where persons are deprived of their liberty by order of an administrative or judicial authority or when the legislation does not contain reference to the instigation, consent or acquiescence of the public authority. National preventive mechanisms have also informed the Subcommittee about practical difficulties in entering certain places of deprivation of liberty owing to an incorrect or limited understanding by the State party, its authorities or other relevant stakeholders of the term "place of deprivation of liberty".

6. In addition, the Subcommittee has observed discrepancies in the places that States parties allow national preventive mechanisms and the Subcommittee to visit, with more restrictions imposed on national preventive mechanisms, notwithstanding the fact that the Optional Protocol imposes the same obligations with regard to both bodies. This is a serious obstacle to the preventive work of the national preventive mechanisms and the Subcommittee and is inconsistent with States' obligations under the Optional Protocol. Consequently, States parties, their places of deprivation of liberty and, most importantly, persons deprived of their liberty do not benefit from that important preventive work.

7. The aim of the present general comment is to clarify and address questions that States parties, national preventive mechanisms and other stakeholders may have regarding the obligations of States parties to the Optional Protocol as they pertain to the definition of places of deprivation of liberty to enable effective and uniform interpretation and implementation of the Optional Protocol. To do this, in the general comment, the Subcommittee examines States' obligations under article 4 of the Optional Protocol, which should be understood in the light of the object and purpose of this treaty and in line with the practice of the Subcommittee and national preventive mechanisms, keeping in mind that the Optional Protocol is a treaty designed to respond to current, emerging and future situations and challenges.

II. Comprehensive approach to defining places of deprivation of liberty

8. Consistent with the overarching preventive aim and spirit of the Optional Protocol, the Subcommittee has recommended and implemented in its practice as extensive an interpretation as possible of the term "places of deprivation of liberty" to maximize the preventive impact of its work and that of national preventive mechanisms.[7] This is also consistent with the comprehensive approach to the term "deprivation of liberty" taken by other United Nations and regional human rights bodies.

A. Object and purpose of the Optional Protocol

9. Article 4 is central to the effective implementation of the core objective of the Optional Protocol. Any restrictive interpretation of this provision would be detrimental to the mechanism enshrined in the Optional Protocol and thus be contrary to its spirit. Therefore,

[5] See E/CN.4/1993/28, E/CN.4/1993/28/Corr.1 and E/CN.4/1995/38.

[6] CAT/C/57/4 and CAT/C/57/4/Corr.1, annex, paras. 1–3.

[7] Ibid., annex, para. 2. See also CAT/OP/POL/ROSP/1 and CAT/OP/POL/ROSP/1/Corr.1, para. 26; and CAT/OP/PRT/1, para. 25.

the Subcommittee has repeatedly underlined that the term "places of deprivation of liberty", as contained in article 4 of the Optional Protocol, should be understood broadly. An interpretation of the term that is restricted to such conventional settings as prisons would be overly limiting and clearly contrary to the Optional Protocol.[8]

10. Moreover, a restrictive interpretation of article 4 would also violate the obligation to interpret treaties in good faith, as contained in article 31 of the Vienna Convention on the Law of Treaties. That obligation requires that all treaties be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in the light of its object and purpose. Given that the objective of the Optional Protocol is the prevention of torture and other cruel, inhuman or degrading treatment or punishment through visits to all places of deprivation of liberty, a good faith interpretation cannot lead to a limited understanding of the term "places of deprivation of liberty" that would exclude certain places where persons are or could be deprived of their liberty.

11. Throughout its history and consistent practice, the Subcommittee has required that the term "places of deprivation of liberty" extend to any place, whether permanent or temporary, where persons are deprived of their liberty by, or at the instigation or with the consent and/or acquiescence of public authorities.[9] It has clarified that any place in which persons are deprived of their liberty, in the sense of not being free to leave, or in which the Subcommittee considers that persons might be deprived of their liberty, should fall within the scope of the Optional Protocol, if the deprivation of liberty relates to a situation in which the State either exercises or might be expected to exercise a regulatory function.[10] The Subcommittee has consistently emphasized that, pursuant to article 4 of the Optional Protocol, the State party must enable and ensure visits to any place where persons are or may be deprived of their liberty.[11]

12. Consequently, in accordance with the comprehensive approach to the definition of the term "places of deprivation of liberty", the Subcommittee has clearly established that the two paragraphs of article 4 must be read together,[12] as they are complementary. In other words, places of deprivation of liberty include private or public settings, as specified in paragraph 2, and deprivation of liberty includes, as specified in paragraph 1, any form of placement in a setting under the State's jurisdiction or control that a person is not permitted to leave at will, including at the instigation or with the consent or acquiescence of a public authority.

B. Approach of other United Nations and regional human rights mechanisms

13. The approach of the Subcommittee to the definition of places of deprivation of liberty is consistent with that of other United Nations and regional human rights mechanisms and bodies. Within the United Nations human rights treaty body system, the Committee against Torture has established that a State party's obligations to prohibit, prevent and redress torture and ill-treatment extends to all contexts of custody or control, for example, prisons, hospitals, schools and institutions that engage in the care of children, older persons or persons with disabilities, including persons with intellectual or psychosocial disabilities, military service and other institutions and contexts.[13]

14. Similarly, the Human Rights Committee has maintained that, under the International Covenant on Civil and Political Rights, the right to be treated with humanity and respect for the inherent dignity of the human person applies "to anyone deprived of liberty under the laws and authority of the State who is held in prisons, hospitals – particularly psychiatric hospitals – detention camps or correctional institutions or elsewhere".[14] The Committee,

[8] CAT/C/50/2, para. 67.
[9] Ibid.
[10] CAT/C/57/4 and CAT/C/57/4/Corr.1, annex, para. 3. See also CAT/OP/POL/ROSP/1 and CAT/OP/POL/ROSP/1/Corr.1, para. 25.
[11] CAT/OP/PRT/1, para. 24; and CAT/OP/POL/RONPM/1, para. 28.
[12] CAT/C/57/4 and CAT/C/57/4/Corr.1, annex, para. 1.
[13] Committee against Torture, general comment No. 2 (2007), para. 15.
[14] Human Rights Committee, general comment No. 21 (1992), para. 2.

referring to the obligation to respect liberty and security of person, has established that deprivation of liberty also includes police custody, *arraigo*, remand detention, imprisonment after conviction, arrest, administrative detention, involuntary hospitalization, institutional custody of children and confinement to a restricted area of an airport, as well as involuntary transport.[15]

15. A broad interpretation of places of deprivation of liberty has also been adopted by the Committee on the Rights of the Child and the Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families. For example, in line with the definition in article 4 of the Optional Protocol, these Committees have explained that immigration detention covers "any setting in which a child is deprived of his/her liberty for reasons related to his/her, or his/her parents', migration status, regardless of the name and reason given to the action of depriving a child of his or her liberty, or the name of the facility or location where the child is deprived of liberty".[16] At a more general level, in the global study on children deprived of liberty, a broad definition of deprivation of liberty and places of deprivation of liberty is used, as set out in article 4 of Optional Protocol. In the study, places of detention are defined as extending to "all places where children may be deprived of liberty, such as prisons, police lock-ups, pretrial detention centres, military camps, social care facilities, institutions for persons with disabilities or for persons addicted to drugs or alcohol, 'orphanages', children's homes, institutions for the educational supervision of children, psychiatric hospitals, mental health centres or migration detention centres".[17]

16. The Committee on the Rights of Persons with Disabilities applies the principles and standards of the Convention against Torture and the Optional Protocol to the situation of persons with disabilities through articles 14 and 15 of the Convention on the Rights of Persons with Disabilities, which prohibit torture or cruel, inhuman or degrading treatment or punishment and deprivation of liberty on the basis of a disability. In this context, the Committee has found that the practice of placing persons with disabilities in residential settings without specific consent or with the consent of a substitute decision maker amounts to arbitrary deprivation of liberty.[18]

17. Equally, the special procedures of the Human Rights Council have developed standards regarding the definition of deprivation of liberty and places of deprivation of liberty that are consistent with the Subcommittee's broad approach. The Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment has emphasized that private custodial settings are also included within the meaning of the terms "deprivation of liberty" and "detention" and that, in practice, deprivation of liberty may include prisons or purpose-built detention facilities, closed reception or holding centres, shelters, guesthouses and camps, and also temporary facilities, vessels and private residences. The Special Rapporteur has been clear that the deciding factor for the qualification of a situation as "deprivation of liberty" is not the name given to a particular placement or accommodation or its categorization in national law but whether individuals are free to leave it.[19]

18. Similarly, the Working Group on Arbitrary Detention has recognized that there is an increasing number of new regimes of deprivation of liberty that arise in different situations and contexts around the world and that, while prisons and police stations remain the most common places in which individuals may be deprived of their liberty, there are a number of different places that individuals are not free to leave at will and that raise a question of de facto deprivation of liberty.[20] Emphasizing that deprivation of liberty is a question not only of legal definition but also of fact, the Working Group has underlined the importance of the

[15] Human Rights Committee, general comment No. 35 (2014), para. 5.
[16] Joint general comment No. 4 of the Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families/No. 23 of the Committee on the Rights of the Child (2017), para. 6.
[17] A/74/136, para. 18.
[18] Committee on the Rights of Persons with Disabilities, general comment No. 1 (2014), para. 40.
[19] A/HRC/37/50, para. 17.
[20] A/HRC/36/37, para. 52.

autonomous examination of each situation and of not being bound by the descriptions in national legislation or by the assessments of domestic authorities.[21]

19. The Independent Expert on the enjoyment of all human rights by older persons has recognized the broad definition of deprivation of liberty and places of deprivation of liberty in article 4 of the Optional Protocol and has considered three specific situations in which older persons may be deprived of their liberty and for which the State holds direct or indirect responsibility based on its obligations under international human rights law: (a) when they have committed crimes or legal offences; (b) when they have been detained because of their migration status; and (c) when they are under the control and supervision of certain institutions or caregiving arrangements, including those provided through legal guardianship by family members.[22]

20. In the context of international humanitarian law, the concept of deprivation of liberty that the International Committee of the Red Cross (ICRC) uses to guide its work is likewise broad and consistent with the Subcommittee's approach.[23] ICRC defines detention as "custodial deprivation of liberty", which "refers to the deprivation of liberty caused by the act of confining a person in a narrowly bounded place, under the control or with the consent of a State, or, in non-international armed conflicts, a non-State actor".[24]

21. A comprehensive approach to the definition of the term "places of deprivation of liberty" has also been adopted by regional human rights mechanisms. The European Court of Human Rights has held that deprivation of liberty is not confined to detention following arrest or conviction, but may take numerous other forms,[25] including being held in psychiatric or social care institutions,[26] being taken by paramedics and police officers to hospital,[27] confinement in airport transit zones,[28] confinement in land border transit zones,[29] placement in a police car to draw up an administrative offence report,[30] stops and searches by the police,[31] not being permitted to leave during a house search,[32] house arrest[33] and holding migrants in reception facilities and on ships[34] and asylum "hotspot" facilities.[35] The Court

[21] Opinion No. 22/2020, paras. 62–65. See also A/HRC/42/39, para. 54; and A/HRC/45/16, annex II, para. 8.

[22] A/HRC/51/27, paras. 11 and 12.

[23] Optional Protocol, art. 32.

[24] ICRC, "Detention", A to Z glossary. Available at https://casebook.icrc.org/a_to_z.

[25] *Guzzardi v. Italy*, Application No. 7367/76, Judgment, 6 November 1980, para. 95.

[26] See *De Wilde,* Ooms *and Versyp v. Belgium*, Applications No. 2832/66, 2835/66 and 2899/66, Judgment, 18 June 1971; *H.L. v. the United Kingdom*, Application No. 45508/99, Judgment, 5 October 2004; *Storck v. Germany*, Application No. 61603/00, Judgment, 16 June 2005; *A. and Others v. Bulgaria*, Application No. 51776/08, Judgment, 29 November 2011; and *Stanev v. Bulgaria*, Application No. 36760/06, Judgment, 17 January 2012.

[27] See *Aftanache v. Romania*, Application No. 999/19, Judgment, 26 August 2020.

[28] See *Z.A. and Others v. Russia*, Applications No. 61411/15, 61420/15, 61427/15 and 3028/16, Judgment, 21 November 2019; *Amuur v. France*, Application No. 19776/92, Judgment, 25 June 1996; *Shamsa v. Poland*, Applications No. 45355/99 and 45357/99, Judgment, 27 February 2022; and *Riad and Idiab v. Belgium*, Applications No. 29787/03 and 29810/03, Judgment, 24 April 2008.

[29] See *R.R. and Others v. Hungary*, Application No. 36037/17, Judgment, 5 July 2021.

[30] See *Zelčs v. Latvia*, Application No. 65367/16, Judgment, 20 June 2020.

[31] See *Foka v. Turkey*, Application No. 28940/95, Judgment, 26 January 2009; *Gillan and Quinton v. the United Kingdom*, Application No. 4158/05, Judgment, 28 June 2010; and *Shimovolos v. Russia*, Application No. 30194/09, Judgment, 28 November 2011.

[32] See *Stănculeanu v. Romania*, Application No. 26990/15, Judgment, 28 May 2018.

[33] See *Buzadji v. the Republic of Moldova*, Application No. 23755/07, Judgment, 5 July 2016; *Mancini v. Italy*, Application No. 44955/98, Judgment, 2 August 2001; *Lavents v. Latvia*, Application No. 58442/00, Judgment 28 November 2003; *Nikolova v. Bulgaria (No. 2)*, Application No. 40896/98, Judgment, 30 December 2004; and *Dacosta Silva v. Spain*, Application No. 69966/01, Judgment, 2 February 2007.

[34] See *Khlaifia and Others v. Italy*, Application No. 16483/12, Judgment, 15 December 2016.

[35] See *J.R. and Others v. Greece*, Application No. 22696/16, Judgment, 28 May 2018.

has also emphasized that it adopts an autonomous interpretation of "deprivation of liberty" and is not bound by the terms of national legislation.[36]

22. Under the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, visits may be organized to various places where persons are deprived of their liberty, whatever the reasons for that deprivation of liberty, and the Convention is applicable to all such places. This includes places where persons are held in custody, imprisoned because of conviction for an offence, held in administrative detention or interned for medical reasons, or where minors are detained by a public authority, including by military authorities.[37]

23. The Inter-American Court of Human Rights has utilized the term "deprivation of liberty" instead of "detention" because it considers it more inclusive in interpreting the right to personal liberty under the American Convention on Human Rights. It has also adopted a broad approach, in keeping with the development of international human rights law and autonomous from the provisions of national legislation. Thus, the Court has established that the particular element that allows a measure to be identified as one that deprives persons of liberty is the fact that they cannot or are unable to leave or abandon at will the place or establishment in which they have been placed.[38]

24. Consistent with this approach, the Inter-American Commission of Human Rights has defined deprivation of liberty as referring to public or private institutions and has clarified that this category of persons includes "not only those deprived of their liberty because of crimes or infringements or non-compliance with the law, whether they are accused or convicted, but also those persons who are under the custody and supervision of certain institutions, such as: psychiatric hospitals and other establishments for persons with physical, mental, or sensory disabilities; institutions for children and the elderly; centres for migrants, refugees, asylum or refugee status seekers, stateless and undocumented persons; and any other similar institution the purpose of which is to deprive persons of their liberty".[39]

25. Similarly, within the African system of human rights, both the African Court on Human and Peoples' Rights and the African Commission on Human and Peoples' Rights interpret the provisions of the African Charter of Human and Peoples' Rights to encompass the broad approach to deprivation of liberty, underscoring that it may occur in different forms.[40] The African Commission on Human and Peoples' Rights understands the right to liberty as the "right to be free": "Liberty thus denotes freedom from restraint – the ability to do as one pleases, provided it is done in accordance with established law."[41]

26. Lastly, the International Court of Justice, the principal judicial organ of the United Nations, has also made it clear that deprivation of liberty can take place in various forms and can occur in various places.[42]

[36] *Khlaifia and Others v. Italy*, para. 71; and *Krupko and Others v. Russia*, Application No. 26587/07, Judgment, 26 June 2014, para. 37.

[37] Council of Europe, "Explanatory report to the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment", European Treaty Series, No. 126, para. 30.

[38] Advisory Opinion OC-21/14 on the Rights and Guarantees of Children in the Context of Migration and/or in Need of International Protection, 19 August 2014, para. 145.

[39] Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas, general provision.

[40] See, for example, African Court on Human and Peoples' Rights, *African Commission on Human and Peoples' Rights v. Libya*, Application No. 002/2013, Judgment, 3 June 2016, paras. 78 ff.

[41] *Sudan Human Rights Organisation & Centre on Housing Rights and Evictions (COHRE) v. Sudan*, Communication No. 279/03-296/05, 27 May 2009, para. 172.

[42] *Ahmadou Sadio Diallo (Republic of Guinea v. Democratic Republic of the Congo)*, *Merits*, *Judgment*, *I.C.J. Reports 2010*, p. 639.

III. Constitutive elements of article 4

A. Public or private custodial setting

27. Article 4 (2) of the Optional Protocol clearly stipulates that deprivation of liberty can occur in any location, be it a public or a private custodial setting. Consequently, the mandates of national preventive mechanisms and the Subcommittee extend to places beyond prison settings and States parties must ensure access to any privately run institutions, be they criminal justice, administrative, health-care, social care or other settings. Any other approach, limiting the mandate of national preventive mechanisms and of the Subcommittee to public custodial settings only, is contrary to article 4.

28. Moreover, while some institutions may be run by State authorities, many others may be private institutions, institutions whose operation has been outsourced or delegated to private actors and/or institutions run by non-State actors. In all such cases, the State remains responsible for the way in which such contractors carry out that delegation and it cannot absolve itself of the responsibility for how the private companies or other entities run such facilities, given that a duty of care is owed by the State to those deprived of their liberty.[43] This includes a duty to allow preventive visits to any such facilities by national preventive mechanisms and the Subcommittee.

B. Jurisdiction or control

29. The physical location and status of a place of deprivation of liberty under international law are highly relevant for determining whether a place falls under the mandates of the Subcommittee and national preventive mechanisms. In this regard, the question may arise as to whether a place of deprivation of liberty has to fall simultaneously under both the jurisdiction of a State party and its effective control, or whether the exercise of either jurisdiction or control by a State party suffices to mean that it falls under the visiting mandate of the Subcommittee and the national preventive mechanisms.

30. There is a linguistic discrepancy in the wording of article 4 of the Optional Protocol among its six authentic texts: the English authentic text contains the phrase “any place under its jurisdiction and control”, while the French authentic text reads “*tout lieu placé sous sa juridiction ou sous son contrôle*” – meaning “any place under its jurisdiction or control”. The discrepancy cannot be resolved by prioritizing a literal interpretation of one version over the others, given that, in accordance with article 33 of the Vienna Convention on the Law of Treaties, all six versions of the Optional Protocol are equally authoritative.

31. Having regard to article 31 of the Vienna Convention on the Law of Treaties[44] and therefore to the object and the purpose of the Optional Protocol and international obligations to prevent torture and other cruel, inhuman or degrading treatment or punishment, the interpretation that maximizes the preventive impact of the work of national preventive mechanisms and the Subcommittee should be applied: article 4 of the Optional Protocol should therefore be read as “jurisdiction or control”. Any other interpretation would lead to unacceptable “grey areas” that cannot be reconciled with the absolute and non-derogable prohibition of torture and cruel, inhuman or degrading treatment or punishment in international law.

32. Consequently, in the Subcommittee’s guidelines on national preventive mechanisms, it is emphasized that the State should allow the national preventive mechanism to visit all, and any suspected, places of deprivation of liberty that are within its jurisdiction. For those purposes, the jurisdiction of the State extends to all those places over which it exercises effective control.[45]

[43] See also Working Group on Arbitrary Detention, revised deliberation No. 5 (A/HRC/39/45, annex), para. 46.

[44] See paragraph 10 above.

[45] CAT/OP/12/5, para. 24.

33. This interpretation is consistent with that of other treaty bodies. In particular, the Committee against Torture has stated that article 2 of the Convention against Torture requires that each State party take effective measures to prevent acts of torture in any territory under its jurisdiction. The Committee has recognized that "any territory" includes all areas where the State party exercises, directly or indirectly, in whole or in part, de jure or de facto effective control, in accordance with international law. The reference to "any territory" refers to prohibited acts committed not only on board a ship or aircraft registered in a State party, but also during military occupation or peacekeeping operations and in such places as embassies, military bases, detention facilities and other areas over which a State exercises factual or effective control. The Committee considers that the scope of "territory" under article 2 must also include situations where a State party exercises, directly or indirectly, de facto or de jure control over persons in detention.[46] The implementation of the Optional Protocol, and specifically the preventive visits undertaken by the mechanisms established pursuant to it, constitute an effective preventive measure that States parties to the Convention against Torture are obliged to undertake, in accordance with articles 2 (1) and 16 (1) of that Convention.

34. Equally, the Human Rights Committee, the Committee on the Rights of the Child and the Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families all hold that States parties' obligations under the respective treaties encompass everyone who may be in a State party's territory, under its jurisdiction or within its power or effective control, even if not situated within its territory.[47]

35. The practical relevance for the mechanisms established under the Optional Protocol arises in particular in situations where parts of a State party's territory are occupied by another State or under the control of non-State actors; where States "outsource" detention or "lease" facilities for detention (e.g. prisons, immigration detention facilities and military bases where deprivation of liberty might take place, including in the context of peacekeeping and peace-enforcement operations) on the territory of another State; during involuntary removals (extradition, expulsion, deportation, etc.) by aircraft, boat or similar; and in cases where States declare certain parts of their territory as "international zones".

36. In practice, the Subcommittee has visited and continues to endeavour to visit places of deprivation of liberty within the jurisdiction of a State party but not under its effective control, and vice versa. Likewise, the practice of other international and regional mechanisms mandated to visit places of deprivation of liberty with a view to preventing torture and other forms of ill-treatment demonstrates that, even if a territory is not under the effective control of a State, it may still fall within its jurisdiction and therefore within the mandate of the mechanism.[48]

37. The Subcommittee, in a compilation of advice in response to requests from national preventive mechanisms published in its ninth annual report, set out the practical details for implementation of the Optional Protocol in cross-border situations, such as the leasing by a State party of prisons or immigration detention facilities located on the territory of another State.[49] The Subcommittee has established that the sending State should ensure that its national preventive mechanism has the legal and practical capacity to visit persons deprived of their liberty in such settings, in accordance with the provisions of the Optional Protocol. After undertaking such visits, the national preventive mechanism of the sending State should be able to present its recommendations and enter into a dialogue with the authorities of both

[46] Committee against Torture, general comment No. 2 (2007), para. 16.

[47] Human Rights Committee, general comment No. 31 (2004), para. 10; and joint general comment No. 3 of the Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families/No. 22 of the Committee on the Rights of the Child (2017), para. 12.

[48] See E/CN.4/2006/6/Add.3; A/HRC/10/44/Add.3; Council of Europe, "Report on the visit to the Transnistrian region of the Republic of Moldova carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment from 27 to 30 November 2000" (CPT/Inf (2002) 35); and Council of Europe, "Report to the Governments of Belgium and the Netherlands on the visit to Tilburg Prison carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment from 17 to 19 October 2011" (CPT/Inf (2012) 19).

[49] CAT/C/57/4 and CAT/C/57/4/Corr.1, annex, paras. 26–31.

the sending and the receiving States. Moreover, if the receiving State is a party to the Optional Protocol, its national preventive mechanism should have the right to visit the place of deprivation of liberty and present its recommendations to both the sending and the receiving authorities. In other words, in cross-border situations involving two States parties to the Optional Protocol, the onus is on both parties to facilitate effective preventive visits by their national preventive mechanisms and by the Subcommittee.

38. It is not inconceivable that the mechanisms of the Optional Protocol will face limits to their ability in practice to visit places where de facto control is exercised by non-State actors, such as armed insurgent groups, or States that are not parties to the Optional Protocol. However, a State party is still obliged to do everything in its power – for example, through bilateral agreements – to facilitate access by the bodies established under the Optional Protocol to places of deprivation of liberty that are outside its effective control. Lastly, States parties cannot in good faith circumvent their obligations under the Optional Protocol to allow visits by deliberately outsourcing deprivation of liberty onto the territory of third States or to international zones, as this would undermine the object and purpose of the Optional Protocol.

39. In this context, it is recalled that article 29 of the Optional Protocol requires that its provisions extend to all parts of federal States without any limitations or exceptions. The Subcommittee emphasizes that all places of deprivation of liberty fall under article 4 of the Optional Protocol, irrespective of whether they are run by federal, state or provincial authorities or are within the jurisdiction or under the control of such authorities acting jointly and irrespective of any domestic regulations adopted in this regard.

C. In which persons are or may be deprived of their liberty

40. Article 4 of the Optional Protocol refers to any place where persons are or may be deprived of their liberty. This is not limited to the conventional view taken of the term “places of deprivation of liberty”, but should be understood comprehensively, in accordance with the object and purpose of the Optional Protocol, to mean any place, facility or setting in which individuals already are or potentially may be deprived of their liberty.

41. The Subcommittee has been unwavering in its view that, in order to properly discharge fulfil their obligations under the Optional Protocol, States parties must allow national preventive mechanisms and the Subcommittee access to any place where persons are, or in their opinion may be, deprived of their liberty.[50] It is therefore imperative that States parties not only allow both the Subcommittee and national preventive mechanisms full access to any places, facilities or settings in which individuals currently are, previously were or potentially may be deprived of their liberty but also ensure the autonomy of the Subcommittee and the mechanisms to decide which places to visit. Such factors as the duration of the deprivation of liberty, the nature of the facility and the status accorded to it in the domestic legal system are irrelevant for the determination of whether a place constitutes a place of deprivation of liberty.

D. In which persons are not permitted to leave

42. The factual element of a person not being “permitted to leave at will” a place, facility or setting is a key consideration of article 4 of the Optional Protocol. Indeed, the deciding factor for the qualification of any place, facility or setting as a place of deprivation of liberty is not the name or title given to it or its categorization in national legislation but whether individuals are free to leave it at will.[51]

43. In this regard, the Subcommittee wishes to emphasize that, in some cases, an individual might be in a place that does not seem to constitute a place of deprivation of liberty but, when examined in the full context of an individual case, does indeed constitute such a place.

[50] CAT/OP/MEX/2, para. 13.
[51] A/HRC/36/37, para. 56; and A/HRC/37/50, para. 17.

44. Similarly, an individual may be free to leave a place, facility or setting at will but may be unable to exercise that freedom for physical, medical, economic or other reasons, and is therefore compelled to remain. This creates a situation where, despite a theoretical right to leave at will, a person is unable to leave in practice. In certain places, facilities or settings, individuals' inability to leave may be coupled with a high degree of vulnerability. This is particularly evident in respect of persons in situations of vulnerability, including children, women, survivors of trauma, older persons and persons with disabilities.

45. Consequently, whether a particular fact or circumstance may be taken to be a deprivation of liberty depends not only on whether the person in question has a de jure right to leave, but also on whether the person is able to exercise that right de facto and is able to do so without being exposed to serious human rights violations.[52] Therefore, if the ability to leave such a place, facility or setting would be somehow limited or expose a person to serious human rights violations, that place, facility or setting should also be understood as a place of deprivation of liberty within the meaning of article 4 of the Optional Protocol.

E. By virtue of an order given by a public authority or at its instigation or with its consent or acquiescence

46. Under article 4 (1) of the Optional Protocol, States parties must allow visits to any place under its jurisdiction or control where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence. The Subcommittee has stated that any place in which persons are or may be deprived of their liberty should fall within the scope of the Optional Protocol, provided that such deprivation of liberty relates to a situation in which the State exercises or might be expected to exercise a regulatory function.[53]

47. Deprivation of liberty that arises from an order given by a public authority concerns places where individuals are or may be deprived of their liberty and a State exercises or may exercise its regulatory or institutional function with regard to that place. That function may occur through a specific decision or order, often originating in the criminal justice system. However, it can also result from decisions made by other State bodies, such as administrative or judicial or quasi-judicial authorities. Deprivation of liberty that arises at a State's instigation or with its consent or acquiescence encompasses a broader spectrum of scenarios wherein the State might be expected to exercise a regulatory function and uses its powers to promote, accept or allow deprivation of liberty.

48. "Instigation" must be understood in its literal sense, namely, as synonymous with "incitement", "stimulation", "inducement", "solicitation", "incentive" or "encouragement". In other words, the authority participates or is involved in the origin of the decision to deprive a person of liberty. Instigation implies using the State's powers to promote or in any other way aim at causing the deprivation of liberty of an individual. Instigation of the deprivation of liberty of individuals may be undertaken by various actions of State officials and could include media or public statements or any other forms of expression that could be understood as instigating a person, a group of persons or a legal entity to deprive an individual of liberty.

49. Consent and acquiescence concern situations in which State authorities are or should have been aware of the deprivation of liberty but fail to take any actions aimed at preventing or ending it, with consent referring to deprivation of liberty that has been expressly agreed to, and acquiescence referring to tacit consent. In the context of the Optional Protocol, acquiescence may concern situations in which the State tolerates, allows or in any other form chooses to turn a blind eye to deprivation of liberty caused by any other entity or person, allowing the specific situation of deprivation of liberty to take place and not exercising the powers of the authority to prevent, disallow or end it. States are accountable for the actions of both their public officials and private persons or non-State actors if the State, in any way, consents to those actions, either expressly or tacitly. The fact that States may choose not to undertake any actions aimed at preventing or ending such deprivation of liberty or that they

[52] A/HRC/43/49, para. 65; and Working Group on Arbitrary Detention, opinion No. 22/2020, para. 69.
[53] CAT/OP/MEX/2, para. 13.

may in any other way allow the existence of places of deprivation of liberty outside their authority does not exclude such places from the mandate of the Subcommittee and national preventive mechanisms.

50. The Subcommittee is mindful of the various traditional forms of justice and treatment prevalent globally that lead or may lead to individuals being deprived of their liberty. In some jurisdictions, traditional forms of justice and treatment, as well as other customary settings, exist alongside the formal legal system and its institutions, with the national legislation explicitly enabling their operation in parallel. In other countries, traditional forms of justice and treatment, as well as various other forms and places of deprivation of liberty, are not designated by national legislation, but nevertheless deprive persons of their liberty in practice. The Subcommittee recalls that all such situations fall within the remit of article 4 of the Optional Protocol through the obligation of the State party to allow visits to any place where a person is or may be deprived of liberty with the consent or acquiescence of a public authority.

IV. Practical implementation of article 4

A. Places of deprivation of liberty visited by the Subcommittee and national preventive mechanisms

51. Neither article 4 of the Optional Protocol nor the Subcommittee, in its practice, provides an exhaustive list of places of deprivation of liberty. It is not the Subcommittee's intention to provide such a list in the present general comment, as that would be restrictive and thus contradict the Optional Protocol. Indeed, throughout the discharge of its mandate, the Subcommittee has established that places and forms of deprivation of liberty include not only prisons and police stations, but also situations of house arrest, closed centres for foreigners and asylum-seekers, centres for children, social care homes, hospital and psychiatric institutions, facilities for military personnel (or detention centres under military jurisdiction),[54] clandestine clinics that "treat" homosexuality[55] and places of compulsory quarantine and isolation.[56] Special boarding or religious schools may also constitute places of deprivation of liberty.[57] For example, the Subcommittee has visited *daaras*[58] because it considers that they are places where persons (in particular young children) are or could be deprived of their liberty, with the tacit consent of the State party.[59] The Subcommittee has also clearly stated in its visit reports that periods of deprivation of liberty during apprehension, transfer and removal are covered by the Optional Protocol.[60]

52. There is convergence in the current practice of national preventive mechanisms regarding a wide, purposeful and effective interpretation of the term "place of deprivation of liberty". Even in cases where national laws include non-exhaustive lists, national preventive mechanisms have generally gone beyond the listed facilities and visited other settings as part of their regular visiting programme. National preventive mechanisms have highlighted to the Subcommittee the need to ensure their access to all places of deprivation of liberty, whether public or private, non-profit or for-profit, and civil or military. They can include places where persons of any age are held on the orders, at the instigation or with the consent of a public authority, for a variety of reasons, such as being in conflict with the law or for protection, humanitarian or educational reasons. Persons held in places of deprivation of liberty can be there for any period of time, including very short periods, even in transit, and the place itself can be any type of facility and on land, at sea or in the air. Persons held in such places may have entered voluntarily or involuntarily. Deprivation of liberty can also take place when persons are arrested by police on public roads or by private guards in shopping malls, for

[54] CAT/OP/KGZ/2, para. 40. See also CAT/OP/NLD/1, para. 45.
[55] CAT/OP/ECU/2, para. 51.
[56] See CAT/OP/9.
[57] CAT/OP/KGZ/2, para. 40.
[58] *Daara* is the name used in some countries to designate traditional Qur'anic schools.
[59] CAT/OP/SEN/RONPM/1, paras. 30 and 31.
[60] CAT/OP/NLD/1, paras. 42 and 45.

example. Other places where persons may be de facto deprived of their liberty, such as privately owned or rented housing for persons with intellectual disabilities, owing to restrictions imposed by specific service providers, are also included within the scope of article 4.

53. The Subcommittee welcomes the practice of many national preventive mechanisms reflecting a comprehensive understanding of the definition of places of deprivation of liberty, in compliance with the Optional Protocol. While emphasizing that article 4 of the Optional Protocol does not call for any type of exhaustive list, the following are illustrative examples of some of the places that national preventive mechanisms around the world have visited and should continue to visit as part of their obligations under the Optional Protocol: adult prisons; pretrial detention centres; juvenile or socioeducational detention centres; police or other law enforcement units; mental health facilities; nursing homes; orphanages; residences for children and adolescents without parental care or who have suffered neglect or abuse; centres for persons with disabilities; migrant detention centres, such as first reception centres for adults and unaccompanied children and detention and removal centres for migrants; transit zones at international borders; military compounds; vehicles, ships and aeroplanes; coronavirus disease (COVID-19) hotels and other formal places of compulsory quarantine and isolation, or home confinement; rehabilitation and treatment centres for persons with drug use disorders; police training schools; State security service detention facilities; boarding schools and religious schools; public demonstrations; and any gatherings where police practices such as kettling[61] are or may be carried out.

54. The worldwide public health emergency in the context of the COVID-19 pandemic led to the widespread application of modern technologies that, for example, individuals were required to use in the context of compulsory quarantine. These had a direct impact on the right of such persons to personal liberty and, indeed, in some instances, led to them being deprived of their liberty. Similarly, the emergence of digital, non-physical spaces has made it possible to use digital environments for meting out treatment prohibited under articles 1 and 16 of the Convention against Torture.

55. Consequently, mindful of the wide variety of circumstances in which deprivation of liberty occurs or may occur, the Subcommittee underlines that the key element in deciding whether a place is or may be a place of deprivation of liberty is the status of the persons who are or may be deprived of their liberty rather than any official title accorded or description allocated by the national authorities and/or national legislation or others. In this regard, it is paramount that the autonomy and functional independence of the Subcommittee and national preventive mechanisms are fully ensured in practice to enable both to make a fully independent decision as to whether a particular place constitutes or may constitute a place of deprivation of liberty and therefore comes under their respective mandates.

B. Persons in situations of vulnerability

56. The Subcommittee is mindful of the various settings in which persons in situations of vulnerability, including children and adolescents, older persons, LGBTIQ+ persons, individuals with physical and psychosocial disabilities, Indigenous Peoples and people who use drugs, may be confined, unable to leave at will. Aside from such places as prisons and remand centres, there are specific settings where people are or may be deprived of their liberty, including but not limited to schools and institutions that engage in the care of children, military camps, social care facilities, institutions for persons with disabilities or for persons with drug or alcohol use disorders, drug use treatment centres, orphanages, children's homes, institutions for the educational supervision of children, psychiatric hospitals, mental health centres, shelters, hostels and migration detention centres. Moreover, in the case of children, there are settings in which they are or may be deprived of their liberty for reasons related to their, or their parents', migration status, regardless of the name and reason given to the child's deprivation of liberty, or the name of the facility or location where the child is deprived of

[61] Kettling is a police practice in which group of demonstrators or protesters are confined in a small space as a method of crowd control.

liberty. All such places fall under article 4 of the Optional Protocol and therefore under the mandate of the Subcommittee and national preventive mechanisms.

57. The Subcommittee notes that many persons with disabilities are presumed to be unable to live independently, or that support to live independently is not available or is tied to specific living arrangements.[62] Although there may be no legal or administrative order confining such persons to a certain facility, the lack of support compels them to remain in living situations that deprive them of their liberty and may subject them to harmful practices. This form of disability-specific deprivation of liberty can occur in family homes and in institutional arrangements, including social care institutions, psychiatric institutions, long-stay hospitals, nursing homes, secure dementia wards, special boarding schools, child welfare institutions, group homes, rehabilitation centres, forensic psychiatric settings, albinism hostels, leprosy colonies, religious communities, family-type homes for children and prayer camps.[63]

58. Therefore, when considering whether a particular place, facility or setting is a place of deprivation of liberty within the meaning of article 4 of the Optional Protocol, it is important that national preventive mechanisms and the Subcommittee ascertain the presence of reasonable accommodation arrangements and support for persons with disabilities. If reasonable accommodation and support are unavailable, the place, facility or setting should be considered a place of deprivation of liberty.

V. Obligations of States parties under article 4

59. With the present general comment, the Subcommittee is setting out authoritative guidance on the effective implementation of the Optional Protocol, aimed at clarifying the obligations of States parties and the mandates of the Subcommittee and national preventive mechanisms under article 4. In compliance with the Optional Protocol, the term “places of deprivation of liberty” must be understood as a comprehensive concept that encompasses all situations, as a result of the cumulative reading of the two paragraphs of article 4. Moreover, the concept of places of deprivation of liberty is not fixed or limited. It evolves with time, allowing for the inclusion of novel situations and circumstances of deprivation of liberty that may arise in new contexts. Equally, the inclusion of places where persons may be deprived of their liberty signifies the importance of the autonomous decision-making in this regard by the Subcommittee and national preventive mechanisms. Only with such an approach and effective application may the Optional Protocol fulfil its core objective of preventing torture and other cruel, inhuman or degrading treatment or punishment through visits by the Subcommittee and national preventive mechanisms to all places of deprivation of liberty.

[62] Committee on the Rights of Persons with Disabilities, general comment No. 5 (2017), para. 1.
[63] CRPD/C/5, paras. 15 and 18.

Appendix 3: Detailed budget modelling for the Office of the Tasmanian NPM 2025 – 2029

Office of the Tasmanian National Preventative Mechanism and Custodial Inspector Budget

Note: all expenses are CPI adjusted (source: IBISworld). New staff positions include on-costs in their year of commencement.

Expenses	2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	Assumptions/Notes
TOTAL	**$4,286,164.90**	**$4,260,307.41**	**$4,283,526.34**	**$ 4,306,784.66**	
JOINT OFFICE STAFF	**$1,019,282.15**	**$1,020,259.10**	**$1,020,923.49**	**$ 1,021,589.01**	These are staff are based in Hobart and will work across both offices. From 2025-2026, it includes the Head of Agency (SES 4), a Senior Community Liaison Officer (Band 6), a Senior Legislative & Policy Officer (Band 6), a Business Manager (Band 5). It also includes an Administrative Assistant (Band 5) based in Launceston.
Salaries and Wages	$763,522.30	$763,522.30	$763,522.30	$763,522.30	5 FTE (SES 4, two Band 5 and two Band 6), 2024-2025 salaries. Rates to be updated from 2025-2026 after scheduled PSUWA negotiations.
Salary Allowances	$-	$-	$-	$-	No salary allowances budgeted.
Higher Duty Allowance	$-	$-	$-	$-	No higher duty allowance budgeted.
Annual Leave	$58,732.48	$58,732.48	$58,732.48	$58,732.48	20 Days
Superannuation	$ 110,328.97	$110,328.97	$110,328.97	$110,328.97	13.95% rate for 2024-2025 as per information provided by the Office of the Ombudsman, 14.95% from 2025-2026, including the 0.5% superannuation increase.
Sick Leave	$29,366.24	$29,366.24	$29,366.24	$29,366.24	10 days
Other Employees Expenses	$38,176.12	$38,176.12	$38,176.12	$38,176.12	5% of salaries and wages to cover other on-costs.
Fringe Benefits Tax	$19,156.03	$20,132.98	$20,797.37	$21,462.89	Allowance in lieu of a motor vehicle. CPI adjusted. Source: Senior Executive Service and Equivalent Specialist Officers - Administrative Arrangements and Conditions of Service of the Tasmanian Government, September 2022
HOBART OFFICE OF THE TASMANIAN NPM	**$1,383,499.11**	**$1,326,228.83**	**$1,328,085.20**	**$1,329,944.72**	This comprises Tasmanian NPM staff based in Hobart. It includes the Director (Band 8), a Principal Monitoring Officer (Band 7), three Senior Monitoring Officers (Band 6), four Monitoring Officers (Band 5) and one Senior Research & Reporting Officer (Band 6). The figures also include consultant fees related to NPM monitoring activities, including those conducted with the Commission for Children and Young People.
Salaries and Wages	$969,532.11	$969,532.11	$969,532.11	$ 969,532.11	Rates to be updated from 2025-2026 after scheduled PSUWA negotiations.
Salary Allowances	$ -	$-	$-	$-	No salary allowances budgeted.
Higher Duty Allowance	$ -	$-	$-	$-	No higher duty allowance budgeted.
Annual Leave	$74,579.39	$74,579.39	$74,579.39	$74,579.39	20 Days
Superannuation	$140,097.39	$140,097.39	$140,097.39	$140,097.39	13.95% rate for 2024-2025 as per information provided by the Office of the Ombudsman, 14.95% from 2025-2026, including the 0.5% superannuation increase.
Sick Leave	$37,289.70	$37,289.70	$37,289.70	$37,289.70	10 days
Other Employees Expenses	$48,476.61	$48,476.61	$48,476.61	$48,476.61	5% of salaries and wages to cover other on-costs.
Other Consultants Fees	$111,900.00	$54,546.90	$56,346.95	$58,150.05	$100,000 budget to support the visiting function of the NPM Office, including the NPM functions delivered by the Commission for Children and Young People Delegation, CPI adjusted. Additional budget for the following activities, which are part of the Tasmanian NPM Implementation Roadmap:

					development and implementation of ICT strategy (2024-25) and strategic review and definition of governance and outcomes measures (2025-2026).
Fringe Benefits Tax	$1,623.92	$1,706.73	$1,763.06	$1,819.47	Car park costs for office staff. CPI adjusted.
LAUNCESTON OFFICE OF THE TASMANIAN NPM	**$597,458.23**	**$597,499.64**	**$597,527.81**	**$597,556.01**	This comprises Tasmanian NPM staff based in Launceston. It includes two Senior Monitoring Officers (Band 6) a two Senior Monitoring Officers (Band 5)
Salaries and Wages	$455,495.29	$455,495.29	$455,495.29	$455,495.29	Rates to be updated from 2025-2026 after scheduled PSUWA negotiations.
Salary Allowances	$-	$-	$-	$-	No salary allowances budgeted.
Higher Duty Allowance	$-	$-	$-	$-	No higher duty allowance budgeted.
Annual Leave	$35,038.10	$35,038.10	$35,038.10	$35,038.10	20 Days
Superannuation	$65,819.07	$65,819.07	$65,819.07	$65,819.07	13.95% rate for 2024-2025 as per information provided by the Office of the Ombudsman, 14.95% from 2025-2026, including the 0.5% superannuation increase.
Sick Leave	$17,519.05	$17,519.05	$17,519.05	$17,519.05	10 days
Other Employees Expenses	$22,774.76	$22,774.76	$22,774.76	$22,774.76	5% of salaries and wages to cover other on-costs.
Other Consultants Fees	$-	$-	$-	$-	Consultancy budget fully allocated to the Office of the Tasmanian NPM
Fringe Benefits Tax	$811.96	$853.37	$881.53	$909.74	Car park costs for office staff. CPI adjusted.
OFFICE OF THE TASMANIAN NPM - COMMISSION FOR CHILDREN AND YOUNG PEOPLE DELEGATION	**$613,273.52**	**$613,273.52**	**$ 613,273.52**	**$613,273.52**	This comprises Tasmanian NPM jurisdiction staff that will be engaged by the Commission for Children and Young People to exercise Tasmanian NPM functions (under delegated authority) related to children and young people. The staff includes a Senior Monitoring Officer (Band 6) and a Monitoring Officer (Band 5) based in Hobart and a Principal Monitoring Officer (Band 7) and a Monitoring Officer (Band 5) based in Launceston. Funding for these positions will be distributed by the Tasmanian NPM to the Commission in accordance with a documented delegation of authority and joint process agreement.
Salaries and Wages	$ 468,188.96	$468,188.96	$ 468,188.96	$468,188.96	4 FTE (two Band 5, one Band 6 and one Band 7). Rates to be updated from 2025-2026 after scheduled PSUWA negotiations.
Salary Allowances	$-	$-	$-	$-	No salary allowances budgeted.
Higher Duty Allowance	$-	$-	$-	$-	No higher duty allowance budgeted.
Annual Leave	$36,014.54	$36,014.54	$36,014.54	$36,014.54	20 Days
Superannuation	$67,653.30	$67,653.30	$67,653.30	$67,653.30	13.95% rate for 2024-2025 as per information provided by the Office of the Ombudsman, 14.95% from 2025-2026, including the 0.5% superannuation increase.
Sick Leave	$18,007.27	$18,007.27	$18,007.27	$18,007.27	10 Days
Other Employees Expenses	$23,409.45	$23,409.45	$23,409.45	$23,409.45	5% of salaries and wages to cover other on-costs.
Other Consultants Fees	$-	$-	$-	$ -	Consultancy budget fully allocated to the Office of the Tasmanian NPM from 2025-2026

OFFICE OF THE CUSTODIAL INSPECTOR	**$739,909.43**	**$743,305.04**	**$745,614.25**	**$747,927.38**	This comprises Custodial Inspector jurisdiction staff. It includes the Office Director (Band 8), a Principal Inspection Officer (Band 7), a Senior Inspection Officer (Band 6), and an Administration and Research Officer (Band 5). The figures also include expert by experience consultant fees required to undertake Custodial Inspector monitoring activities.
Salaries and Wages	$514,036.82	$514,036.82	$514,036.82	$514,036.82	4 FTE (Band 5, Band 6, Band 7 and Band 8). Rates to be updated from 2025-2026 after scheduled PSUWA negotiations.
Salary Allowances	$-	$-	$-	$-	No salary allowances budgeted.
Higher Duty Allowance	$-	$-	$-	$-	No higher duty allowance budgeted.
Annual Leave	$39,541.29	$39,541.29	$39,541.29	$39,541.29	20 Days
Superannuation	$74,278.32	$74,278.32	$74,278.32	$74,278.32	13.95% rate for 2024-2025 as per information provided by the Office of the Ombudsman, 14.95% from 2025-2026, including the 0.5% superannuation increase.
Sick Leave	$19,770.65	$19,770.65	$19,770.65	$19,770.65	10 Days
Other Employees Expenses	$25,701.84	$25,701.84	$25,701.84	$25,701.84	5% of salaries and wages to cover other on-costs.
Consultants Expenses	$64,956.60	$68,269.39	$70,522.28	$72,778.99	CI budget 2023-2024. CPI adjusted.
Fringe Benefits Tax	$1,623.92	$1,706.73	$1,763.06	$1,819.47	Car park costs for office staff. CPI adjusted.
SHARED EXPENSES - BUSINESS ENABLEMENT	**$530,200.69**	**$557,240.93**	**$575,629.88**	**$594,050.03**	
Motor Vehicle Leases	$28,580.90	$30,038.53	$31,029.80	$32,022.76	Two vehicles leased from FY24/25 onwards: one for NPM, one for Custodial Inspector Estimated cost (myfleet.lease for small/medium car, $30,000 purchase price, 20,000 annual km, 48 months term. Quote obtained on 27/06/24. Additional vehicle included from FY25/26 for the Launceston office. CPI adjusted.
Motor Vehicle Oils & Lubricants	$1,623.92	$1,706.73	$1,763.06	$1,819.47	$500 per car, as per CI and NPM assumptions. CPI adjusted.
Motor Vehicle parking	$23,579.25	$24,781.79	$25,599.59	$26,418.77	Account: 52514 Car parking. CI budget assumption of $7,260 per car (2023-2024). CPI adjusted.
Part Day Travel - Meal Allowance	$8,072.51	$8,484.20	$8,764.18	$9,044.64	NPM budget, increased by 50% to cover the NPM Launceston Office. CPI adjusted.
Interstate Actual Travel Costs (Hotels etc)	$31,926.01	$33,554.24	$34,661.53	$35,770.70	Consolidated budget (CI+NPM). Budget increased by 50% to cover the NPM Launceston Office. CPI adjusted.
Interstate Incidental Expenses (Overnight Stay)	$446.04	$468.78	$484.25	$499.75	CI budget. CPI adjusted.
Intrastate Actual Travel Costs (Hotels etc)	$19,766.18	$20,774.26	$21,459.81	$22,146.52	Consolidated budget (CI+NPM). Budget increased by 50% to cover the NPM Launceston Office. CPI adjusted.
Intrastate Other Travel Expenses	$17,321.76	$18,205.17	$18,805.94	$19,407.73	CI budget. CPI adjusted.
Voice (VOIP) – Calls and usage charges	$6,766.31	$7,111.39	$7,346.07	$7,581.14	Consolidated budget (CI+NPM). CPI adjusted.
Entertainment					No entertainment budgeted.

Service Level Agreement Services	$52,708.66	$55,396.81	$57,224.90	$59,056.10	Corporate services to be outsourced. CPI assumption of $2,213.03 per staff (2023-2024), updated as per the new number of staff (12 in 2024-2025 and 22 from 2025-2026). CPI adjusted.
Electricity	$10,508.61	$11,044.55	$11,409.02	$11,774.11	Avg electricity bill for small business in Tas, CPI adjusted.
Insurance	$7,563.58	$7,949.32	$8,211.65	$8,474.42	Account: 52852 Insurance Other. Consolidated budget (CI+NPM). CPI adjusted.
Plant and Equipment Maintenance	$1,497.25	$1,573.61	$1,625.54	$1,677.56	Consolidated budget (CI+NPM). CPI adjusted.
Telephone & Internet	$7,928.09	$8,332.43	$8,607.40	$8,882.83	NPM budget assumption of $110 (2021-2022) for an office of 4 staff (2023-2024), updated as per the new number of staff (12 in 2024-2025 and 22 from 2025-2026). CPI adjusted.
Other Printing/Binding	$2,164.35	$2,274.74	$2,349.80	$2,425.00	Consolidated budget (CI+NPM). CPI adjusted.
Office requisites	$2,638.86	$2,773.44	$2,864.97	$2,956.65	CI budget assumption of $500 for an office of 4 staff (2023-2024), updated as per the new number of staff (12 in 2024-2025 and 13 from 2025-2026). CPI adjusted.
Office rent	$51,697.76	$54,334.35	$56,127.38	$57,923.46	120sqm office, average price for Hobart, accessed in Dec/23 and 30sqm office, average price for Launceston. CPI adjusted from 2025-2026. 10sqm per staff member
Cleaning products	$243.59	$256.01	$264.46	$272.92	Increased by 50% from 2025-2026 to cover the Launceston Office. CPI adjusted.
Software and Licences	$5,259.43	$5,527.66	$5,710.08	$5,892.80	Consolidated budget (CI+NPM). CPI adjusted.
Computer Leases	$129,913.20	$136,538.77	$141,044.55	$145,557.98	CI budget assumption of $5000 per staff, updated as per the new number of staff (12 in 2024-2025 and 16 from 2025-2026). CPI adjusted.
Other Computers / IT	$-	$-	$-	$-	Other Computers/IT budget incorporated into Computer Leases budget.
Marketing and Communications	$8,344.55	$8,770.12	$9,059.53	$9,349.44	NPM budget, includes development of marketing and communication plans and collateral for marketing purposes ($125 per hour, 50 hours per year. Includes 52820 Graphic Design and 52342 Publications. CPI adjusted from 2024-2025)
Public Relations	$4,181.62	$4,394.88	$4,539.91	$4,685.19	NPM budget, CPI adjusted.
Memberships and Affiliations	$-	$-	$-	$-	No memberships and affilliations budgeted.
Miscellaneous	$48,200.06	$50,658.27	$52,329.99	$54,004.55	Increased miscellaneous budget in FY2024-2025 and 2025-2026 to support the establishment of the Offices of the Tasmanian NPM. Budget for 2026-2027 and 2027-2028 contingency calculated as 10% of Shared Expenses Budget (except miscellaneous).
Training	$49,800.06	$52,339.86	$54,067.08	$55,797.23	Consolidated budget (CI+NPM]). CPI adjusted.
Security	$1,759.24	$1,848.96	$1,909.98	$1,971.10	CI budget assumption of $250 for an office of 4 staff (2023-2024), updated as per the new number of staff (12 in 2024-2025 and 16 from 2025-2026). CPI adjusted.
External Audit fees	$4,190.41	$4,404.12	$4,549.45	$4,695.04	CI budget assumption of $1,935.53 (2023-2024), increased by 100% to cover the NPM Offices. No financial audit fees budgeted for the Offices of the Tasmanian NPM, as the Audit will be undertaken by the Tasmanian Audit Office. CPI adjusted.
Workers' Compensation Insurance Premium	$-	$-	$-	$-	Not budgeted separately as it is part of the the scope of the DoJ SLA for Corporate Services.
Occupational Health and Safety Advice	$3,518.48	$3,697.93	$3,819.96	$3,942.20	CI budget assumption of $500 for an office of 4 staff (2023-2024), updated as per the new number of staff (12 in 2024-2025 and 22 from 2025-2026). CPI adjusted.

Appendix 4: Service provider survey example

SAMPLE AGED RESIDENTIAL CARE SERVICE PROVIDER SURVEY

Understanding Care Environments and Consumer Demographics

Please complete this survey to help the Tasmanian National Preventive Mechanism better understand the care environment and the demographics of consumers served in your facility. Your insights are valuable in shaping our efforts to ensure compliance with human rights obligations and to prevent the deprivation of liberty.

The United Nations Subcommittee on the Prevention of Torture defines deprivation of liberty as any situation where a person is unable to leave a particular setting at will. This can include circumstances where restrictive practices are applied, such as restraints or locked wards, making it difficult for the person to freely leave.

To help us understand your facility better, please confirm if your facility fits this definition of deprivation of liberty. If your facility does fit this definition, you will be asked further questions about your services and the people you care for.

Does your facility involve any circumstances where people cannot freely leave at will?

- **Yes**
- **No**

Section 1: Provider and Facility Information

1. **What is the facility name?** [Text Entry]

2. **Where is the facility address?** [Text Entry]

3. **What type of facility do you operate?**
   - Aged Care
   - Disability Support
   - Both

   Other (Please specify): [Text Entry]

4. **Please indicate the types of services your facility provides by checking all that apply:**
   - General aged care
   - Respite care
   - Dementia care
   - Palliative care
   - Home care
   - Specialised medical units (e.g., stroke units, diabetes care)
   - Specialised units (e.g., dementia wards)
   - Sub-acute care
   - Disability support (specify types of disabilities)
   - Rehabilitation services
   - Transitional care

- Day programs

Mental health services

- Individual counselling and psychotherapy
- Group therapy sessions
- Behavioural support and intervention
- Crisis intervention services
- Psychiatric support (e.g., consultations with a psychiatrist)
- Peer support programs

Other (please specify): [Text Entry]

5. **Please describe any specialised units within the facility, e.g., closed dementia wards.** [Text Entry]

Section 2: Consumer Information

1. **What is the current number of consumers at the facility?** [Number Entry]

2. **What is the consumer age distribution?**
   - 35- 64
   - 65-74 years
   - 75-84 years
   - 85-94 years
   - 95+ years

   [Text Entry for specific age ranges if needed]

3. **Do you have consumers in your facility from Aboriginal or Torres Strait Islander or Culturally and Linguistically Diverse (CALD) backgrounds?**

   - Yes, Aboriginal or Torres Strait Islander
   - Yes, CALD
   - Yes, both
   - No

4. **Does your facility provide care for LGBTQI residents?**
   - Yes
   - No

5. **Please describe the specific care or support services you provide for different disabilities or age-related needs in your facility:** [Text Entry]

Example:

- *Dementia-specific care programs with trained staff.*
- *Physical therapy sessions for mobility support.*
- *Palliative care services focusing on comfort and pain management.*

Section 3: Service Delivery and Consumer Journey

1. **How do consumers typically enter your facility?** [Tick all that apply]
    - Referrals from hospitals, family doctors, or community health services
    - Direct admissions from the community due to care needs
    - Placement by family members or guardians
    - Family caregivers utilising respite care services
    - Referrals from disability service provider
    - Transfer from another care facility

    Other [Text Entry]

2. **What is the average length of stay for consumers for the different services offered?** *Please provide the average length of stay for each service type in days or months. Example: General aged care: 24 months. If a service is not offered, please indicate "N/A".*
    - General aged care [Text Entry]
    - Respite care [Text Entry]
    - Dementia care [Text Entry]
    - Palliative care [Text Entry]
    - Specialised medical units (e.g., stroke units, diabetes care) [Text Entry]
    - Specialised units (e.g., dementia wards) [Text Entry]
    - Sub-acute care [Text Entry]
    - Disability support (specify types of disabilities) [Text Entry]
    - Mental health services [Text Entry]
    - Rehabilitation services [Text Entry]
    - Constant care [Text Entry]
    - Intermittent care [Text Entry]
    - Transitional care [Text Entry]
    - Day programs [Text Entry]

    Other (please specify): [Text Entry]

3. **What are the common reasons for consumers exiting your facility?**
    - Deceased
    - Transfer to another care facility
    - Hospitalisation
    - Transition to hospice care
    - Transition to independent living
    - Return to family care
    - Discharge to home with outpatient services
    - Move to a specialised care facility
    - Completion of rehabilitation program
    - Transition to long-term care
    - Voluntary exit against medical advice
    - Completion of temporary respite care

    Other [Text Entry]

4. **Are there consumers with both complex care needs and high-intensity support requirements present in your facility?**

    ☐ Yes

    ☐ No

5. **If yes, how frequently are these consumers present in your facility?**

    - Very Often – Regularly seen and a routine part of our care.
    - Often – Common, but not a daily occurrence.
    - Sometimes – Occurs with some regularity, but not frequently.
    - Rarely – Seldom seen at our facility.
    - Never – We have not encountered this combination at our facility.

Please specify the types of assistance required by consumers. For example, you might note that some residents require both mobility support and cognitive assistance:

- Activities of daily living: Do consumers require assistance with activities of daily living (e.g., bathing, dressing, toileting)?

- Mobility: Do consumers require assistance with mobility (e.g., walking, transferring)?
- Feeding: Do consumers require assistance with feeding?
- Cognitive tasks: Do consumers require support with tasks requiring cognitive abilities (e.g., problem-solving, memory, managing finances)?
- Fine motor skills: Do consumers require assistance with fine motor tasks (e.g., buttoning, writing)?
- Gross motor skills: Do consumers require assistance with gross motor tasks (e.g., standing, climbing stairs)?

Other specific needs (please specify): [Text Entry]

6. **How do different consumer characteristics (e.g., disabilities, age, behaviour) affect their care needs and risks? Please provide examples.** [Text Entry]

   Example: For consumers with severe cognitive impairments, we need constant supervision to prevent wandering. We manage this by having dedicated staff and secure units, and all have behaviour support plans in place.

7. **What barriers may restrict consumers at your facility?** [Tick all that apply]
   - Medication (The use of medication to control or sedate a consumer, rather than treating a specific health condition).
   - Physical barriers (Measures that physically limit a consumer's movement, such as using bed rails or restraints).
   - Environmental barriers (Restrictions that confine a consumer to a specific area, like locked doors or seclusion).
   - Use of seclusion– removed from other common areas- in individual room- isolated from other residents

   Other (Please specify): [Text Entry]

8. **How many residents are subject to restrictive practices?** [Text Entry]

   Medication (The use of medication to control or sedate a consumer, rather than treating a specific health condition). [Text Entry]

   Physical barriers (Measures that physically limit a consumer's movement, such as using bed rails or restraints). [Text Entry]

Environmental barriers (Restrictions that confine a consumer to a specific area, like locked doors or seclusion). [Text Entry]

Use of seclusion– removed from other common areas- in individual room- isolated from other residents. [Text Entry]

Other (Please specify): [Text Entry]

9. **Do you have any feedback or additional comments?** [Text Entry]

Thank You

Thank you for taking the time to complete this survey. Your responses are valuable in helping us understand the settings where people may be deprived of their liberty and improving the services provided.

All information collected in this survey will be kept confidential and used solely for the purposes of this project. If you have any questions or need further information, please do not hesitate to contact us at [contact information].

Once again, thank you for your participation and contribution to this important project.

SAMPLE DISABILITY SUPPORT SERVICE PROVIDER SURVEY

Understanding Care Environments and Consumer Demographics

Please complete this survey to help the Tasmanian National Preventive Mechanism better understand the care environment and the demographics of consumers served in your facility. Your insights are valuable in shaping our efforts to ensure compliance with human rights obligations and to prevent the deprivation of liberty.

The United Nations Subcommittee on the Prevention of Torture defines deprivation of liberty as any situation where a person is unable to leave a particular setting at will. This can include circumstances where restrictive practices are applied, such as restraints or locked wards, making it difficult for the person to freely leave.

To help us understand your facility better, please confirm if your facility fits this definition of deprivation of liberty. If your facility does fit this definition, you will be asked further questions about your services and the people you care for.

Does your facility involve any circumstances where people cannot freely leave at will?

- **Yes**
- **No**

Section 1: Provider and Facility Information

1. **What is the facility name?** [Text Entry]

2. **Where is the facility address?** [Text Entry]

3. **What type of facility do you operate?**
   - Disability Support

   Other (Please specify): [Text Entry]

4. **Please indicate the types of services your facility provides by checking all that apply:**
   - Respite care
   - SDAs and SILs
   - Home care
   - Rehabilitation services
   - Transitional care
   - Day programs
   - Therapeutic supports

   Mental health services
   - Individual counselling and psychotherapy
   - Group therapy sessions
   - Behavioural support and intervention
   - Crisis intervention services
   - Psychiatric support (e.g., consultations with a psychiatrist)
   - Peer support programs

Other (please specify): [Text Entry]

5. **Please describe any specialised units within the facility, e.g., units for individuals with mental health or behaviour supports.** [Text Entry]

Section 2: Consumer Information

1. **What is the current number of consumers at the facility?** [Number Entry]

2. **What is the consumer age distribution?**
   - 0-17 years
   - 18-34 years
   - 35-49 years
   - 50-65 years

   [Text Entry for specific age ranges if needed]

3. **Do you have consumers in your facility from Aboriginal or Torres Strait Islander or Culturally and Linguistically Diverse (CALD) backgrounds?**

   - Yes, Aboriginal or Torres Strait Islander
   - Yes, CALD
   - Yes, both
   - No

4. **Does your facility provide care for LGBTQI residents?**
   - Yes
   - No

5. **Please describe the specific care or support services you provide for different disabilities in your facility**: [Text Entry]

   Example:

   - *Autism spectrum disorder support programs with trained staff.*
   - *Sensory integration therapy sessions.*
   - *Social skills training focusing on community integration and independence. .*

Section 3: Service Delivery and Consumer Journey

1. **How do consumers typically enter your facility?** [Tick all that apply]
    - Referrals from hospitals, family doctors, or community health services
    - Direct admissions from the community due to care needs
    - Placement by family members or guardians
    - Family caregivers utilising respite care services
    - Referrals from disability service provider
    - Transfer from another care facility

    Other [Text Entry]

2. **What is the average length of stay for consumers for the different services offered?** *Please provide the average length of stay for each service type in months or years. Example: Disability support (physical disabilities): 36 months. If a service is not offered, please indicate "N/A".*

    - Respite care
    - SDAs and SILs
    - Residential care units (high needs for physical or mental disability
    - Individual counselling and psychotherapy
    - Group therapy sessions
    - Behavioural support and intervention
    - Crisis intervention services
    - Psychiatric support (e.g., consultations with a psychiatrist)
    - Peer support programs
    - Rehabilitation services
    - Transitional care
    - Day programs
    - Therapeutic supports [Text Entry]
    - Other (please specify): [Text Entry]

    Other (please specify): [Text Entry]

3. **What are the common reasons for consumers exiting your facility?**
    - Deceased
    - Transfer to another care facility
    - Hospitalisation
    - Transition to hospice care
    - Transition to independent living
    - Return to family care
    - Discharge to home with outpatient services
    - Move to a specialised care facility
    - Completion of rehabilitation program
    - Transition to long-term care

- Voluntary exit against medical advice
- Completion of temporary respite care

Other [Text Entry]

4. **Are there consumers with both complex care needs and high-intensity support requirements present in your facility?**

   ☐ Yes

   ☐ No

5. **If yes, how frequently are these consumers present in your facility?**

   - Very Often – Regularly seen and a routine part of our care.
   - Often – Common, but not a daily occurrence.
   - Sometimes – Occurs with some regularity, but not frequently.
   - Rarely – Seldom seen at our facility.
   - Never – We have not encountered this combination at our facility.

Please specify the types of assistance required by consumers. For example, you might note that some residents require both mobility support and cognitive assistance.:

- Activities of daily living: Do consumers require assistance with activities of daily living (e.g., bathing, dressing, toileting)?
- Mobility: Do consumers require assistance with mobility (e.g., walking, transferring)?
- Feeding: Do consumers require assistance with feeding?
- Cognitive tasks: Do consumers require support with tasks requiring cognitive abilities (e.g., problem-solving, memory, managing finances)?
- Fine motor skills: Do consumers require assistance with fine motor tasks (e.g., buttoning, writing)?
- Gross motor skills: Do consumers require assistance with gross motor tasks (e.g., standing, climbing stairs)?
- Other specific needs (please specify): [Text Entry]

6. **How do different consumer characteristics (e.g., disabilities, age, behaviour) affect their care needs and risks? Please provide examples.** [Text Entry]

   Example: For consumers with severe cognitive impairments, we need constant supervision to prevent wandering. We manage this by having dedicated staff and secure units, and all have behaviour support plans in place.

7. **What barriers may restrict consumers at your facility?** [Tick all that apply]
    - Medication (The use of medication to control or sedate a consumer, rather than treating a specific health condition).
    - Physical barriers (Measures that physically limit a consumer's movement, such as using bed rails or restraints).
    - Environmental barriers (Restrictions that confine a consumer to a specific area, like locked doors or seclusion).
    - Use of seclusion– removed from other common areas- in individual room- isolated from other residents

      Other (Please specify): [Text Entry]

8. **How many residents are subject to restrictive practices?** [Text Entry]

    - Medication (The use of medication to control or sedate a consumer, rather than treating a specific health condition).
    - Physical barriers (Measures that physically limit a consumer's movement, such as using bed rails or restraints).
    - Environmental barriers (Restrictions that confine a consumer to a specific area, like locked doors or seclusion).
    - Use of seclusion– removed from other common areas- in individual room- isolated from other residents

      Other (Please specify): [Text Entry]

9. **Do you have any feedback or additional comments?** [Text Entry]

Thank You

Thank you for taking the time to complete this survey. Your responses are valuable in helping us understand the settings where people may be deprived of their liberty and improving the services provided.

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Once again, thank you for your participation and contribution to this important project.

Appendix 5:
Segmentation analysis

Segmentation Overview

01 Physical Disability

Description: This segment focuses on individuals with physical disabilities, including mobility impairments and other physical limitations that impact daily living.
Risks: Potential risks include increased dependency on care, physical injury due to inadequate support or adaptive technologies, and misuse of mechanical aids.

02 Sensory Impairments

Description: Encompasses individuals with impairments in hearing, vision or other sensory functions, which can affect communication, mobility, and social integration.
Risks: Social isolation, communication barriers, and challenges in navigating environments.

03 Dementia

Description: Older people as well as early-onset cases with dementia, characterised by memory loss, cognitive decline and difficulty with everyday activities.
Risks: Increased risk of wandering, injury and exploitation; challenges in communication and personal care.

04 Complex Medical Needs

Description: Individuals with multiple chronic conditions or severe medical issues requiring ongoing, complex medical management and frequent healthcare interventions.
Risks: Complications due to polypharmacy, coordination of multiple treatments and potential for hospital readmissions.

05 Psychosocial Disability

Description: This segment includes individuals dealing with disabilities which can affect their ability to function, engage socially, and manage daily stress and relationships.
Risks: Social isolation, inappropriate care, and potential for both under and overtreatment, including misuse of psychological restraints.

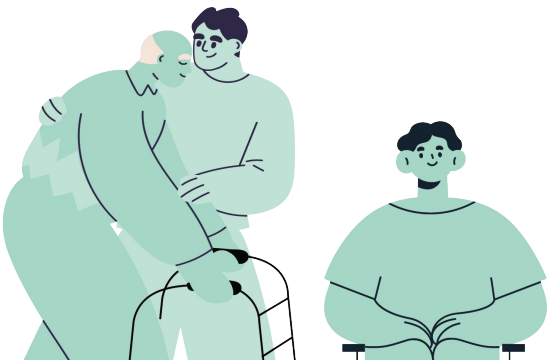
06 Developmental Disability

Description: This segment includes conditions like intellectual disabilities, autism and cerebral palsy, arising during early development and affecting lifelong functionality.
Risks: Challenges include social isolation, educational barriers and increased vulnerability to neglect and abuse.

07 Diverse Needs

Description: This segment addresses the unique cultural, linguistic and diverse backgrounds of individuals and communities, ensuring care delivery is respectful and responsive to their varied cultural identities and lifestyle preferences.
Risks: Cultural insensitivity, miscommunication and inadequate care that does not respect cultural preferences.

1 | Physical Disability



Moderate Risk

Physical disabilities, unlike some other conditions that might impair judgement or communication more severely, often allow for some level of personal advocacy and interaction with caregivers, which can further help in ensuring proper care.

Segment Description

Physical disabilities cover a diverse range of conditions that impact an individual's physical capabilities and daily functioning. This category includes mobility impairments caused by congenital factors, diseases or physical injuries, as well as conditions that affect motor skills, physical coordination and body strength.

These disabilities can occur at any stage of life and may lead to significant lifestyle adjustments and adaptations. Effective support for physical disabilities requires comprehensive, multifaceted interventions that not only facilitate mobility but also address the broad physical and health needs of the individual. This includes medical treatment, physical therapy, adaptive technologies and support systems designed to enhance independence, promote health and wellbeing, and integration to social and vocational settings.

Disabilities may include, but are not limited to:

- Cerebral Palsy
- Spinal Cord Injury
- Multiple Sclerosis (MS)
- Spina Bifida
- Stroke
- Acquired Brain Injury (ABI)
- Parkinson’s Disease
- Muscular Dystrophy
- Amputations and loss of limbs
- Other Physical

Age Groups

Older People

Older adults with physical disabilities may experience a range of conditions including osteoarthritis, severe osteoporosis, Parkinson's disease, stroke, or advanced multiple sclerosis. The focus for this group is on managing chronic pain and mobility restrictions with comprehensive care plans that address multiple coexisting medical conditions and comorbidities such as heart disease or diabetes. Supports aim to sustain independence as much as possible while adapting living environments to enhance safety and accessibility.

Adults

This group requires multifaceted support that addresses not only immediate physical rehabilitation but also includes vocational training and social engagement to maintain employment and active community participation. Support systems focus on empowerment and independence, aiming to improve health and reduce secondary conditions like sensory loss, blackouts or seizures.

Children & Young People

Children with physical disabilities, including congenital spinal disorders, cerebral palsy or traumatic injuries, face challenges that significantly influence their development and social integration. Additional conditions such as congenital amputations or muscular dystrophies also require early and continuous support. The care focus is on enabling growth and development through therapy, adaptive educational tools and family support to promote physical, cognitive and emotional growth in inclusive settings.

Care Needs

Personalised assistive devices: Access to a range of mobility aids tailored to individual needs.

Therapeutic and rehabilitation services: Physical and occupational therapies to enhance pain management, mobility, and daily living skills.

Personal care and assistance: Personal care assistance for activities like bathing and dressing.

Accessibility and environmental adaptations: Adapted environments with ramps, handrails, non-slip floors, wide doorways.

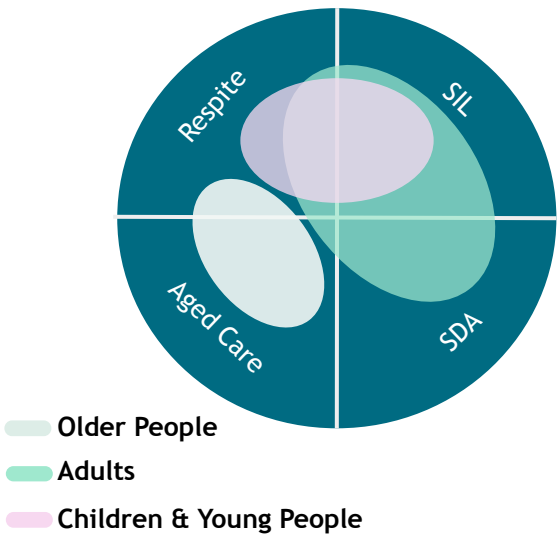
Integrated care plans: Address chronic conditions and comorbidities such as heart disease or diabetes.

Vocational training and education: Enhance employment opportunities and social engagement.

Social skills development: Promote the improvement of interpersonal skills through structured social skills training.

Behavioural management: Safe handling of acute behavioural episodes through staff training and effective management strategies.

Permanent Care Settings



Risks

Mechanical restraints: Inappropriately configured or used mobility aids or bed rails can lead to unnecessary confinement, especially when used without considering individual mobility capabilities, increasing the risk of physical and psychological harm.

Physical restraints: Improper use of belts, straps or special chairs can lead to abuse, particularly if used for convenience rather than necessity.

Environmental restraints: Excessive use of locking mechanisms and barriers can restrict movement and social interaction, negatively affecting mental health and autonomy.

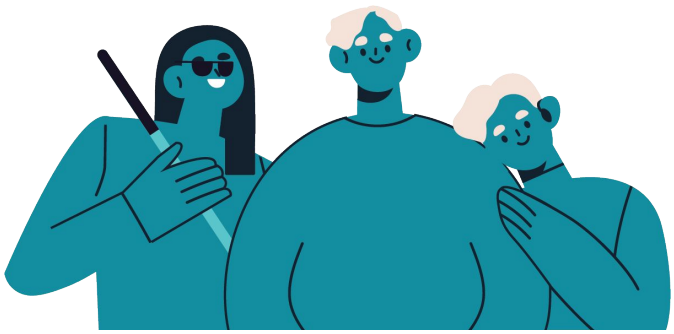
Adaptation and accessibility: Inadequate environmental adaptations can lead to indirect restrictive practices by confining individuals to accessible areas only, limiting personal autonomy.

Vulnerability to neglect: Dependency on caregivers for mobility and daily tasks increases the risk of neglect or abuse, particularly in settings that are not specialised or adequately staffed.

Communication barriers: Depending on the nature of the physical disability, some individuals might face challenges in communicating their needs or discomfort, which can lead to unmet needs or inappropriate care solutions being applied.

Social isolation: Physical barriers and sometimes the lack of adequate support can lead to social isolation, which diminishes residents' ability to report or advocate against poor treatment or abusive practices.

2 | Sensory Impairments



Moderate Risk

A moderate risk rating recognises the challenges that seniors with sensory impairments face, showing how well-established care practices can significantly lessen these risks.

Segment Description

Sensory disabilities significantly affect a person's communication and interaction with the environment. Examples of sensory disabilities include hearing impairments, vision impairments and autism. With basic daily activities such as using a phone, speaking and learning becoming a challenge, these impairments can severely impact communication and mobility, as well as the ability to participate in community life.

A sensory disability can be congenital or acquired through injury, illness or aging. The impact of sensory disabilities often increases with age, necessitating varying levels of support and intervention to maintain independence and quality of life. Effective support includes the use of adaptive technologies, specialised therapies and comprehensive care plans tailored to individual needs.

Disabilities may include, but are not limited to:

- Cerebral Palsy
- Deafness
- Hard of Hearing
- Blindness
- Low Vision
- Speech Impairments (e.g. stuttering, articulation disorders)
- Non-verbal Communication Disorders (e.g. aphasia)
- Deafblindness (combined hearing and vision loss)

Age Groups

Older People

Older people frequently experience sensory disabilities, such as hearing loss, vision impairments, or both, which significantly affect their daily lives. According to the AIHW, 93% of individuals over 65 years old have a long-term vision disorder, while the Department of Health and Aged Care reports that 50% of people aged 60-70 experience some form of hearing loss, rising to 80% for those over 80 years old.

Adults

Adults with sensory disabilities, such as hearing and vision impairments, require comprehensive support to maintain independence and active community participation. While most adults with sensory disabilities maintain a high level of independence, support needs can vary significantly based on the severity and progression of the impairment.

Children & Young People

Children and young people with sensory disabilities face unique challenges that significantly influence their development and social integration. Speech difficulties are particularly prevalent among children, affecting about one in four individuals under 25 years old, with hearing and vision becoming more common with age. Early and continuous support is key in managing these conditions effectively and promoting overall development.

Care Needs

Training for staff: Caregivers and staff trained to enhance understanding of sensory impairments and effectively use of assistive technologies.

Social integration support: Programs and activities designed to help individuals with sensory impairments navigate social interactions and reduce isolation.

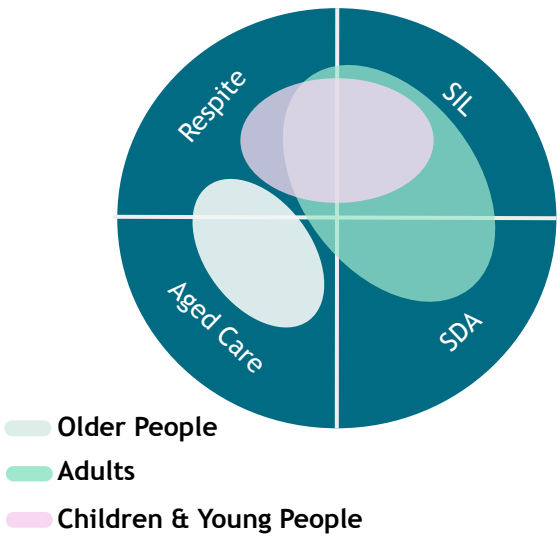
Training and education for independence: Tools designed to teach skills for daily living, such as cooking with adaptive tools, using public transportation and managing personal finances.

Personalised assistive devices: Provision of devices such as hearing aids, tactile watches and text-to-speech software.

Therapeutic and rehabilitation services: Therapies for the management and mitigation of sensory impairment challenges, e.g. speech therapy, braille literacy etc.

Accessibility and environmental adaptations: Facilities equipped with adaptive technologies like audio guides, braille labels and visual alarms.

Permanent Care Settings



Risks

Neglect in personalised care: Facilities might overlook tailored adaptations due to resource constraints or lack of specialised knowledge, leading to reduced autonomy for residents.

Resource limitations: High turnover of staff or lack of specialised training in handling elderly patients with sensory impairments, particularly in emergency rooms and intensive care units.

Assistive technologies: Risk of inadequate access to necessary assistive technologies and proper communication aids, leading to communication barriers and increased isolation.

Educational barriers: Without proper support in educational settings, such as sign language interpreters, braille resources, or other necessary accommodations, young people may face significant barriers to achieving their educational potential.

Environmental restraints: Poorly adapted physical environments that fail to support safe and independent navigation, leading to potential isolation and restraint.

Social isolation: Reduced sensory capabilities, coupled with inadequate support, can lead to greater isolation from community and family, impacting mental health and quality of life. Isolation in rooms without stimulation or interaction may serve as an unintentional form of control, effectively cutting off sensory experiences.

Communication barriers: Inadequate support for communication needs can prevent residents from effectively advocating for themselves, leading to feelings of powerlessness and exclusion.

Consent and participation: Insufficient consultation of consumers in decision-making, can result in decisions being made without their input or consent.

3 | Dementia (including early onset)

Very High Risk

Particularly high in the middle and advanced stages, due to the necessity of managing significant behavioural changes, high propensity for accidents, such as falls, and the need for close supervision.

Segment Description

Involves progressive cognitive decline that interferes with daily functioning, including memory loss, language problems and impaired judgement. This segment often requires specialised care and environments designed to manage their symptoms and enhance their quality of life.

Typically affecting people aged 65 and older, dementia also occurs in younger people due to factors like genetic predispositions, severe head injuries or cardiovascular issues.

In Tasmania, it is estimated that more than 10,600 people are living with all forms of dementia in 2024. This figure is projected to rise to around 16,500 by 2054. Additionally, about 700 individuals suffer from younger onset dementia, a number expected to remain stable through 2054.

Disabilities may include, but are not limited to:

- Alzheimer's Disease
- Parkinson's Disease Dementia
- Early-Onset Dementia
- Vascular Dementia
- Lewy Body Dementia
- Frontotemporal Dementia
- Combination of symptoms from different types of dementia (e.g. Alzheimer's and Vascular Dementia)

Age Groups

People with dementia often require high levels of care in residential settings, with more than half needing complex health care. As dementia progresses, the challenge of maintaining in-home NDIS services and informal care grows. This is often due to caregiver struggle to provide the necessary care, as well as insufficient safety and accessibility adaptations at home.

In residential aged care, neurological issues and injuries are the most frequent reasons for emergency department visits, and dementia is the primary cause for overnight hospital stays. Residents with dementia are more likely to move to aged care and have a higher mortality rate within 12 months post-hospitalisation compared to non-dementia residents. Furthermore, towards the end of life, these individuals typically use hospital services less often and are more likely to pass away in their care settings.

Older People

As people with dementia age, they are more likely to move into residential aged care homes and so the proportion living in the community decreases with increasing age.

Adults

In Australia, the majority of people with younger onset dementia (aged less than 65) were living in the community. One-quarter of younger people (30-64 years old) with dementia enter residential aged care directly from hospital. The median length of stay in permanent residential aged care for younger people with dementia is longer (3.4 years) compared to older individuals (2 years).

Care Needs

Personal care and assistance: Increasing levels of assistance to support personal care tasks such as bathing, dressing and eating, which becomes increasingly necessary as the disease progresses.

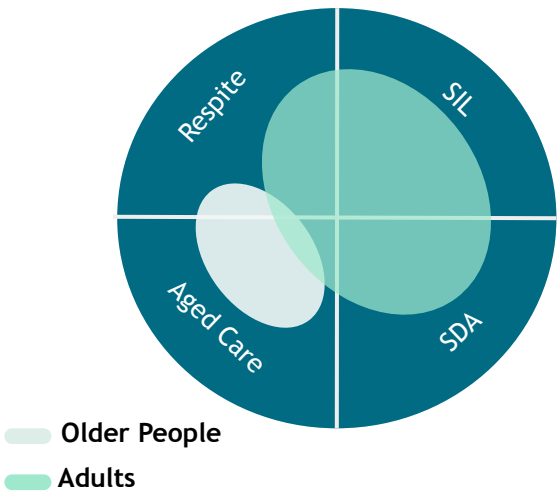
Accessibility and environmental adaptations: Design modifications to minimise confusion and enhance safety, including clear signage, uncluttered pathways, and secure areas to prevent wandering.

Specialised care programs: Activities specifically designed to engage cognitive functions and slow disease progression. These may include memory exercises and structured social interactions that cater to both older adults and those with early-onset dementia.

Preventative care and monitoring: Dementia is the most common reason for overnight hospital stays. Ongoing health assessments to manage neurological illnesses and prevent injuries that often lead to emergency department visits.

Structured social programs: Activities that encourage social participation and maintain cognitive engagement, adapted to the abilities and progression of dementia patients.

Permanent Care Settings



Risks

Environmental restraints: The use of secure areas and locked dementia wards is intended to prevent wandering. However, these measures can significantly restrict residents' freedom of movement, leading to feelings of confinement and isolation.

Seclusion: High risk of misinterpreting behaviours that might actually be communicative as merely disruptive. Such misunderstandings can lead to unnecessary seclusion of residents, resulting in their isolation and lack of engagement, which can worsen their condition instead of addressing the underlying causes of their behaviour.

Chemical restraints: Upon entry to permanent residential aged care, there is a notable increase in the prescription of multiple medications and psychotropic drugs. This notable escalation in use indicates a greater reliance on these medications shortly after admission. This practice can lead to using medications as chemical restraints to manage agitation and anxiety, rather than providing proper supervision or engagement.

Mechanical restraints: Mechanical restraints, such as bed rails and specialised chairs, are sometimes used to prevent falls and ensure safety. However, their use can lead to prolonged immobility, discomfort and physical harm if not carefully monitored and justified.

Health and consent issues: Frequent need for medical interventions can lead to deprivation of liberty if not managed with proper consent, risking non-consensual treatments or prolonged hospital stays without adequate justification.

4 | Complex Medical Needs

High Risk

High, due to the complexities of medical interventions and the potential for overuse of restraints in medical settings.

Segment Description

This segment includes consumers with higher-level needs due to disability, chronic conditions, illness or frailty. These individuals often have multiple interrelated medical conditions requiring continuous, intensive medical care and management. Conditions frequently seen in this group include chronic neurological disorders, severe metabolic diseases, and other complex medical issues that necessitate frequent interventions and highly coordinated care across various medical specialties.

Older adults in permanent aged care settings often face higher incidences of neurological illnesses, including ABI and stroke, due to their age and the prevalence of comorbid conditions. These conditions are significant contributors to hospital admissions and long-term stays, which align with the general care challenges and medical complexities observed in aged care populations.

Disabilities may include, but are not limited to:

- Neurological Conditions (e.g. Parkinson's)
- Cognitive Impairments (e.g. Alzheimer's)
- Chronic Systemic Diseases (e.g. Chronic Kidney Disease)
- Musculoskeletal Disorders (e.g. Severe Arthritis)
- Cardiovascular Diseases (e.g. Coronary Artery Disease)
- Severe Psychiatric Conditions (e.g. Schizophrenia)
- Complex Disabilities
- Combination of Disabilities

Age Groups

Older People

Older adults in aged care often face a convergence of chronic conditions as they age. These can include progressive neurological disorders, heart diseases, diabetes and mobility impairments, which may be compounded by age-related cognitive declines such as dementia. The complexity of their conditions necessitates a comprehensive care approach that typically involves multidisciplinary medical support, continuous nursing care, and specialised management plans to address both physical and cognitive health challenges.

Adults

Adults with disabilities often require personalised care to support a range of disabilities. Their care is oriented towards enhancing independence and integrating them into the community. Supports are tailored to individual needs and may include technological aids, physical therapies and modifications to living spaces, enabling them to live as independently as possible.

Children & Young People

Children with disabilities and complex medical needs are at a high risk of abuse and neglect due to physical dependencies and communication barriers. They often struggle to be heard, and the demands of their care can significantly stress parents or caregivers, increasing the risk of mistreatment. Effective, person-centered behaviour support plans, along with collaborative case planning and information sharing with community medical and support services, can ensure their safety and comprehensive care.

Care Needs

Comprehensive medical access: Regular consultations with a range of specialists to manage and coordinate care for complex medical conditions.

Integrated care plans: Development of integrated care strategies that ensure coordination among healthcare and other service providers to address all medical needs.

Facility readiness: Facilities equipped with necessary tools and protocols for emergency medical situations.

Emergency medical coordination: Efficient coordination with hospitals and clinics to ensure prompt response during medical emergencies.

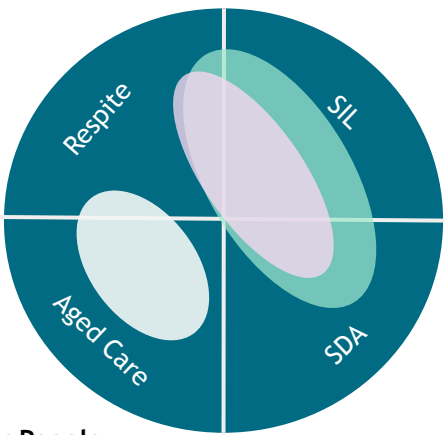
Specialised caregiver training: Caregivers trained in specific medical care requirements and the use of medical equipment.

Personal care and assistance: High-level personal care attendants available round-the-clock.

Psychosocial support: Regular access to mental health professionals to address the psychological impact of living with complex medical conditions.

Advanced care planning: Proactive planning for future healthcare preferences, including end-of-life care.

Permanent Care Settings



Risks

Chemical restraints: Overuse or inappropriate use of medications to manage behaviour or symptoms without proper monitoring can lead to dependency, side effects and diminished overall health.

Inadequate access to care: The absence of integrated care for individuals with complex care needs may lead to fragmented care and frequent hospitalisations. This can hinder access to necessary treatments, making care less affordable and accessible, and often results in patients having reduced autonomy over their health decisions.

Nutritional health risks: The potential for malnutrition or dietary neglect arises particularly in settings where individual dietary needs are complex but not adequately monitored or managed, risking serious health deterioration.

Inadequate medical oversight: Complex medical conditions require precise management. This can be jeopardised by inadequate medical oversight, leading to unaddressed health issues and deteriorating conditions.

Potential for neglect: Where care is not adequately coordinated, there is a risk that individuals' health needs are not comprehensively addressed, leading to medical neglect. This can result in worsened health outcomes and an inability to advocate for oneself, further diminishing personal freedom and quality of life.

Inadequate behaviour support: For children in Out of Home Care (OOHC), inadequate behaviour support planning for those with challenging behaviours related to their disability can lead to risks of physical, sexual, and emotional harm to themselves and others.

5 | Psychosocial Disability

High Risk

High risk due to misunderstandings, communication barriers, challenging behaviours, and often inadequate protective policies. These factors can lead to stigma and inappropriate use of restraints and coercive treatments.

Segment Description

Psychosocial disability arises from mental health conditions that significantly affect someone's ability to participate fully in daily life. Conditions such as schizophrenia, bipolar disorder, major depression and PTSD can have varying impacts. These disorders, ranging from mild anxiety to severe psychosis and aggressive behaviours, require customised behavioural management and psychological care strategies.

Typically manifesting during adolescence or early adulthood, these conditions are especially prevalent among those aged 15-64, significantly affecting educational achievements and employment opportunities. In 2018, Tasmania had the highest rate in Australia of people with psychosocial disability. According to the ABS, while most people with psychosocial disability lived in households, one in eight lived in cared-accommodation, including hospitals and aged care facilities.

Disabilities may include, but are not limited to:

- Schizophrenia
- Bipolar Disorder
- Major Depressive Disorder
- Post-Traumatic Stress Disorder (PTSD)
- Borderline Personality Disorder (BPD)
- Anxiety Disorders
- Attention Deficit Hyperactivity Disorder (ADHD)

Age Groups

Older People

Older people with psychosocial disabilities often experience an increase in the severity and profundity of their conditions. This group sees a notable rise in memory problems or periods of confusion, illustrating the intersection of psychosocial symptoms with cognitive decline associated with aging. The care for older adults thus becomes increasingly complex as they face both mental health issues and chronic physical conditions.

Adults

Adults with psychosocial disabilities consistently face nervous or emotional conditions, affecting 20% of this group. While mental health issues are slightly less prevalent than in younger groups, they still significantly impact adults, necessitating integrated support systems. These systems should include mental health care, employment support, and vocational and family assistance to help adults manage their work and family roles, promoting long-term stability and wellbeing.

Children & Young People

This age group is also more susceptible to mental health issues, with one in five experiencing mental illnesses. Social or behavioural difficulties are notably higher in this developmental phase, affecting one-quarter of young people. These challenges can significantly impact their ability to navigate social settings and fulfil educational demands. Early and proactive interventions are essential and should be integrated with educational support to help manage these impacts effectively.

Care Needs

Behavioural management: Ongoing counselling and structured therapy programs.

Community engagement: Access to support groups and counselling services.

Therapeutic interventions: Safe environments where staff are trained to manage and de-escalate crises without the use of restraints.

Employment support: Career-oriented training and tailored job placement services.

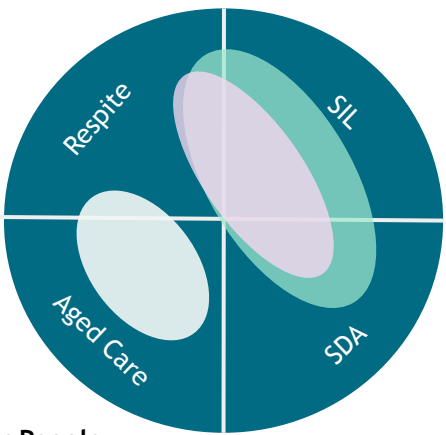
Integrated care: Coordination of mental and physical health services to manage overall wellbeing.

Specialised care: Targeted support in residential aged care for those with severe psychosocial impairments, including dementia-specific care and memory support.

Employment support: Career-oriented training and tailored job placement services, helping individuals integrate into the workforce.

Educational and psychological support: Strong educational support systems and focused psychological therapies to aid learning and improve mental health outcomes across all ages.

Permanent Care Settings



Risks

Behavioural challenges: Behaviours perceived as challenging or disruptive can result in the more frequent use of physical, mechanical or chemical restraints. These behaviours can sometimes be responses to the environment or unmet needs rather than symptoms that need to be controlled.

Misunderstanding and stigma: Psychosocial disabilities, which include conditions related to mental health such as bipolar disorder, schizophrenia and severe depression, are often less understood by the public and even by healthcare providers. This lack of understanding can lead to stigma and discriminatory practices.

Environmental restraints: Environments that are overly structured or restrictive can exacerbate feelings of confinement and powerlessness. Secure areas or specialised settings designed to manage behaviours can sometimes limit personal freedom excessively, leading to isolation from the wider community.

Seclusion: Used in extreme cases, seclusion can sometimes be a premature response in crises, potentially undermining the dignity and recovery of the individual.

Physical and mechanical restraints: These may be used in situations where individuals exhibit aggressive or self-harming behaviours. These restraints might be employed more as control measures rather than for safety, especially without proper staff training.

Chemical restraints: There is a heightened risk in settings managing psychosocial disabilities that medication, particularly psychotropic drugs, is used excessively or inappropriately as a first line of intervention. This reliance often increases sharply upon admission to care facilities or during acute episodes. Over-medication can be employed to control behaviour deemed challenging or disruptive, without sufficient attempts to employ alternative therapeutic interventions.

6 | Developmental Disability

High Risk

This group has a high presence in care settings in Tasmania. Additionally, communication barriers and issues around consent are factors that hinder a person's ability to express needs or understand and agree to treatments, increasing vulnerability to both unintentional neglect and intentional abuse.

Segment Description

Developmental disabilities are a group of conditions due to a physical, learning, language or behaviour impairment. These conditions begin during the developmental period, may impact day-to-day functioning, and usually last throughout a person's lifetime.

Each disability varies greatly in severity and manifestations but commonly affects multiple aspects of development. Early intervention, specialised care and continued support can significantly improve outcomes for affected individuals. In Tasmania, the most common disabilities among those eligible for SDA and SIL include Intellectual Disability, which is the top disability in every region. Autism also ranks consistently among the top three disabilities across all regions, while Tasmania has the highest NDIS participant rate in the nation for Cerebral Palsy.

Disabilities may include, but are not limited to:

- Intellectual Disabilities
- Autism Spectrum Disorder (ASD)
- Down Syndrome
- Attention Deficit Hyperactivity Disorder (ADHD)
- Genetic disorders (e.g. Fragile X Syndrome, Williams Syndrome, Rett Syndrome)
- Fetal Alcohol Spectrum Disorders (FASD)
- Specific Learning Disabilities

Age Groups

Adults

For older adolescents and adults, the focus shifts towards vocational training, employment support and independence. Adults with developmental disabilities may continue to face challenges in social integration and employment. Support services often include job coaching, life skills training, and supported employment to ensure individuals lead fulfilling and productive lives.

Children & Young People

During early childhood (0 to 6 years), developmental delay, including Global Developmental Delay, is the most prevalent disability type, affecting approximately 48% of young NDIS participants. This period is crucial for early diagnosis and intervention, which can significantly influence long-term outcomes. Autism is also commonly diagnosed in this age group, affecting 33% of participants, highlighting the need for early specialised interventions that address communication, behavioural and social challenges.

As children grow, autism remains a predominant condition, affecting about 65% of participants in the 7 to 14 years age group, followed by intellectual disabilities, including Down syndrome, which account for 15%. This stage focuses on enhancing learning strategies and social skills, and furthering behavioural interventions that support educational and social inclusion.

In older adults, the term is generally used if they have lived with the condition since childhood. In aged care, the focus might often shift to how aging interacts with and impacts the management of these lifelong disabilities.

Care Needs

Therapeutic and educational support: Provide personalised therapeutic interventions and special education programs to support social skills development and integration.

Daily living and personal care: Assistance with routine daily activities, ensuring adaptability to individual needs.

Community engagement: Foster social integration through inclusive activities and support groups, enhancing community interaction.

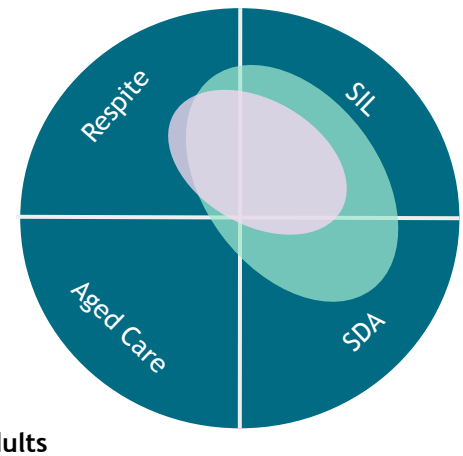
Adaptive technologies: Utilise assistive devices and technologies to enhance communication and functional capabilities.

Mental health services: Offer targeted mental health support, including counselling and therapies, especially for those with co-occurring mental health conditions.

Transition support: Facilitate seamless transitions from childhood to adult life with tailored planning for education, employment and independence.

Staff training: Equip staff with the skills to effectively respond to and manage crises or challenging behaviours without escalating the situation.

Permanent Care Settings



Risks

Inadequate staff responses: In care homes where staff are not properly trained to handle the specific needs of people with developmental disabilities, there can be instances of neglect, where personal care, medical needs and social interactions are inadequately addressed.

Physical abuse: In extreme cases, staff overwhelmed by challenging behaviours may resort to physical interventions that are harmful and abusive, rather than employing recommended de-escalation techniques or supportive measures.

Physical restraints: During acute behavioural episodes, staff might use physical restraints such as straps or holding techniques.

Chemical restraints: In residential and healthcare settings, there might be an over-reliance on medications to manage behaviours associated with developmental disabilities, such as using antipsychotics or sedatives beyond the therapeutic need, which can lead to medication dependency and side effects.

Mechanical restraints: Use of bed rails, restraint chairs, or other devices in hospitals to prevent individuals from injuring themselves or others.

Locked rooms and seclusion: In some care settings, seclusion might be used not just in extreme cases, but as a regular method to manage challenging behaviours, which can lead to social isolation and exacerbate psychological distress.

Limited social interaction: Residents in SIL environments typically interact with only a small number of fellow participants and the support worker on duty. Even with NDIS funding for community participation, the opportunities for meaningful social engagement are minimal. This limited social interaction can lead to feelings of isolation and depression.

7 | Diverse Needs

Moderate Risk

The risk for deprivation of liberty and restrictive practices is moderate due to improving but not yet fully adequate culturally sensitive practices, low visibility of specific community groups, and insufficient data for tailored interventions in Tasmania.

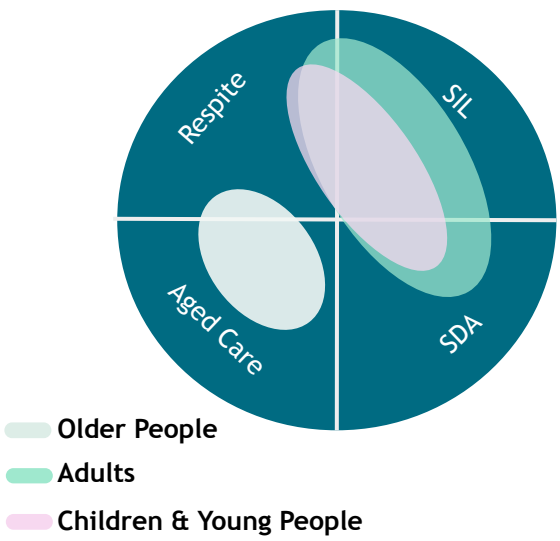
Segment Description

This segment spans all care settings, ensuring that the unique challenges faced by Indigenous Australians, individuals from CALD backgrounds, and LGBTQIA+ individuals are acknowledged and addressed comprehensively.

Diversity is not limited to any single environment. The objective is to recognise the intersectionality of disability with cultural, linguistic and identity factors, advocating for a holistic approach that respects and responds to the diverse needs of each group within the disability community.

Permanent Care Settings

This is a cross-cutting segment, which would cross-cut all conditions and settings, especially where culturally appropriate care is needed.



Groups

Indigenous Australians
Care strategies must actively integrate cultural practices and community values to meet the unique healthcare needs of Indigenous populations, acknowledging historical impacts and the critical role of spirituality in healing and wellbeing. Over half of Indigenous Tasmanians aged 55 and over live with disabilities, with common conditions including physical and sensory impairments, and psychological or intellectual disabilities. Culturally sensitive services are crucial, as many existing services do not fully accommodate their specific cultural and communication needs.

Cultural and Linguistic Diversity (CALD)
Individuals from CALD backgrounds face challenges due to language barriers and differing cultural norms that affect their access to health care. In Tasmania, this group represents a smaller proportion of the population compared to other areas of Australia. Care strategies must go beyond translation, embracing a holistic approach that respects cultural customs, religious practices and dietary preferences to improve care effectiveness and patient comfort.

LGBTQIA+ Members of the LGBTQIA+ community require care settings that are inclusive and affirming to prevent isolation and discrimination. This group faces unique challenges that intersect with their sexual orientation, gender identity or expression, necessitating environments that foster understanding and provide tailored support. The NDIA does not currently collect data on gender identity or sexuality, which hampers the ability to monitor and support the specific needs of LGBTQIA+ individuals accessing services.

Care Needs

Cultural and diversity representation: Environments with symbols, artwork and literature that reflect the diversity of the resident population to foster belonging.

Cultural competence and sensitivity: Ongoing training for staff in cultural competence, understanding diverse sexual orientations and identities, and using inclusive language.

Cultural sensitivity in care: Cultural preferences in diet, religious practices and medical treatments within care plans.

Community and cultural engagement: Hosting cultural events and activities that celebrate and educate about diverse heritages, including Indigenous cultures, and support for LGBTQIA+ community events like Pride Day.

Language services: Provision of translation and interpreter services to ensure clear communication for all residents, enhancing understanding and participation in their care.

Community liaison: Linking residents with external cultural resources and community leaders, such as elders and cultural liaisons, to maintain strong cultural connections and support external community engagement.

Proactive inclusion practices: Public promotion of the facility's commitment to inclusiveness across all spectrums, including LGBTQIA+ communities, using affirmative practices like respecting preferred pronouns, and ensuring that all facility policies affirm diverse identities.

Risks

Cultural insensitivity: Practices that fail to recognise or respect Indigenous cultural rights and practices can inadvertently restrict cultural expression and identity.

Involuntary seclusion: Misinterpretation of culturally specific behaviours as problematic may lead to inappropriate use of seclusion or restraint.

Lack of consent: Medical and care decisions made without proper consultation with the individual or their community representatives, which may violate personal rights and autonomy.

Language barriers: Failure to provide adequate translation services can result in misunderstandings and inappropriate care, effectively limiting the autonomy of the individual in managing their health and care decisions.

Cultural misunderstanding: Practices that do not consider cultural norms and expectations can lead to the inappropriate use of restraints or seclusion, perceived as discriminatory or exclusionary.

Restricted access to services: Inadequate understanding of cultural needs can restrict access to necessary care services, potentially leading to neglect.

Misgendering and inappropriate care: Failure to respect an individual's gender identity can lead to psychological distress and is a form of ill-treatment.

Involuntary confinement: Instances where individuals may be isolated or segregated due to their LGBTQIA+ identity under the guise of protection or medical necessity.

Inadequate support: Lack of proper training in LGBTQIA+ health needs can lead to inappropriate medical treatment and use of psychiatric medications or physical restraints based on bias or misunderstanding.

Appendix 6:
Journey maps

Aged Care & Disability Journey Map

Assessment & Admission

Consumer Activities

NDIS or My Aged Care eligibility checks

Consumers often manage their care at home. The trigger for change is usually a progression of disability, an accident, or increasing care needs due to aging.

Referral & Transfer

Entry pathways include transition from hospital, home care, respite or transferring from other providers. In some cases, children may enter under the care of Child Safety Services.

Admission & Orientation

Initial meeting with facilities and assessment of physical environment needs and personal care requirements.

Internal Processes

Assessment of Needs
NDIS: Detailed assessments by Allied Health Providers to determine the level of support and type of housing that best suits the individual's needs.

Aged Care: My Aged Care performs initial screenings and then directs individuals requiring more complex care to the Aged Care Assessment Team (ACAT).

Support Coordination
NDIS: Support Coordinators assist in navigating the NDIS process and ensuring that the participants receive the supports they are eligible for.

Aged Care: ACAT conducts a detailed assessment, develops a personalised care plan, and communicates the results back to My Aged Care, which facilitates access to the recommended services and support.

Care Planning
Detailed care plans are prepared and discussed with consumers and their families.

Behaviour Support Plans
Service Providers review existing NDIS behaviour support plans.

Compatibility Assessment
Service providers evaluate consumer compatibility with other residents and the facility's environment.

Key Stakeholders

Family Members and Guardians

Child Safety Services (in cases where children require intensive support and care management)

Support Services

- NDIS
- My Aged Care
- Support Coordinator
- Legal Representatives or Advocates

Medical Care

- General Practitioners (GPs)
- Geriatricians
- Specialist Healthcare Professionals
- Mental Health Professionals
- Registered Nurses
- Dietitians/Nutritionists
- Allied Health Providers

Identified Challenges

Consent

Consent and understanding in NDIS plans: The complexity of processes and documentation makes it challenging for consumers to fully understand and consent to their care plans, especially regarding restrictive practices.

Language barriers: Minimal use of translation services or culturally appropriate resources can leave CALD consumers disconnected from important information and less engaged in social activities.

Care Setting Challenges

Respite care: The temporary nature of respite care can prevent staff from fully understanding consumer needs and routines, leading to gaps in continuity and risking less effective care.

Care challenges in regional facilities: Regional facilities may face difficulties in providing high-level care for severe dementia or complex medical needs, often leading to necessary transfers that disrupt social ties.

Cultural bias: CALD consumers may receive lower standards of care due to bias, limited access to cultural accommodations, and lack of culturally relevant activities.

Assessment and documentation gaps: Incomplete assessments and inconsistent documentation of consumer needs and care plans, especially when conducted by non-clinical staff, can lead to fragmented or inadequate care, increasing the risk of suboptimal support for consumers.

Support & Advocacy

Lack of family support: Consumers who lack family advocacy, or awareness of available advocacy services, face an increased risk of receiving substandard care and having their rights overlooked. The provider may lack mechanisms to address situations where consumers refuse care, which leaves these individuals particularly vulnerable without family involvement.

Service-family communication gaps: Poor communication between service providers and families often results in misunderstandings regarding care and changes in the consumer's condition, which can negatively impact the quality and appropriateness of care provided.

Ethical Management Challenges

Restrictive practices management: Maintaining ethical oversight of restrictive practices can be difficult, requiring ongoing vigilance and active involvement from both staff and families to safeguard consumer rights and dignity.

Aged Care & Disability Journey Map

Daily Living & Care

Consumer Activities

While in care, consumers engage in a variety of activities designed to support their health, wellbeing and social connections, including participating in social activities, receiving routine care, accessing medical support, specialist consultations and therapeutic programs.

Internal Processes

Staff Development and Safety

- Ongoing training on best practices and risk management.
- Administering, monitoring and documenting medications.
- Training on policies and approval processes for restrictive practices.

Compliance Checks

- Regular audits to ensure compliance with care standards.
- Identification and implementation of improvement areas.
- Adherence to safety protocols.

Feedback and Quality Improvement

- Channels for participant and family feedback.
- Regular reports to oversight bodies on quality of care and consumer safety.

Governance and Documentation

- Governance structures for standards compliance.
- Documentation of all care activities.
- Ongoing oversight of medication management and restrictive practices.

Key Stakeholders

Family Members and Guardians

Community and Community Support Organisations

Child Safety Services

Regulatory Bodies

- NDIS Quality and Safeguards Commission
- Aged Care Quality and Safety Commission

Medical Care

- General Practitioners (GPs)
- Geriatricians
- Specialist Healthcare Professionals
- Mental Health Professionals
- Registered Nurses
- Dietitians/Nutritionists
- Allied Health Providers

Identified Challenges

Staffing & Training

Staffing shortages: Chronic shortages and high turnover, especially in regional areas, compromise personalised and consistent care. Reliance on online-only training limits practical competency, affecting care quality.

NDIS-funded training: High turnover and workforce strain may reduce the effectiveness of NDIS-funded training programs.

Training on restrictive practices: Misclassification of actions as restrictive practices indicates a need for improved training in proper identification.

Cultural competence: Limited training on cultural competence can result in unconscious bias or the use of culturally inappropriate resources, which undermines care for diverse clients.

Behaviour Support Plans: Behaviour support plans, written by practitioners with varying levels of training, are inconsistently implemented, leading to improper or excessive use of restrictive practices.

Medical & Care Management

GP shortages: GP shortages in aged care have increased reliance on telehealth, reducing in-person interactions and potentially lowering assessment quality.

Managing multiple chronic conditions: Aging and comorbidities require an integrated care approach, often hindered by limited resources.

Medication management: Inadequate training and supervision in medication management, particularly for dementia patients, often result in improper dosages and unrecognised adverse reactions.

Human factors in medication errors: Cognitive overload, fatigue and miscommunication among staff contribute to medication errors, necessitating more rigorous monitoring.

Essential oversight in care management: Inconsistent oversight, particularly in lone worker settings, raises risks of abuse and neglect, highlighting the need for stronger management and adequate staffing.

Communication Barriers

Cultural diversity: Language and cultural barriers impede effective communication between staff and consumers from diverse backgrounds, requiring enhanced cultural sensitivity and tailored care approaches.

Safeguarding non-verbal consumers: The lack of standardised communication tools highlights significant resource gaps for non-verbal consumers, who require customised communication solutions.

Younger Residents

SDA resident dynamics: The presence of family in SDA accommodation can significantly affect care dynamics for young adults, requiring clear boundaries and coordinated care plans.

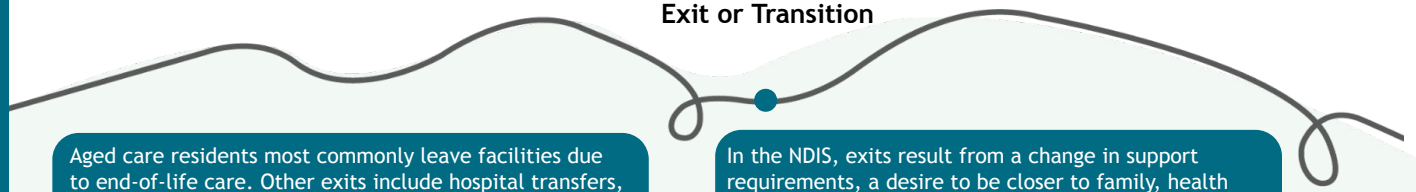
Rostered care concerns: Rostered care, which frequently changes caregivers, may be unsuitable for children, leading to trauma and disrupted development.

Aged Care & Disability Journey Map

Transition & Discharge

Consumer Activities

Exit or Transition



Aged care residents most commonly leave facilities due to end-of-life care. Other exits include hospital transfers, moves to other residential settings or returns to the community. The average stay ranges from a few months to 3 years, dependent on age at entry and care complexity.

In the NDIS, exits result from a change in support requirements, a desire to be closer to family, health improvements or declines, aging needs or behavioural issues. Additionally, preference or financial changes can impact the choice of accommodation.

Internal Processes

Emergency Management
Following detailed protocols for managing emergencies, including resident-specific evacuation considerations.

Internal Transfers
Procedures and protocols for moving residents within the facility, such as transitions to more intensive care units.

End-of-Life Support
Services and support for families during end-of-life stages, including palliative care coordination.

Post-Discharge Arrangements

- Protocols for transferring residents to hospitals for specialised care.
- Follow-up services and coordination to ensure continuity of care.

Key Stakeholders

Family Members and Guardians

Community and Community Support Organisations

Child Safety Services

Regulatory Bodies

- NDIS Quality and Safeguards Commission
- Aged Care Quality and Safety Commission

Medical Care

- General Practitioners (GPs)
- Geriatricians
- Specialist Healthcare Professionals
- Mental Health Professionals
- Registered Nurses
- Dietitians/Nutritionists
- Allied Health Providers

Identified Challenges

Discharge Communication

Discharge communication: CALD consumers often struggle with discharge documents not tailored to their language or cultural needs, causing confusion about their care.

Respite discharge information gaps: Comprehensive discharge summaries are often missing, causing information gaps for care providers and families.

Care Continuity & Coordination

Onsite medical capacity: Some facilities experience a high rate of hospital transfers due to the lack of onsite medical capacity, which can be disruptive for residents and may not always be the most appropriate solution.

Delayed follow-up: When consumers experience incidents like falls, delays in following up with medical practitioners can worsen health outcomes.

Coordinated care: Ensuring continuity of care is challenging, especially when services are shared among multiple providers or when there is a change in care providers. This can disrupt the care process and negatively impact the wellbeing of consumers.

External care services: Facilities may not consistently use available external services like palliative care and pain management, potentially missing opportunities to improve consumers' quality of life and manage complex symptoms.

End-of-Life Considerations

Palliative support in rural areas: Timely access to palliative care specialists, grief counsellors and spiritual support may be limited in rural areas, creating barriers to comprehensive end-of-life care for residents and their families.

Gaps in end-of-life care: The limited presence of adequately trained and skilled staff for end-of-life care leads to unmet needs and discomfort **for residents**.

Variability in care standards: Despite clear standards, there is significant variability in how well providers adhere to end-of-life care protocols, resulting in inconsistent care quality.

Care Pathways and Needs Journey Map

Assessment & Admission

Actions

Referral & Transfer

Referral from healthcare providers, family, guardians, or self-referral.

Common Entry Pathways

Most common consumer entry pathways are home or respite, except for children who may come from Child Services.

Respite Care

Consumers often enter permanent care after one or more respite care stays. The average stay here is 3 weeks.

Aged Care

Common Entry Pathways:

- **Hospital transfers:** Individuals are often transferred from hospitals after receiving acute medical care or once their immediate health needs have been stabilised.
- **Home or respite care:** Transition occurs when home care is no longer sufficient or after a respite period indicating the need for permanent care.

Disability Support

- **Home or respite care:** Entry into NDIS services as disabilities become formally diagnosed or as existing conditions progress.
- **Community programs:** Transition from community-based support to more structured NDIS programs as needs increase.
- **Other service providers:** Transitioning from other service providers may happen when current services no longer match the evolving needs of the individual.

Children & Young People

- **Home or respite care:** Transition occurs when home care is no longer sufficient or after a respite period indicating the need for permanent care.
- **Child services:** Involvement due to recommendations from pediatric care or child protective services.

Care Pathways and Needs Journey Map

Daily Life & Care

Actions

Routine Care

Residential care provides personalised daily living support, medical oversight and medication management.

Activities & Social

Engaging regular activities foster social connections, while integrated skills development programs encourage personal growth and independence.

Aged Care

Care Needs:

- Tailored medical and personal care for physical and cognitive needs.
- Coordination between healthcare providers.
- Support for smooth transitions to ensure care continuity.
- Involvement of family, caregivers, and consumers in care decisions.
- Activities to reduce loneliness and enhance social connections.
- Staff training on medication administration and monitoring.
- Access to palliative care, grief counseling, and spiritual support.

Disability Support

- Therapies and assistive devices to enhance independence and community integration.
- Community and peer engagement to promote inclusion and mental well being.
- Collaboration among service providers for cohesive and consistent care.
- Contingency plans for emergencies, especially for complex needs.
- Life skills training, job coaching, and vocational programs to foster independence.
- Staff training to manage challenging behaviours and reduce restrictive practices.
- Tailored transition support and coordination across service providers.

Children & Young People

- Early interventions tailored to developmental stages.
- Educational support to ensure uninterrupted developmental progress.
- Mental health support for anxiety, depression, and trauma.
- Community engagement to foster social skills and participation.
- Recognition of families' role in care and decision making.
- Support for adolescent mental health issues like anxiety and depression.
- Preparation for smooth transitions into adulthood.
- Activities to promote community participation and social skills.
- Protective measures and staff training to prevent abuse and neglect.

Care Pathways and Needs Journey Map

Transition & Discharge

Actions

Exit or Transition

Individuals under NDIS care generally remain within the NDIS framework long-term, unless their aging needs necessitate a transition to aged care facilities.

Aged care residents most commonly leave facilities due to end-of-life care.The average stay ranges from a few months to 3 years, dependent on age at entry and care complexity.

Aged Care

Common Exit Pathways:

- **End-of-life care:** The most common reason for leaving.
- **Hospital transfers:** For acute medical needs that cannot be met in-house.
- **Moves to other residential settings:** Due to preference or specialised care requirements as needs evolve.
- **Returns to the community:** When residents recover or improve sufficiently to live independently or with less support.

Disability Support

- **Change in support requirements:** Significant improvements or declines in health, necessitating adjustments in the level or type of care provided.
- **Desire to be closer to family:** Relocation to facilities near loved ones.
- **Aging Needs:** Transitioning to aged care facilities as part of aging.
- **Personal preference or financial changes:** Decisions influenced by personal choice or financial considerations.
- **End-of-life care:** This could become a necessary transition for individuals with terminal conditions or those nearing the end of life.

Children & Young People

Transition to adult services: Preparing for and moving into services designed for adults, with a focus on fostering independence, continuity of care, and adaptation to the unique needs of adult life. This transition includes support for independent living, employment, and higher education, ensuring a comprehensive approach to meeting the evolving needs of young adults.

Segment Care Needs Across the Journey Stages

Segment	Assessment & Admission	Daily Life & Care	Transition & Discharge
Physical Disability 	Identify and provide tailored mobility aids and accessibility adaptations (e.g. ramps, handrails, wide doorways). Develop integrated care plans to manage chronic conditions and support independence.	Ongoing physical and occupational therapy for pain management, mobility, and daily living skills. Provide personal care assistance for activities like bathing and dressing. Career training and programs to enhance employment opportunities and social engagement. Structured social skills training and support for managing behaviours.	Review care plans to ensure continuity during transitions. Ensure new environments maintain accessibility and provide ongoing support for employment and skills development. Train staff at receiving facilities to handle acute behavioural episodes safely.
Sensory Impairment 	Assess and provide assistive devices such as hearing aids, tactile watches, and text-to-speech software. Ensure facilities are equipped with adaptive technologies (e.g. braille labels, visual alarms).	Ongoing programs to improve social interactions and reduce isolation. Integrated daily living skills training and regular therapies (e.g., speech therapy, braille literacy). Train caregivers to use assistive technologies and meet sensory needs.	Ensure accessibility adaptations and communication support during transitions. Train new staff to understand sensory impairments and meet ongoing needs.
Dementia (including early-onset) 	Develop tailored care plans addressing the needs of both older adults and those with early-onset dementia. Plan for environmental modifications to enhance safety and minimise confusion. Include legal and financial planning in initial care discussions.	Provide ongoing support for daily tasks (bathing, dressing, eating) as the disease progresses. Conduct regular health assessments to manage neurological conditions and reduce hospital visits. Offer activities promoting cognitive engagement and social participation. Ensure staff understand and interpret communicative behaviours properly.	Seamless coordination among healthcare providers and caregivers during transitions. Involve family members in care planning and decision-making.

Segment Care Needs Across the Journey Stages

Segment	Assessment & Admission	Daily Life & Care	Transition & Discharge
Complex Medical Needs 	Collaborate with specialists and develop coordinated care strategies for managing complex medical conditions. Ensure facilities are equipped for medical emergencies and high-level personal care.	Provide round-the-clock personal care and regular access to mental health professionals. Offer social activities to prevent isolation and depression. Regularly update care plans to reflect changing health needs and goals.	Ensure smooth transitions with prompt transfer of medical records and follow-up care. Maintain collaboration with healthcare providers to ensure continuity in managing complex conditions.
Psychosocial Disability 	Conduct thorough evaluations of mental, physical, and cognitive health. Establish ongoing counseling and mental health support from the start.	Provide safe environments where staff manage crises without restraints. Offer access to support groups, counseling services, and employment support programs. Strong educational and psychological support to improve mental health outcomes.	Ensure detailed discharge planning and continued access to mental health services. Support reintegration into the community, workplace, or educational settings.
Developmental Disability 	Assess the need for personalised interventions, assistive devices, and educational programs. Plan for accessible environments and supportive tools from the start.	Provide assistance with daily activities, inclusive social integration, and mental health support. Ensure staff are trained to handle crises and challenging behaviours efficiently.	Tailored plans for education, employment, and independence during transitions. Involve family, caregivers, and the consumer in planning and decision-making.
Diverse Needs 	Care plans respect and incorporate cultural, religious, and gender identity preferences to ensure dignity and individualised care. Provide translation and interpreter services to to facilitate clear communication and prevent misunderstandings.	Activities that reflect their cultural, religious, and personal identities to foster a sense of belonging and inclusivity. Ongoing staff training on cultural sensitivity, inclusive language, and unconscious bias to support equitable care for CALD, Indigenous, LGBTQIA+, and other minority groups.	Ensure cultural preferences are maintained during transitions, including dietary and religious practices. Involve community liaisons and family members in care planning during transitions.

Segment Risks Across the Journey Stages

Segment	Assessment & Admission	Daily Life & Care	Transition & Discharge
Physical Disability 	Inadequate accessibility adaptations may limit autonomy. Communication challenges can lead to unmet needs or inappropriate care plans. Early assessment failures may result in neglect or abuse due to caregiver dependence.	Misuse of mobility aids or restraints (e.g., belts, chairs) can lead to confinement and harm. Excessive use of locking mechanisms restricts movement and social interaction. Physical barriers and lack of support can lead to isolation and loss of self-advocacy.	Poor adaptation in new environments can reduce autonomy. Communication breakdown during transitions can lead to confusion, unmet needs, or anxiety. Lack of social support and increased dependence on caregivers can heighten risks of neglect and isolation. Improper use of restraints can cause harm and diminish trust.
Sensory Impairment 	Failure to identify sensory needs or adaptations may result in insufficient support. Lack of consultation with individuals can lead to care decisions made without their input.	Inadequate staff training leads to inconsistent care for sensory impairments. Lack of assistive technologies (e.g., sign language interpreters) hinders communication and independence. Environments need adaptations to prevent restrictive practices and promote self-advocacy.	Overlooking sensory needs in discharge planning can lead to inappropriate care. Failure to involve individuals in planning and lack of communication can increase isolation and misunderstanding.
Dementia (including early-onset) 	Consent issues in medical interventions can lead to non-consensual treatments. Vulnerability to financial exploitation and legal issues. Lack of consumer involvement in decision-making risks misaligned care plans.	Excessive use of secure areas or locked wards restricts freedom, causing isolation. Misinterpretation of behaviours may lead to unnecessary restraints or isolation. Overuse of medications or mechanical restraints can cause harm and immobility.	Poorly managed transitions increase stress and gaps in care. Inappropriate use of restrictive practices in new settings harms well-being.

Segment Risks Across the Journey Stages

Segment	Assessment & Admission	Daily Life & Care	Transition & Discharge
Complex Medical Needs 	Fragmented care due to poor integration can lead to frequent hospitalisations and reduced autonomy. Isolation and lack of advocacy increase vulnerability.	Malnutrition or unaddressed dietary needs can cause health deterioration. Poor medical oversight and inadequate behaviour support planning lead to unmet needs and neglect. Over-reliance on medications can reduce overall health.	Gaps in care during transitions can exacerbate conditions and reduce access to essential services. Poor communication and lack of coordination during transitions can disrupt care continuity.
Psychosocial Disability 	Lack of early recognition can lead to stigma and discriminatory practices. Failure to plan for challenging behaviours may result in overuse of restraints.	Over-reliance on physical, mechanical, or chemical restraints harms well-being. Overly restrictive environments lead to confinement and loss of autonomy. Premature use of seclusion undermines dignity and recovery.	Poor communication and gaps in care coordination during transitions can worsen conditions. Loss of support services during transitions can lead to regression in independence. Isolation due to loss of familiar networks increases risk of mental health decline.
Developmental Disability 	Inadequate training can lead to neglect in personal care and medical needs. Poor stakeholder engagement may result in care plans that do not align with individual needs.	Improper use of restraints or reliance on medications can lead to harm, dependency, and diminished health. Lack of meaningful social engagement can lead to isolation and depression.	Poor coordination and communication during transitions lead to fragmented care and unmet needs. Lack of individual planning can reduce opportunities for independence and quality of life.
Diverse Needs 	Poor understanding of cultural and identity needs can limit access to necessary care, leading to neglect. Insufficient training on cultural competence may result in inappropriate medical treatments or use of restraints.	Poor understanding of cultural and identity needs can limit access to necessary care, leading to neglect. Insufficient training on cultural competence may result in inappropriate medical treatments or use of restraints.	Failing to recognise cultural preferences during transitions can result in loss of access to essential services, isolation, or inappropriate care. Misunderstandings due to lack of translation services during transitions can lead to inappropriate care or isolation.

Appendix 7:
Risk metrics and assessment workflow

Risk metrics - aged care services organisations

VARIABLE ID	VARIABLE	UPDATING FREQUENCY	DATA SOURCE	KEY METRIC	KEY METRIC used to assess and prioritise organisations that will be visited*	LOW	MEDIUM	HIGH	ADDITIONAL METRICS**	Relevance to Article 4 of OPCAT
1	**Physical Restraints and Confinement**									
1.1	**Level of Restrictive Practices**	Quarterly	My Aged Care Portal, Provider records and reports	Percentage of residents subjected to restraints	YES	Equal or below national average	Above national average or unknown	Significantly above national average	Frequency and duration of restraints, types of restraints used	VERY HIGH - Directly related to deprivation of liberty and potential abuse.
1.2	**Reportable Incidents**	During on-site visit	Provider records and reports	Not specified - to be assessed during the visit	NO				Number of incidents reported, percentage of restraints with comprehensive documentation	HIGH - Directly relevant as it involves safety and rights breaches.
2	**Access and Quality of Healthcare and Services**									
2.1	**Availability of Specialised Services**	Annually	provider service offerings, healthcare provider partnerships	List and availability of specialised services	NO					HIGH - A lack of specialised services can significantly impact residents with complex medical needs, leading to potential neglect and inadequate care.
2.2	**Timeliness of Access**	During on-site visit	Provider records and reports, resident feedback	Not specified - to be assessed during the visit	NO				Average time to access healthcare services, frequency of timely interventions	MEDIUM - Timely access to healthcare and support can prevent deterioration in health and ensure ongoing management of chronic conditions.
2.3	**Transition and Continuity of Care**	During on-site visit	Transition plans, case conferencing records, feedback from residents and families	Not specified - to be assessed during the visit	NO				Number of transition plans executed, frequency of case conferences, resident satisfaction with transitions	MEDIUM - Ensures continuity and stability of care and smooth transitions to maintain continuity of care and reduce risks associated with abrupt changes in care settings.
2.4	**Behavioural and Psychological Support**	During on-site visit	Provider records and reports	Not specified - to be assessed during the visit	NO				Number of incidents involving challenging behaviours, frequency of psychological support sessions, staff training completion rates	MEDIUM - Adequate behavioral and psychological support is crucial for well-being.
3	**Resident Autonomy and Decision-Making**									
3.1	**Residents' Experience Ratings**	Quarterly	My Aged Care Portal, Provider records and reports	Residents' Experience Star Rating	YES	Excellent/Good (4-5 stars)	Improvement needed or acceptable (2-3 stars)	Significant improvement needed (1 star)	Level of involvement in care decisions, satisfaction with decision-making processes	HIGH - Empowering residents supports autonomy and upholds dignity, which is critical for quality of life.
3.2	**Supported Decision-Making**	During on-site visit	Provider policies, resident care plans	Not specified - to be assessed during the visit	NO				Number of residents with supported decision-making plans, effectiveness of support structures	HIGH - Supported decision-making is essential for respecting individual autonomy.
3.3	**Informed Consent Practices**	During on-site visit	Provider records, resident feedback	Percentage of documented consents, resident satisfaction	NO				Consent processes and documentation practices	HIGH - Directly impacts residents' autonomy and rights.
3.4	**Conflict of Interest Management**	During on-site visit	Internal audits, staff reports	Number of identified conflicts, resolution effectiveness	NO				Conflict of interest policies and incidents	MEDIUM - Ensures transparency and fairness in care provision.
4	**Infrastructure, Environmental Factors and Living Conditions**									
4.1	**Secure dementia beds**	Annual	My Aged Care Portal, Provider website	Presence of secure dementia beds	YES	Not present		Present		HIGH - Secure environments are necessary for the safety of residents with cognitive impairments.
4.2	**Secure garden**	Annual	My Aged Care Portal, Provider website	Presence of secure garden	YES	Not present	Present			HIGH - Secure environments are necessary for the safety of residents with cognitive impairments.
4.3	**Falls or Injuries**	Quarterly	My Aged Care Portal, Incident reports, health and safety audits	Percentage of residents that experienced one or more falls	YES	Equal or below national average	Above national average or unknown	Significantly above national average	Severity of falls incidents, preventive measures in place	HIGH - High frequency of falls indicates potential neglect and need for safety improvements.
4.4	**Living Conditions**	During on-site visit	provider inspections, resident feedback	Cleanliness, safety, adequacy of living spaces, provider amenities	NO	Excellent/Good	Acceptable	Poor or unsafe	Maintenance of cleanliness, safety, and adequacy of living spaces	MEDIUM - Maintaining a safe and adequate living environment helps protect residents' rights.
4.5	**Physical Environment and Accessibility**	During on-site visit	provider inspections, resident feedback, Audit and reaccreditation reports	Audit findings	NO	Compliant with relevant Aged Care Quality Standard(s)	Compliant with relevant Aged Care Quality Standard(s), but improvements suggested	Non-compliance with relevant Aged Care Quality Standard(s)	Number of accessibility features (ramps, handrails, etc.), resident satisfaction with accessibility	HIGH - Adequate physical environment and accessibility features are crucial for mobility and support.
5	**Access to Family and External Support**									
5.1	**Frequency of Visits**	During on-site visit	Provider visitor logs, resident and family surveys	Average number of family visits per month, ease of access for visitors	NO	High frequency of family visits	Moderate frequency	Low or no family visits		LOW - Family visits support emotional well-being, reducing feelings of isolation.
5.2	**Communication Channels**	During on-site visit	Provider policies, resident feedback	Availability of communication options (e.g., phone, video calls), effectiveness and usage rates	NO	Comprehensive and effective	Limited effectiveness	Ineffective or no communication channels		MEDIUM - Effective communication channels are essential for maintaining connections and addressing issues promptly.
5.3	**Language Support Services**	During on-site visit	Service usage reports, resident feedback	Availability and usage of translation services	NO				Assessment of language support infrastructure and effectiveness	HIGH - Essential for clear communication and ensuring residents' needs and preferences are understood and respected
6	**Staffing and Training**									
6.1	**Level of Staffing**	Quarterly	Staffing records, provider reports	Staffing Rating	YES	Excellent/Good (4-5 stars)	Improvement needed or acceptable (2-3 stars)	Significant improvement needed (1 star)		HIGH - Adequate staffing levels and training are critical for ensuring high-quality care and safety.
6.2	**Training and Competency**	Quarterly	Training logs, staff certifications, performance evaluations	Not specified - to be assessed during the visit	NO				Number of staff trained in critical areas (e.g., dementia care, rights awareness), frequency of training sessions	HIGH - Competent staff are essential for providing appropriate and safe care and managing complex needs.
6.3	**Cultural Competence Training**	During on-site visit	Training records, staff feedback	Percentage of staff trained, training satisfaction	NO				Review of training programs and staff competency	HIGH - Promotes respect for cultural diversity and prevents discrimination.
7	**Rights Awareness and Legal Compliance**									
7.1	**Compliance with Standards**	Quarterly	My Aged Care Portal, Accreditation and compliance reports, external audit results	Compliance Rating	YES	Excellent/Good (4-5 stars)	Acceptable (3 stars)	Improvement needed or significant improvement needed (1-2 stars)	Frequency of compliance issues, types of deficiencies noted, corrective actions taken	VERY HIGH - Ensures adherence to legal standards, directly protecting residents' rights.
7.2	**Staff Knowledge of Customers' Rights**	During on-site visit	Staff surveys, training records	Not specified - to be assessed during the visit	NO				Percentage of staff trained in rights awareness, effectiveness of training programs	HIGH - Ensures staff are aware of and respect residents' rights, preventing rights violations.
7.3	**Customer Knowledge of Their Rights**	During on-site visit	Resident surveys, educational program records	Not specified - to be assessed during the visit	NO				Percentage of residents informed about their rights, accessibility of rights information	VERY HIGH - Ensures residents are aware of their rights, enabling them to protect themselves.

Information is publicly available ot can be supplied by regulators. To be collected on Step 2 of the Risk Assessment Porcess

***To be collected and assessed during on-site visits on Step 5 of the Risk Assessment Process*

Risk metrics - disability services organisations

VARIABLE ID	VARIABLE	UPDATING FREQUENCY	DATA SOURCE	KEY METRIC	KEY METRIC used to assess and prioritise organisations that will be visited*	LOW	MEDIUM	HIGH	ADDITIONAL METRICS**	Relevance to Article 4 of OPCAT
1	**Physical Restraints and Confinement**									
1.1	**Restrictive Practices**	Bi-annually	Facility	Presence of restrictive practices	YES	No restrictive practices	Restrictive practices present		Frequency and types of restrictive practices	VERY HIGH - Directly related to deprivation of liberty and potential abuse.
1.2	**Incident Management**	During on-site visit	Incident reports, compliance records	Number of incidents, types of incidents, resolution time	NO				Satisfaction with incident handling among residents and families.	HIGH - Directly relevant as it involves safety and rights breaches.
2	**Access and Quality of Healthcare and Services**									
2.1	**Support Plan Reviews**	During on-site visit	Support plan documents	Frequency of reviews, updates made	NO				Effectiveness of support plan implementation.	MEDIUM - Ensures plans are up-to-date, reducing risks of neglect.
2.2	**Behaviour Support**	During on-site visit	Behaviour support plans, incident logs	Number of plans, frequency of interventions	NO				Effectiveness of interventions as measured by reduction in incidents over time.	HIGH - Directly impacts how behaviour-related issues are managed, including restrictive practices.
2.3	**Transition and Continuity of Care**	During on-site visit	Transition plans, case conferencing records, feedback from residents and families	Not specified - to be assessed during the visit	NO				Number of transition plans executed, frequency of case conferences, resident satisfaction with transitions	MEDIUM - Ensures continuous and adequate care, reducing risks of neglect.
2.4	**Quality and Risk Management**	During on-site visit	Risk management plans audit reports	Continuous improvement initiatives, participant feedback, Documentation of strategies	NO				Number of audits conducted	MEDIUM - Ensures ongoing quality improvement, indirectly protecting rights.
3	**Infrastructure, Environmental Factors and Living Conditions**									
3.1	**Living Conditions**	During on-site visit	provider inspections, resident feedback	Cleanliness, safety, adequacy of living spaces, provider amenities	NO				Maintenance of cleanliness, safety, and adequacy of living spaces	MEDIUM - Ensures a safe and adequate living environment, indirectly protecting rights.
4	**Access to Family and External Support**									
4.1	**Feedback and Complaints Management**	During on-site visit	Complaints logs, feedback records	Number of complaints, resolution time, types of complaints	NO				Feedback from residents on their confidence in the complaints process.	HIGH - Addresses concerns and ensures complaints are resolved, preventing rights violations.
4.2	**Communication Accessibility**	During on-site visit	Facility records, resident feedback	Availability and use of communication aids, frequency of interpreter services	NO				Customer feedback on accessibility and usability of communication options	HIGH - Enhances communication, ensuring residents can express their needs and rights.
4.3	**Engagement with Cultural and Community Representatives**	During on-site visit	Facility records, resident and community feedback	Number of cultural and community engagement activities, resident satisfaction	NO					MEDIUM - Promotes inclusion and respect for cultural identities.
5	**People and Governance**									
5.1	**Human Resource Management**	During on-site visit	HR records	Staff qualifications, staff-to-participant ratios, training hours	NO				Percentage of staff receiving ongoing training, resident feedback on staff performance	MEDIUM - Ensures adequate and qualified staffing to prevent rights violations.
5.2	**Rights and Responsibilities**	During on-site visit	Policies, resident feedback	Evidence of policies, satisfaction with respect and dignity	NO				Customer and family satisfaction with rights information provided, assessment of adherence to rights policies	HIGH - Directly relevant to protecting the rights of individuals.
5.3	**Staff Ethical Training**	During on-site visit	Training records, staff feedback	Frequency and quality of staff training on ethical practices	NO				Incidents of ethical breaches and subsequent actions.	HIGH - Ensures that staff are well-trained in ethical standards, protecting residents' rights.
5.4	**Cultural Competence Training**	During on-site visit	Training records, staff feedback	Frequency and effectiveness of cultural competence aining	NO					HIGH - Ensures respectful and appropriate care for individuals from diverse backgrounds.
6	**Rights Awareness and Compliance**									
6.1	**Compliance with Legal Standards**	Quarterly	Accreditation and compliance reports, external audit results	Compliance Rating	YES	No non compliance notices		Non compliance notices	Frequency of compliance issues, types of deficiencies noted, corrective actions taken	VERY HIGH - Ensures adherence to legal standards, directly protecting residents' rights.
6.2	**Staff Knowledge of Customers' Rights**	During on-site visit	Staff surveys, training records	Not specified - to be assessed during the visit	NO				Percentage of staff trained in rights awareness, effectiveness of training programs	HIGH - Ensures staff are aware of and respect customers' rights, preventing rights violations.
6.3	**Customer Knowledge of Their Rights**	During on-site visit	Customer surveys, educational program records	Not specified - to be assessed during the visit	NO				Percentage of residents informed about their rights, accessibility of rights information	VERY HIGH - Ensures customers are aware of their rights, enabling them to protect themselves.
					*Information is publicly available ot can be supplied by regulators. To be collected on Step 2 of the Risk Assessment Porcess				**To be collected and assessed during on-site visits on Step 5 of the Risk Assessment Process	

Risk assessment workflow

RISK ASSESSMENT WORKFLOW		
The following detailed process guides users through the risk assessment process to calculate overall risk ratings for aged care and disability services facilities. This step-by-step guide ensures that users can systematically evaluate and prioritise facilities based on their risk levels.		
Step 1: Baseline Risk Rating		
Identify Customer Segments:		
Determine the customer segments served by each facility (e.g., seniors with cognitive impairments, adults with physical disabilities).		
Assign Baseline Risk Ratings:		
Assign a baseline risk rating to each facility based on the customer segments. Facilities serving higher-risk segments (e.g., those with severe mobility issues) may receive a higher baseline rating.		
Document the baseline risk rating for each facility.		
Step 2: Data Collection		
Collect Data: Gather data for all risk variables associated with each facility as specified for each variable. Verify the accuracy and completeness of the data collected. **Update the GREY CELLS of the following tabs: Resourcing Projections, Service Detailes - Disability and Service Details - Aged Care**		
Step 3: Data Analysis – Overall Risk Rating		
Compile Collected Data: Organise the collected data for each facility by risk variable.		
Compare Against Benchmarks: Compare each facility's data against national averages and best practices to highlight deviations and potential risks.		
Assign Risk Levels: Evaluate the severity and likelihood of risks for each identified variable and assign risk levels (low, medium, high) to each variable based on the analysis.		
Weight Variables: Assign weights to each variable based on their relevance to Article 4 of OPCAT:	***Points***	
Very High	4	
High	3	
Medium	2	
Low	1	
Not Relevant	0	
Score Variables: Score each variable based on key metrics	***Points***	
Low	1	
Medium	2	
High	3	
Very High	4	
Step 4: Calculation of Overall Risk Rating		
Calculate Weighted Scores: Multiply the score for each variable by its weight and sum these weighted scores to get a total score for each facility.		
Combine with Baseline Rating: Add the baseline risk rating (from Step 1) to the total weighted score.	27	
Determine Overall Risk Rating - DISABILITY SERVICES : Use the combined score to assign an overall risk rating to each facility:	***%***	
Low Risk: 0 to 11	41%	
Medium Risk: 12 to 18	67%	
High Risk: 19 to 22	81%	
Very High Risk: 23 to 27	100%	
Document the Results: Record the overall risk rating for each facility in the assessment tool and generate heat maps for aged care and disability services, listing facilities with their overall risk ratings.	97	
Determine Overall Risk Rating - AGED CARE SERVICES: Use the combined score to assign an overall risk rating to each facility:	***%***	
Low Risk: 0 to 30	31%	
Medium Risk: 31 to 45	46%	
High Risk: 46 to 60	62%	
Very High Risk: 61 to 94	100%	
Document the Results: Record the overall risk rating for each facility in the assessment tool and generate heat maps for aged care and disability services, listing facilities with their overall risk ratings.		
Step 5: Visits and Further Enquiries		
Prioritise Facilities for Visits: Prioritise facilities with higher overall risk ratings for on-site visits.		
Conduct On-Site Visits: Schedule and conduct visits to medium, high and very high risk **DISABILITY SERVICES** facilities and high and very high risk **AGED CARE SERVICES** facilities**.** During visits, perform additional qualitative and quantitative assessments, using the identified risk variables and metrics as guidance		
Validate and Update Risk Ratings: Validate the initial risk ratings based on findings from the on-site visits.		
Update the overall risk ratings if necessary, based on new information obtained during the visits.		

Appendix 8: Letter from DECYP to the Tasmanian NPM, 20 September 2024.

Department for Education, Children and Young People
OFFICE OF THE SECRETARY

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OfficeoftheSecretary@decyp.tas.gov.au
Ph (03) 6165 5757

Tasmanian Government

File no: DOC/24/174137

20 September 2024

Mr Richard Connock
Tasmanian National Preventative Mechanism
By email: enquries@npm.tas.gov.au

Dear Mr Connock

RESTRICTIVE PRACTICES IN OUT OF HOME CARE

Thank you for your letter of 30 July 2024 in which you request information pertaining to the use of restrictive practices by out of home care (OOHC) service providers. I note that you seek this information to assist in scoping the implementation of the Tasmanian National Preventative Mechanism (NPM) in relation to health and social care settings.

1. Restrictive practices policy or approval processes in OOHC

The Department for Education Children and Young People (the Department) does not have a policy or formal approval process regarding the use of restrictive practices in OOHC at this point in time.

Comprehensive work is being undertaken in the Department to determine the most appropriate policy approach with regards to the use of restrictive practices by all our services, including services for OOHC. To this end, a draft whole-of-agency Restrictive Practice Policy has been developed and has undergone preliminary internal consultation. However, before we can further progress this policy, there are legal and definitional concerns that need further clarification. A draft Restrictive Practices Procedure for OOHC is also being developed, the finalisation of this work is dependent on the direction of the policy work.

Currently, if the child or young person in OOHC is not an National Disability Insurance Scheme (NDIS) participant, approval process is informal without a dedicated policy/procedure, but the expectation is that any proposed restrictive practices should be considered within the individual's Care plan and should be endorsed by a senior Child Safety practitioner other than the individual care provider. The Department relies on OOHC service providers, Child Safety Officers, and Practice Leaders to use restrictions that are reasonable and necessary to keep the child or young person safe.

All Special care packages delivered by service providers contracted by the Department are reviewed annually by the Australian Childhood Foundation, to ensure that measures used to manage behaviour are reasonable and necessary, and that the placement in general is providing a therapeutic environment.

2. Data on OOHC places where restrictive practices are approved

For any children and young people who are not NDIS participants, interventions are captured within Care plans or externally developed Behavioural support plans. They would be captured in the context of supporting behaviours or responding to safety concerns, not necessarily as a restrictive intervention. Outside of manually reviewing the Care plans or Behavioural support plans, the Department is not able to export data on restrictive practices.

It is not possible to provide an exact list of restrictive practices in OOHC given the varying presentations of children in care. They could range from restricting access to technology, locking external doors, removing knives, restricting kitchen access, and physically holding a child to prevent them from harming themselves or others.

If you have any questions or would like any additional context or detail to the responses above you are welcome to contact [redacted] in the first instance. I note that your office is also in contact with [redacted]

I very much welcome the establishment of the Tasmanian NPM as an additional mechanism to protect the rights of some of our most vulnerable children and young people and I look forward to learning more about the scope of the NPM in due course.

Yours sincerely

Jenny Burgess
ACTING SECRETARY

Appendix 9: Expectations on the treatment of people deprived of their liberty in health and social care settings

Tasmanian NPM National Preventive Mechanism

Expectations on the treatment of people deprived of their liberty in **health and social care**

Aged residential care, disability support and related services

Version 1 – November 2024 [Consultation Draft]

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, cruel, inhuman or degrading treatment or punishment of people deprived of their liberty by embedding best practice human rights. It does this through proactive oversight of places 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

Contents

Introduction

Mental health

Detention settings covered by these Expectations	**Aged residential care, disability support residences and related environments and transport in Tasmania.**
Date of publication	**November 2024**

Around Tasmania, people in the community are or may be deprived of their liberty by law while receiving health and social care services. This particularly includes people in aged residential care or who are receiving disability support services, which is the focus of this document. 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 expert, Dr Yvette Maker.[1]

The expectations were drawn up in codesign with representative and advocacy organisations of persons with disability, older persons, and group residential aged care and disability support services. They are referenced against international and domestic human rights instruments and were devised in light of relevant Tasmanian and national standards, sources and regulations. They made extensive use of the Expectations and Standards developed for other Tasmanian settings and other jurisdictions, especially the New Zealand Office of the Ombudsman's *OPCAT Expectations for Aged Residential Care* (2024) and *OPCAT Expectations – Intellectual Disability and Community Secure Services* (2024). A complete list of the materials considered and referred to in the document is provided at Annex 1.

Preparation of these expectations involved in-person familiarisation visits to Tasmanian operated aged care settings, including the Roy Fagan Centre, King Island District Hospital and Health Centre, and the Flinders Island Multi-Purpose Centre. In addition, to understand the service delivery landscape in Tasmania, the Office of the Tasmanian NPM engaged with the Interim Disability Commissioner Tasmania, the National Disability Insurance Scheme (NDIS) Quality and

[1] Senior Lecturer, School of Law, University of Tasmania and Honorary Senior Fellow, Melbourne Law School.

Safeguards Commission, the National Disability Insurance Agency (NDIA), Office of the Senior Practitioner, and many private sector Aged Care and Disability Services providers.

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

What are expectations?

The *Optional Protocol to the Convention against Torture* (OPCAT) provides that the central function of a national preventive mechanism (NPM) is to regularly examine the treatment of persons deprived of their liberty in places of detention with a view to strengthening, if necessary, their protection against torture and other cruel, inhuman or degrading treatment or punishment. Flowing from this visiting function, the NPM also provides education and advisory services, and engages cooperatively with government, administrators of places of detention, detainees, stakeholders and the public.

Expectations documents are commonly released by NPMs 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 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 (SPT).

The experience of persons deprived of their liberty is at the heart of each expectations document. They serve as a guide to assist with identifying areas of concern, and not whether 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.

The Tasmanian NPM understands that aged residential care and disability services are provided in diverse and often complex environments, and that services need to comply with a range of Tasmanian and Commonwealth legal requirements. The Tasmanian NPM recognises that care and support service providers are often required to balance multiple rights considerations, such as balancing a service user's right to life and health with their right to make their own decisions, including risky decisions (known as 'dignity of risk'). Services will also at times need to balance competing rights, needs and preferences of multiple service users.

The Tasmanian NPM also recognises that the provision of care and support to children and adults with disability and older persons in congregate or group settings has been characterised by some bodies as inherently incompatible with human rights.[2] In these environments deprivation of liberty can occur in many ways, shaped by both environmental and personal factors. In some circumstances a person may be unaware that their liberty has been deprived, and the duration of this event may also be ongoing or temporary.

Examples include being physically or mechanically restrained, being subject to seclusion or confined to a particular room or area within a building, being placed on/in an object or vehicle from which the person cannot freely remove themselves, being subject to a chemical restraint, or requiring permission to leave.

The Tasmanian NPM's approach to exercising its functions in aged residential care and disability services settings has been informed by guidance from the SPT,[3] the

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[2] For example, Committee on the Rights of Persons with Disabilities, *General Comment No. 5 (2017) on Article 19: Living Independently and Being Included in the Community*, UN Doc CRPD/C/GC/5 (27 October 2017); Office of the High Commissioner for Human Rights, *Getting a Life – Living Independently and Being Included in the Community* (United Nations, April 2012).

[3] Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *General Comment No. 1 (2024) on Article 4 of the Optional Protocol (Places of Deprivation of Liberty)*, 53rd session, UN Doc CAT/OP/GC/1 (4 July 2024) [56]-[57]:

> The Subcommittee notes that many persons with disabilities are presumed to be unable to live independently, or that support to live independently is not available or is tied to specific living arrangements. Although there may be no legal or administrative order confining such persons to a certain facility, the lack of support compels them to remain in living situations that deprive them of their liberty and may subject them to harmful practices. This form of disability-specific deprivation of liberty can occur in family homes and in institutional arrangements, including social care institutions, psychiatric institutions, long-stay hospitals, nursing homes, secure dementia wards, special boarding schools, child welfare institutions, group homes, rehabilitation centres, forensic

practice of other state NPMs, as well as feedback from community stakeholders, service providers, and relevant government agencies.

Under these expectations the Tasmanian NPM will be focusing on conditions of treatment in residential settings and related transport, where it has evaluated deprivation of liberty may occur. This includes, but is not limited to, disability group homes and daytime support centres, specialised disability accommodation residences, closed community-based accommodation and residences for people with disability, aged care facilities (including in hospital/medical centres) and dementia units, and nursing homes. People using supported independent living services may also be included, depending on the nature of services provided and the service user.

The aged residential care, disability support and related services addressed in this expectations document represent just part of the health and social care system in Tasmania. These services may be funded and operated by multiple agencies, organisations and professionals, and the Tasmanian NPM's monitoring and prevention function involves examining and making recommendations on all relevant parts of the system that fall within its jurisdiction, under the *OPCAT Implementation Act 2021* (Tas). Other health and social care settings that may constitute places of detention include secure mental health facilities, hospitals, and education settings providing support to children and young people with disability or where restrictive practices are applied. The Tasmanian NPM has prepared additional expectations materials covering these and other settings.[4]

> psychiatric settings, albinism hostels, leprosy colonies, religious communities, family-type homes for children and prayer camps.
>
> Therefore, when considering whether a particular place, facility or setting is a place of deprivation of liberty within the meaning of article 4 of the Optional Protocol, it is important that national preventive mechanisms and the Subcommittee ascertain the presence of reasonable accommodation arrangements and support for persons with disabilities. If reasonable accommodation and support are unavailable, the place, facility or setting should be considered a place of deprivation of liberty.

[4] 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.

Language used in these expectations

Service users

This expectations document uses the term ‘service user’ to refer to a person who resides in or uses an aged residential care setting, a disability support setting, or a similar service. The Tasmanian NPM recognises that language is complex and contested, and different people, services and sectors may prefer and use other language to refer to themselves and their communities.

This document refers to the United Nations *Convention on the Rights of Persons with Disabilities* as one source of relevant human rights standards in relation to monitoring of aged residential care, disability support and related settings. While many older persons may have or develop disability or impairment during their lives and may be subject to restrictions or violations of their rights on this basis, the Tasmanian NPM recognises that not all aged residential care service users have (or identify as having) a disability, and that ageing is not necessarily associated with disability.

Staff

This expectations document uses the term ‘staff’ to refer to the range of persons involved in the provision of aged residential care, disability support or similar services to service users. Depending on the context, this may include care and support workers, health and allied health professionals, agency staff, volunteers, security staff and others

Supporters and substitute decision-makers

The Tasmanian NPM recognises that users of aged residential care, disability support or related services may receive informal support or assistance from one or more trusted people, such as family members, carers, friends or supporters, including assistance with making and carrying out decisions. They may also use paid or professional supports such as independent advocates, and/or use formal processes to appoint representatives of their choice (such as nominees and authorised representatives). Where relevant, the expectations refer to people chosen by service users to provide support and assistance as ‘supporters’.

The Tasmanian NPM further recognises that aged residential care, disability support or related service users may have ‘substitute decision-makers’ legally appointed by others (such as guardians and administrators appointed by the Tasmanian Civil and Administrative Tribunal). These appointments, and the decisions made by appointees, may or may not be consistent with the will and preferences of the service user, although substitute decision-makers may also be the preferred supporter for a service user.

In these expectations, some references to 'the service user' may apply to both the service user and substitute decision-maker where the latter is legally authorised or required to be involved in processes or decisions, while recognising that human rights standards (and, increasingly, domestic law and guidelines) require respect for the will, preferences and legal capacity of individuals to the maximum possible extent.[5]

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 in health and social care*. 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.

[5] For further discussion, see Committee on the Rights of Persons with Disabilities, *General Comment No. 1 (2014) on Article 12: Equal Recognition Before the Law*, UN Doc CRPD/C/GC/1 (19 May 2014).

Summary of expectations

Topic 1: The living environment

The physical living environment is safe, welcoming, comfortable and tailored to the individual; it promotes the dignity, autonomy, privacy and wellbeing of all service users.

1.1 Service users live in a safe, clean and well-maintained environment.

1.2 Service users can move freely around areas in the service, including outdoors.

1.3 The living environment is comfortable.

1.4 Design and resourcing ensure the living environment is appropriate for the varied individual needs of service users and enables them to enjoy dignity, autonomy, privacy and other rights.

1.5 Service users' bedrooms are private, comfortable and personalised.

1.6 Children and young people live in an age-appropriate environment that promotes their rights, safety and wellbeing.

Topic 2: Procedural safeguards

All processes and safeguards relating to service users' deprivation of liberty are accessible, fair and transparent in their nature and application and are applied rigorously. Service users are presumed to be the primary decision-makers in matters, processes and decisions that affect them, and are supported and facilitated to express their views, preferences and choices.

2.1 Service users are free to come and go unless there is a clear, justified and documented reason for their deprivation of liberty.

2.2 Information about the reason service users are in a secure placement or otherwise deprived of liberty is recorded and communicated to the service user in a clear and accessible way.

2.3 Service users receive effective communication, including communication about their rights.

2.4 Service users can access effective complaints and feedback mechanisms.

2.5 Service users can freely access their legal representatives, supporters and advocates.

2.6 Service users' consent, consultation and participation in decision-making (including supported decision-making) are facilitated and prioritised.

2.7 Service users' privacy and confidentiality are respected and preserved.

Topic 3: Healthcare

Service users enjoy the highest attainable standard of physical and mental health, including access to healthcare services and treatment on an equal basis with others in the community that promotes their wellbeing, dignity, privacy and autonomy and meets their individual needs and preferences.

3.1 Service users make their own choices about healthcare and treatment wherever possible, and can access support to make decisions.

3.2 Physical and mental health needs of service users are assessed appropriately by suitably qualified professionals.

3.3 Service users can access a range of services to support holistic, person-centred, culturally appropriate and trauma-informed healthcare.

3.4 Service users' medical confidentiality and privacy is upheld.

3.5 Service users are supported and encouraged to optimise their health and wellbeing through preventive healthcare practices.

3.6 Service users dealing with substance misuse are identified and can access support through joined-up, comprehensive services and pathways.

Topic 4: Care and support

Service users live in an enabling environment that supports their autonomy and self-determination; they have access to high quality, person-directed, culturally and life-course appropriate care and support that meets their needs, will and preferences and maintains their dignity.

4.1 Service users make their own choices about care and support to the fullest extent possible.

4.2 The care and support needs of service users are assessed and addressed appropriately by suitably qualified workers.

4.3 Service users can access a range of services, workers and other supports to provide holistic, person-centred, culturally appropriate and trauma-informed care and support.

4.4 Service users are supported and encouraged to optimise their health and wellbeing through accessing early intervention and rehabilitation.

4.5 Discharge or transition planning is proactive and comprehensive with a view to ensuring service users are not deprived of liberty, or stay in the service, for longer than is necessary.

Topic 5: Connection to the community

Service users are encouraged and supported to be part of the community and maintain contacts and connections that are important to them through a range of measures they freely choose

5.1 Service users are connected with and part of the community, and are engaged as citizens.

5.2 Service users regularly have time away from their residence.

5.3 Service users live as close as reasonably possible to their community and support networks.

5.4 Service users can communicate freely, with their privacy respected, and with support where needed. Any restrictions on contact are individually justified, proportionate and fully explained.

5.5 The fullest visiting arrangements possible are facilitated. Visits are as comfortable and easy as possible for service users and visitors.

Topic 6: Diversity, equality and non-discrimination

The diversity of the service user group is recognised and welcomed. The distinct and individual needs of service users are identified and fully met in relation to disability, age, Aboriginal and Torres Strait Islander background, culture, gender, sex, sexuality, gender identity, nationality, religion or spirituality, and other grounds. Organisational policies, culture, processes and practices ensure service users are not subject to discrimination, bullying or harassment.

6.1 Service users are respected and valued as individuals; their individual needs and preferences are identified and met.

6.2 Aboriginal and Torres Strait Islander service users can exercise their cultural rights and live in a culturally safe service.

6.3 Service users from culturally and linguistically diverse backgrounds, including Deaf community and culture, can exercise their cultural rights and live in a culturally safe service.

6.4 LGBTIQA+ service users are supported to understand, explore and express their identity in a safe and supportive environment.

6.5 Service users live in an environment where tolerance, understanding and respect are actively promoted.

6.6 Service users live in an environment where discriminatory conduct, bullying and harassment are not tolerated and any instances are challenged.

6.7 Service users are treated fairly and swift action is taken to address any evidence of discriminatory processes and conduct.

6.8 Reasonable adjustments and other accommodations are made to ensure equality of access and treatment of people with disability.

Topic 7: Safety, order, discipline, and restrictive practices

Service users feel safe and are free from all forms of harm or maltreatment. Service users' safety is secured, and their needs met, via alternatives to restriction to the maximum possible extent. All aspects of safety and security are informed by an understanding of individual needs, characteristics and experiences, including experiences of trauma.

7.1 The service takes a holistic, trauma-informed, person-centred and proactive approach to maintaining a safe environment for all service users.

7.2 The service responds promptly and appropriately to concerns or allegations (including potential concerns or indications) about exploitation, violence, abuse, coercion, neglect or other forms of harm to service users.

7.3 Alternatives to restriction are prioritised and implemented effectively.

7.4 Staff are trained in trauma-informed practice and least restrictive practice, and have adequate resources, to respond to potentially harmful or risky incidents and behaviour.

7.5 Any use of restraint or seclusion is conducted with proper legal authority, used only as a last resort and for the shortest time possible, and causes the minimum interference with the person's autonomy, dignity and privacy.

7.6 The service provides a safe and secure environment which reduces the risk of self-harm and suicide. Service users at risk of self-harm or suicide are identified at an early stage and given the necessary support.

7.7 The service provides a safe and secure environment which reduces the risk of self-harm and suicide. Service users at risk of self-harm or suicide are identified at an early stage and given the necessary support.

7.8 Any searches are undertaken with proper legal authority, are proportionate to an identified risk and carried out with due regard to, and respect for, dignity and privacy.

Topic 8: Daily life

The living situation in the service promotes dignity, respect, autonomy, wellbeing and rights of all service users; service users have choice and control over their everyday lives to the fullest extent possible, and care and support facilitates this.

8.1 Service users are welcomed and well-oriented when they arrive at the service.

8.2 Service users are the primary decision-makers in relation to day-to-day life decisions, and their dignity, autonomy and wellbeing is fostered.

8.3 Service users are treated with dignity and respect.

8.4 Service users have access to meaningful activities and are encouraged and supported to engage in activities of their choice.

8.5 Service users can freely practice their culture, religion and spirituality.

8.6 Service users have access to adequate amounts of water and nutritious food which promote their health and wellbeing.

8.7 Service users have access to appropriate clothing and laundry facilities.

8.8 Service users have access to personal possessions and property.

Topic 9: Leadership and culture

The leadership, culture and staffing of residential services promotes and protects the rights of service users.

9.1 Service users and representative organisations are involved in governance and decision-making processes.

9.2 Leaders and staff promote, operationalise and demonstrate a human rights-based approach to providing the service to service users.

9.3 Leaders are committed to and take responsibility for promoting and providing high quality care and support, and continuous quality improvement.

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

9.5 The service emphasises its commitment to service users' rights, safety and wellbeing when advertising for, recruiting and screening staff and volunteers.

9.6 Staff are equipped with the resources, knowledge, skills and awareness to protect and promote service users' rights.

9.7 Ongoing supervision and people management is focused on promoting the safety, dignity, rights and wellbeing of service users.

Expectations and indicators

Topic 1: The living environment

Overarching expectation: The physical living environment is safe, welcoming, comfortable and tailored to the individual; it promotes the dignity, autonomy, privacy and wellbeing of all service users

Expectations	Indicators
1.1 Service users live in a safe, clean and well-maintained environment.	• All buildings and grounds are appropriate for service users and their accessibility and support requirements. • All areas are in a good state of repair, regularly cleaned and well-decorated. • Regular cleaning, maintenance and replacement schedules are documented and followed. • Sleeping, washing and communal areas are organised in a way that ensures the safety of service users. Appropriate measures are used to address risks or vulnerabilities and ensure all service users' physical, sexual and psychological safety, including with regard to gendered spaces. • Washing and toilet facilities are sufficient for the number of service users. They are accessible, in good working order, ensure privacy, and are clean and hygienic. • Service users and staff can raise an alarm in the case of emergency (such as fire or flood), and staff respond promptly. • Documented policies and procedures exist to report and manage emergencies, disasters and major incidents, including personalised emergency plans where required. • Staff responses to emergencies, disasters and major incidents are documented and reviewed. • Service users and staff can access appropriate supports following an emergency event, disaster or major incident.
1.2 Service users can move freely around areas in the service, including outdoors	• Service users can access different areas of the service on a regular basis and are facilitated to do so. • The service has areas for leisure and communal time as well as quiet time. • Safe, green outdoor areas (with seating and shelter) are readily accessible to service users for exercise,

	social interaction and engaging with the natural environment to the fullest extent possible. • Signage and other wayfinding information is appropriate to the setting and presented in languages, formats and locations suited to service users' and visitors' needs. • Toilet and washing facilities are accessible (with adaptation where necessary) for all residents.
1.3 The living environment is comfortable	• Occupancy levels are appropriate and the service environment is not crowded. • All living areas have natural light and access to fresh air. • All living areas are at an appropriate temperature, with heating, cooling and ventilation where needed. • If a residential service, the service looks and feels home-like, including through appropriate fixtures, fittings, furniture and decoration.
1.4 Design and resourcing ensure the living environment is appropriate for the varied individual needs of service users and enables them to enjoy dignity, autonomy, privacy and other rights	• Service users, supporters and representative organisations have opportunities to have input into the design of the living environment and contribute to decisions about the living environment to the greatest extent possible. • Service users can physically access all areas they have a right to be in. • Each service user's mobility, physical, sensory and learning needs are accommodated. • Accessible facilities for faith, worship and cultural practices are provided for all service users. • The sensory environment and its design features are appropriate to individual service users and minimise stress and distress. • Service users can access areas that provide a sanctuary from stress or over-stimulation, where they can experience their feelings, seek or avoid sensory input as needed, and relieve discomforts in private. • There are sufficient multi-purpose and single-purpose activity rooms and spaces to meet the need for programs, visits, recreation, leisure, education and other activities.

	• Service users enjoy physical, visual, auditory, and personal privacy to the fullest extent possible. Any infringement on privacy is justified and proportionate. • Service users are not required to share accommodation unless they choose to do so.
1.5 Service users' bedrooms are private, comfortable and personalised	• Service users have a dedicated and comfortable bedroom to sleep, securely store their belongings, and relax in privacy. • Bedrooms have adequate floor space to meet service users' accessibility and health requirements. • Bedrooms have natural light and service users can control lighting including blinds or curtains. • Bedrooms and surrounding areas are quiet and calm to promote rest and sleep. • Bedroom temperatures are appropriate and can be adjusted to meet service users' health and wellbeing needs. • Service users have their own room and are able to lock the door independently of staff, unless individual circumstances require otherwise. • Service users can personalise their bedrooms, including with their own possessions and items familiar or important to them, and are supported to do so where necessary. • Bedrooms include an adequately sized place for service users to securely store their belongings. • Hygienic, clean and private sanitary and washing facilities in good working order are available to all service users. • Spouses who wish to live together can be accommodated together.
1.6 Children and young people live in an age-appropriate environment that promotes their rights, safety and wellbeing	• Children and young people are supported and facilitated to reside with family to the maximum extent possible. • Children and young people feel and are safe in the service, including in bedrooms and communal areas. • Setting-appropriate safeguards are documented and followed to ensure all children are kept and feel safe. • Communal areas meet the needs of children and are supervised by staff.

	• Staff undertake regular, unobtrusive supervision of sleeping areas to ensure children's safety.

Explanatory note

The physical environment in aged residential care, disability support and related environments is crucial to service users' comfort, safety, wellbeing and rights enjoyment. The design, maintenance and use of the service's buildings and facilities must prioritise service users' individual needs, access, dignity, privacy, autonomy and participation.

This requires, for example, clean, hygienic and comfortable residences that are easy to access and navigate for the full diversity of service users, and private and personalised bedrooms. Universal design principles, which promote the design of environments and services that are accessible and usable by all people to the greatest extent possible, can support the design of rights-compliant services for persons with disability and older persons (CRPD, articles 2, 4(f)).

Specific standards and sources

International

- *International Covenant on Economic, Social and Cultural Rights* (ICESCR) articles 11, 12.
- *International Covenant on Civil and Political Rights* (ICCPR) articles 7, 9, 17.
- *Convention on the Rights of Persons with Disabilities* (CRPD) articles 2, 3, 4(f), 9, 14, 15, 17, 19, 22, 25, 28.
- *Convention on the Rights of the Child* (CRC) articles 16, 24, 27, 37.
- *Convention on the Elimination of all Forms of Discrimination Against Women* (CEDAW) article 12.
- *United Nations Principles for Older Persons*, GA Res 46/91 (Adopted 16 December 1991) [1], [5], [13], [14].
- *Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment*, GA Res 43/173 (Adopted 9 December 1988), Principle 1.
- United Nations General Assembly, *Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (on protecting persons with disabilities from torture, and solitary confinement)*, 63rd session, UN Doc A/63/175 (28 July 2008) [52]-[54].
- Committee on the Rights of Persons with Disabilities, *Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities* (2015), [17], [18].

- Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), *Prevention of Torture and Ill-treatment of Women Deprived of their Liberty*, 27th session, UN Doc CAT/OP/27/1 (18 January 2016) [28]-[30], [43]-[44].
- World Health Organization, *WHO QualityRights Tool Kit: Assessing and Improving Quality and Human Rights in Mental Health and Social Care Facilities* (2012) Annex 4, Standard 1.
- *Yogyakarta Principles: Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity* (2006), Principles 9, 14.
- *Yogyakarta Principles Plus 10: Additional Principles and State Obligations on the Application of International Human Rights Law in Relation to Sexual Orientation, Gender Identity, Gender Expression and Sex Characteristics to Complement the Yogyakarta Principles* (10 November 2017) Principle 35.

Topic 2: Procedural safeguards

Overarching expectation: All processes and safeguards relating to service users' deprivation of liberty are accessible, fair and transparent in their nature and application and are applied rigorously. Service users are presumed to be the primary decision-makers in matters, processes and decisions that affect them, and are supported and facilitated to express their views, preferences and choices.

Expectations	Indicators
2.1 Service users are free to come and go unless there is a clear, justified and documented reason for their deprivation of liberty[6]	• Staff receive training on, and understand, the range of practices that may constitute the deprivation of liberty of a service user. • Service users who are not subject to approved restrictive practices or other lawful deprivation of liberty can freely come and go without requiring approval to leave. • Appropriate procedures and supports are in place to ensure service users can enter and exit freely unless there is a legally authorised restriction on their movement. • Any instance of deprivation of liberty without free and informed consent or other lawful authority is documented and reported to appropriate authorities in a timely manner.
2.2 Information about the reason service users are in a secure placement or otherwise deprived of liberty is recorded and communicated to the service user in a clear and accessible way	• Clear and comprehensive medical and legal records are maintained for all service users. • The correct processes for authorisation and monitoring of any deprivation of liberty of each service user are followed and documented. • The factual and legal basis for service users being deprived of liberty is recorded and explained to the service user and supporters. • Service users and supporters are informed of the length of time the deprivation of liberty will continue and the criteria for its potential extension or termination. This explanation is given in a timely manner and in a way the service user understands.

[6] See also expectation 7.5.

	• The factual and legal basis for supporters, substitute decision-makers, and/or others to be involved in decision-making and consent processes for service users is documented and regularly reviewed. • If service users who were admitted voluntarily subsequently withdraw their consent, or are no longer able to give consent, this is recorded. In this circumstance, deprivation of liberty processes and safeguards are initiated and followed.
2.3 Service users receive effective communication, including communication about their rights	• Service users' communication needs are assessed and discussed when the service user arrives at the services and are reviewed regularly. Adjustments or accommodations are considered and planned for, including identifying any need for funding and funding sources and responsibilities. • Service users are communicated with in a manner that meets their communication needs and preferences and provides necessary adjustments. • Planning for and meeting service users' communication needs and adjustments involves consideration of factors including disability, impairment, age, difficulties with reading or writing, gender, religion or belief, cultural background, and preferred languages other than English. • Staff receive regular training to develop and maintain the skills necessary to meet service users' individual communication needs and styles. • Interpreters are made available and chosen based on their appropriateness to individual need. • Service users and supporters have access to a person independent of the service to assist them to understand their rights, self-advocate and raise complaints and feedback. • Service users who are subject to deprivation of liberty or treatment or restrictive practices without informed consent, and their supporters, are given clear, accurate, timely and comprehensive information about their right to seek review, and access legal representation.

	• Service users and supporters are given clear, accurate, comprehensive, and timely information about their right to make complaints and give feedback. • Service users and supporters are given clear, accurate, comprehensive, and timely information about available avenues to give feedback and make complaints, recognising that these may vary depending on the nature of the complaint and the regulatory and funding frameworks that apply to the service and service user. • Information about service users' rights is provided in multiple and accessible formats (including both orally and in writing), in a way the service user and supporters can understand and use. • Service users are reminded of their rights on a regular basis and at crucial milestones (such as when their placement or living situation changes or when a behaviour support plan is made or amended). • Staff regularly check that service users have understood information provided. If necessary, staff adapt the information or make other arrangements to facilitate understanding, such as arranging for the presence of a supporter or independent advocate.
2.4 Service users can access effective complaints and feedback mechanisms	• Complaints policies and procedures are documented followed, and regularly reviewed. • Service users and supporters are aware of, and know how to use, accessible avenues to raise concerns, make complaints or give feedback. • All service users have a nominated staff member to turn to if they have a problem or complaint, and they can easily access or contact that person. • Service users and supporters can make complaints independently of staff and without fear of negative consequences or reprisals. • When they raise concerns and complaints, service users and supporters are listened to, taken seriously, and responded to in a manner appropriate for the complaint and the service user.

	• Outcomes of complaints are transparent, fair, timely, documented, and in line with a policy of full disclosure. • Outcomes of complaints are communicated to service users and supporters in a way they understand. • The issues raised in complaints or feedback are addressed to the fullest extent possible. • If issues raised in complaints or feedback are not fully resolved, the service user, supporters or other complainant are given an explanation why and given clear options for escalating their complaint. • Service users and supporters can make complaints to independent oversight bodies and receive responses which are timely, effective, and transparent. • Service users can make complaints in a format that meets their communication needs. • Service users are aware of, and can access, assistance or support within the service in relation to making or dealing with complaints, concerns, feedback, or other matters. • Service users are aware of, and can access, assistance or support outside the service in relation to complaints, concerns, feedback, or other matters. • Efforts are made, through trauma-informed and culturally aware processes, to build trust in complaints processes to ensure all service users and others are able and motivated to report misconduct or other concerns. • There are quality assurance arrangements in place to assess the effectiveness of complaints and feedback processes.
2.5 Service users can freely access their legal representatives, supporters and advocates	• Aboriginal and Torres Strait Islander service users are supported to access advocacy and/or legal advice from representative organisations. • Service users have the option to have a family member or other supporter with them when desired. Service users are reminded of this option at appropriate times. • Service users and supporters are informed of the availability of independent advocates and advocacy

	services, legal representatives and other forms of independent assistance and support. • Contact between service users and their chosen independent advocates and legal representatives is regular, timely and available anytime the service user requests. • The service arranges regular visits from independent advocacy services for service users who, for any reason, cannot choose, contact and/or access independent advocates and legal representatives without assistance from the service or their other supporters or substitute decision-makers.
2.6 Service users' consent, consultation and participation in decision-making (including supported decision-making) are facilitated and prioritised	• Service users are assumed to be the primary decision-makers in all matters, processes and decisions concerning themselves. • Supported decision-making is the predominant model and substitute decision-making is avoided to the maximum extent possible within legal frameworks.[7] • Service users' involvement in decisions affecting them is encouraged and facilitated. • Staff respect the advance directives of service users when providing care, support and treatment. • If they wish to do so, service users are supported and facilitated to make advance directives for any reasonably foreseeable circumstances in which they may not have decision-making capacity. • Service users are invited to identify one or more trusted supporters, including independent advocates, to help them make and carry out decisions.

[7] Supported decision-making has been defined by the Committee on the Rights of Persons with Disabilities as a form of support that is chosen by the supported person and, gives primacy to that person's will and preferences and upholds their human rights, including their right to legal capacity (CRPD article 12). This is contrasted with substitute decision-making regimes, which remove legal capacity from the person and enable the appointment by a third party of someone else to make decisions on the basis of the affected person's 'best interests' (regardless of the views, will or preferences of the affected person): Committee on the Rights of Persons with Disabilities, *General Comment No. 1 (2014) on Article 12: Equal Recognition Before the Law*, UN Doc CRPD/C/GC/1 (19 May 2014) [27]-[29]

	• Service users can involve supporters, including independent advocates in decisions or actions that affect the service user. • Information about service users' chosen supporters, including independent advocates, is recorded and communicated to relevant staff and kept up-to-date. Service users can change or delete this information upon request. • Staff respect the authority of nominated supporters to participate in and communicate the decisions of the supported service user. • Service users who have no listed supporters and wish to appoint one are assisted to access appropriate support or advocacy. • Service users' informed consent is sought for all medical treatment, restrictive or other related practices, and appropriately recorded. Informed consent is sought from service users themselves even if a refusal may, according to law, be overridden. • Staff understand the distinction between consent to admission and consent to treatment. • Where a service user's capacity to consent or make decisions is legally restricted, the duration of the restriction is as limited as necessary in the circumstances, documented, and opportunity exists for regular review. • If a service user's consent cannot be obtained, and a substitute decision-maker is authorised to consent on the service user's behalf, the substituted consent is obtained and documented. • Except in emergency circumstances, if a service user's consent cannot be obtained and there is no substitute decision-maker, or all avenues of contact have been reasonably exhausted and documented, appropriate guardianship authorisation is obtained and documented. • Feedback from service users is actively sought, considered and used to inform and improve service planning and delivery.

	• Feedback from service users' supporters and representatives, and from representative organisations of service users, is actively sought, considered and used to inform and improve service planning and delivery.[8]
2.7 Service users' privacy and confidentiality are respected and preserved	• All service user information is kept securely to preserve privacy and confidentiality. • Confidentiality and its limits are explained to service users and supporters in a way they understand, on arrival at the service and as necessary. • 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.

[8] See also expectation 9.1.

Explanatory note

International human rights instruments prohibit the unlawful or arbitrary deprivation of any person's liberty. Any deprivation of liberty must be in conformity with the law, and the presence of disability shall in no case justify deprivation of liberty (ICCPR article 9; CPRD article 14). All people, including people with disability and older people, have a related right to be recognised as a person before the law and to exercise their legal capacity (ICCPR article 14; CRPD article 12).

Service users who are deprived of their liberty in aged residential care, disability support and related environments are placed in a vulnerable position. This is especially so if they are also deprived of their legal capacity, either formally or informally. Procedural safeguards are therefore essential to ensuring service users can enjoy and assert their rights. These include processes and procedural safeguards to:

- ensure the lawfulness of deprivations of liberty
- inform service users about their rights
- enable service users to access advocacy and support, challenge deprivations of liberty and make complaints without fear of negative consequences or reprisals
- protect service users' privacy and confidentiality

Procedural safeguards must be disability inclusive. For example, each service user's information and communication needs must be ascertained and met. Access to support for decision-making – whether from family members, other supporters, legal or non-legal advocates, or others – is of particular importance to many users of aged residential care, disability support and related services. Such support can enable people to enjoy their legal capacity and challenge violations of their rights.

Specific standards and sources

International

- *International Covenant on Civil and Political Rights* (ICCPR) articles 9, 16.
- *Convention on the Rights of Persons with Disabilities* (CRPD) articles 3, 9, 12, 13, 14, 15, 16, 21.
- *Convention on the Rights of the Child* (CRC) articles 13, 16, 19, 25, 34, 37.
- *United Nations Declaration on the Rights of Indigenous Peoples*, GA Res 61/295 (Adopted 13 September 2007) articles 1, 7, 13, 17, 18, 21, 22.

- *United Nations Principles for Older Persons*, GA Res 46/91 (Adopted 16 December 1991) [12], [14].
- *Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment*, GA Res 43/173 (Adopted 9 December 1988), Principles 2, 4, 11, 13, 14, 15, 16, 17, 18, 28, 31, 33.
- United Nations Committee on the Rights of Persons with Disabilities, *Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities* (2015), [6]-[9].
- Human Rights Council, *Report of the Special Rapporteur on the Rights of Persons with Disabilities (on Disability-Specific Forms of Deprivation of Liberty)*, 40th session, A/HRC/40/54 (11 January 2019) [44]-[56].
- Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), *Approach of the SPT to the Concept of Prevention*, 12th session, UN Doc CAT/OP/12/6 (30 December 2010) [5(c)].
- Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), *Approach of the SPT Regarding the Rights of Persons Institutionalized and Treated Medically Without Informed Consent*, 27th session, UN Doc CAT/OP/27/2 (26 January 2016) [6].
- Human Rights Committee, *General Comment No. 35*: *Liberty and Security of Person*, 112th session, UN Doc CCPR/C/GC/35 (16 December 2014).
- Committee on the Rights of Persons with Disabilities, *General Comment No*. 1 *(2014) on Article 12: Equal Recognition Before the Law*, UN Doc CRPD/C/GC/1 (19 May 2014) [16]-[19], [38]-[39].
- United Nations, *International Principles and Guidelines on Access to Justice for Persons with Disabilities* (Geneva, August 2020).
- Council of Europe, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, *Means of Restraint in Psychiatric Establishments for Adults (Revised CPT Standards)*, CPT/Inf(2017) 6, 21 March 2017, [12].
- World Health Organization, *WHO QualityRights Tool Kit: Assessing and Improving Quality and Human Rights in Mental Health and Social Care Facilities* (2012), Annex 2; Annex 4, Standards 2, 3 and 4.
- *Yogyakarta Principles* (2006), Principles 3, 6, 7, 9, 10, 11, 28, 29.
- *Yogyakarta Principles Plus 10* (10 November 2017) Principle 36.

Topic 3: Healthcare

Overarching Expectation: Service users enjoy the highest attainable standard of physical and mental health, including access to healthcare services and treatment on an equal basis with others in the community that promotes their wellbeing, dignity, privacy and autonomy and meets their individual needs and preferences.

Expectations	Indicators
3.1 Service users make their own choices about healthcare and treatment wherever possible, and can access support to make decisions	• Healthcare services and treatments provided to service users are based on a person-directed and person-centred understanding of the service user's history, goals, interests and needs. • Service users can be accompanied by a supporter of their choice to health assessment and treatment appointments. • Service users and supporters are actively involved in all discussions and decisions about the health care, treatment and medication the service user receives, to the maximum extent possible. • Service users' own opinions, will and preferences regarding medication and other treatments are ascertained, considered and followed to the maximum extent possible. • Changes to treatment and/or medication are discussed with service users and supporters before they commence, including any treatment from community services. • Service users are genuinely able to exercise their right to decline or refuse assessment or treatment. • Clear, comprehensive information about assessment, diagnosis and treatment options is given to service users and supporters in a form they understand, and which allows them to make free and informed decisions. • Service users and supporters are helped to understand the clinical actions and effects, limitations, and potential side effects of the treatment or medication prescribed. • Health assessments and treatments are based on the free and informed consent of service users.

	• If service users' consent cannot be obtained, or a substitute decision-maker is authorised to consent on the service user's behalf, all legal requirements are followed and documented. • Service users who are subject to substitute decision-making have their will and preferences respected in all aspects of healthcare and treatment wherever possible, and to the fullest extent possible. • Treatment contrary to the consent, will and preferences of service users subject to substitute decision-making is minimised. When taken, reasons for doing so, and the details of the treatment that was provided are documented and explained to service users and supporters in a way they understand. • Service users are not subject to medical or scientific research or experimentation without their free consent.
3.2 Physical and mental health needs of service users are assessed appropriately by suitably qualified professionals	• Service users are offered a comprehensive health assessment, covering physical and psychological needs, on arrival at the service and on a regular basis thereafter. • Health assessments include review of prescribed medications and their side effects. • Service users and supporters are informed of the outcome of health assessments and offered the opportunity to seek a second opinion if they disagree with the outcome. • Health assessments and examinations are conducted in private and in a manner which is comfortable and appropriate to the service user's needs. • Any physical or mental health conditions identified at assessment receive timely attention.
3.3 Service users can access a range of services to support holistic, person-centred, culturally appropriate and	• Service users receive physical and mental health care that is equivalent to that received by others in the community. • Service users have equal access to health and wellbeing services regardless of location, environment, disability, cultural or language needs.

trauma-informed healthcare	• Service users have access to, and are supported to access, physical and mental healthcare and professionals that meet their needs in relation to disability, age, culture, religious or spiritual practice, gender, experience of trauma and other characteristics. • Service users' access to physical and mental healthcare includes direct confidential access to a range of appropriately trained, and if necessary, specialist, healthcare professionals to discuss and meet their health and wellbeing needs. • Service users with intellectual disability, cognitive disability or dementia have access to health services and professionals who are trained to meet their specific requirements. • Service users who have language, speech or comprehension barriers, are non-speaking, or are non-verbal, have access to health services and professionals who are trained to meet their specific requirements. • LGBTIQA+ service users have access to health services and professionals who are trained to meet their specific requirements. • Health professionals and staff understand the differing physical, sexual, and mental healthcare needs and barriers of service users with inherent variations in sex characteristics (intersex) compared to transgender service users. • Service users have access to primary health care services that promote continuity of care, such as a consistent general practitioner. • Service users have access to trained nursing care that meets their needs. • Service users have timely and regular access to quality dental services based on clinical need, including oral health promotion. • Service users and supporters are fully informed of the reasons for any referrals to appropriate services and specialists in a timely manner (unless emergency or urgent treatment is required).

	• When a service user is referred to a health service, there is relevant planning, coordination and clear communication between services consistent with the service user's rights. • Every service user has a single clinical record developed in line with current record-keeping standards. • The type and dosage of medication administered to service users by the service provider is appropriate for their clinical diagnosis, documented, and reviewed regularly. • Administration of medication to service users is consistent with safe practice, including individualised prescription with the signature of the responsible clinician, clear dosage and frequency. • Service users have access to adequate pain treatment. • Service users are informed of and have access to sexual and reproductive health services. • A service user having a diagnosis of a disability or mental health condition is never treated as a reason for administering contraception, sterilisation, or abortion. • In discussions and decisions about contraception, sterilisation, abortion, or other procedures or treatments that may affect a service user's fertility, consideration is given to the need to balance any perceived or potential medical risks with the person's right to maintain their fertility or choose to have children in the future. • Staff are trained to respond promptly and competently to medical emergencies with appropriate emergency equipment. • Incontinence pads, briefs and related products that maximise independent and comfort, including adaptive products, are available for residents who need them and are frequently changed. • Incontinence products are not used when residents can access the toilet with support.

	• Sanitary items and period products that maximise independence and comfort, including adaptive products, are available for residents who need them and are frequently changed. • Where necessary, prompt arrangements are made for transfer to a hospital or hospice of service users who are dying or who have life-limiting conditions.
3.4 Service users' medical confidentiality and privacy is upheld	• Information about a service user's health is kept confidential unless formal consent to share information is provided. • Confidential health information is stored securely. • Where health information is stored electronically, staff with access to relevant systems have received appropriate cybersecurity training. • Service users are entitled to know any information collected about their health. • Any service user's wish not to be informed of information about their health is respected. • Service users can access support to understand the information collected about their health.
3.5 Service users are supported and encouraged to optimise their health and wellbeing through preventive healthcare practices	• Healthcare treatment and planning for all service users includes relevant preventive healthcare practice. • Service users are offered, and actively encouraged to engage with, preventive and early detection services and interventions to promote their health and wellbeing. • Service users have access to, and are proactively provided with, information, education and support to promote their sexual and reproductive health. This information is tailored to individual service users' identities, characteristics and needs, including service users of all genders and LGBTIQA+ service users. • The service follows a specific and comprehensive strategy addressing prevention, testing and management of communicable diseases.

3.6 Service users dealing with substance misuse are identified and can access support through joined-up, comprehensive services and pathways	• Newly arrived service users receive prompt assessment of their substance use. • Service users have timely access to specialised, safe, effective, and individualised clinical and psychosocial support, with consent, in line with Tasmanian and Australian standards. • Service users receive relevant harm reduction information in an accessible format and in a way they understand.

Explanatory note

Users of aged residential care, disability support and related services have a right to the enjoyment of the highest attainable standard of physical and mental health. According to the Committee on Economic, Social and Cultural Rights, the enjoyment of this right requires that healthcare facilities, goods and services are (i) available in sufficient quantity, (ii) accessible to everyone without discrimination, (iii) acceptable to all in terms of cultural appropriateness and compliance with medical ethics and confidentiality, and (iv) of good quality and scientifically and medically appropriate.[9]

The Convention on the Rights of Persons with Disabilities reiterates that all persons with disabilities must have access to desired and necessary health facilities, goods and services of the same range, quality and standard as other people in the community (CRPD article 25(a)). Health care and treatment must be provided on the basis of individuals' free and informed consent, and people who require support to exercise their legal capacity and make decisions in relation to health care and treatment must have access to that support (CRPD article 12, 25(d)). The provision of person-centred health care on this basis will protect and promote the dignity, bodily integrity, privacy and autonomy of service users of aged residential, disability and related services.

[9] Committee on Economic, Social and Cultural Rights, *General Comment No. 14*: *The Right to the Highest Attainable Standard of Health (Article 12)*, 22nd session, UN Doc E/C.12/2000/4 (11 August 2000) [12].

Specific standards and sources

International

- International Covenant on Economic, Social and Cultural Rights (ICESCR) article 12.
- International Covenant on Civil and Political Rights (ICCPR) article 17.
- Convention on the Rights of Persons with Disabilities (CRPD) articles 3, 12, 15, 16, 17, 22 23, 25.
- Convention on the Rights of the Child (CRC) article 24.
- *United Nations Declaration on the Rights of Indigenous Peoples*, GA Res 61/295 (Adopted 13 September 2007), articles 7, 21, 24.
- *United Nations Principles for Older Persons*, GA Res 46/91 (Adopted 16 December 1991) [11].
- Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, GA Res 43/173 (Adopted 9 December 1988), Principles 22, 24, 25, 26.
- Committee on Economic, Social and Cultural Rights, *General Comment No. 14*: *The Right to the Highest Attainable Standard of Health (Article 12)*, 22nd session, UN Doc E/C.12/2000/4 (11 August 2000).
- Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), *Prevention of Torture and Ill-treatment of Women Deprived of their Liberty*, 27th session, UN Doc CAT/OP/27/1 (18 January 2016) [28]-[30].
- Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), *Approach of the SPT Regarding the Rights of Persons Institutionalized and Treated Medically Without Informed Consent*, 27th session, UN Doc CAT/OP/27/2 (26 January 2016) [12]-[19].
- Committee Against Torture, Ninth Annual Report of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment of Lesbian, Gay, Bisexual, Transgender and Intersex Persons), 57th session, UN Doc CAT/C/57/4 (22 March 2016) [68]-[70], [76]-[77].
- Human Rights Council, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (on the Right to Health in the Context of Confinement and Deprivation of Liberty), 38th session, A/HRC/38/36 (10 April 2018).

- World Health Organization, WHO QualityRights Tool Kit: Assessing and Improving Quality and Human Rights in Mental Health and Social Care Facilities (2012) Standards 2.2., 2.3, 2.4, 2.5, 3.2, 3.3, 3.4.
- ITHACA Project Group, *ITHACA Toolkit for Monitoring Human Rights and General Health Care in Mental Health and Social Care Institutions* (Health Service and Population Research Department, Institute of Psychiatry, King's College London, 2010) Parts 11, 16, 17, 18-26, 28-30.
- *Yogyakarta Principles* (2006), Principles 5, 6, 9, 17, 18, 25.
- *Yogyakarta Principles Plus 10* (10 November 2017) Principle 32.

Topic 4: Care and support

Overarching Expectation: Service users live in an enabling environment that supports their autonomy and self-determination; they have access to high quality, person-directed, culturally and life-course appropriate care and support that meets their needs, will and preferences and maintains their dignity.

Expectations	Indicators
4.1 Service users make their own choices about care and support to the fullest extent possible	• Care and support services provided to service users are based on a person-directed and person-centred understanding of their history, goals, interests and needs. • Service users and supporters are actively involved in all assessments, discussions and decisions about the care and support they receive, to the maximum extent possible. • Service users' opinions, will and preferences regarding care and support are ascertained, considered and followed to the maximum extent possible. • Changes to care and support arrangements are discussed with service users and supporters before they commence. • Clear, comprehensive information about care and support options is given to service users and supporters. Information is provided in a form the service user understands and which allows them to make free and informed decisions. • Service users can be accompanied by a support person of their choice to care and support assessment and planning appointments and meetings. • Service users who are subject to substitute decision-making have their choices, opinions and feelings respected in all aspects of care and support wherever possible, and to the fullest extent possible. • The provision of care and support contrary to the views or wishes of service users is minimised. When taken, reasons for doing so, and the details of the care and support that was provided are documented

	and explained to service users and supporters in a way they understand.
4.2 The care and support needs of service users are assessed and addressed appropriately by suitably qualified workers	• Service users' care and support needs are assessed comprehensively on admission or arrival by an appropriately qualified person and are recorded in a plan which is kept up to date and shared appropriately with all relevant staff. • Care and support assessment and planning take into account information and documentation provided by the service user, supporters, external agencies and other relevant parties. • Service users are able to view their own care and support plan and the results of assessments, to the extent possible, and are provided the opportunity to ask questions, disagree and give feedback. • Care and support assessment and planning recognises that service users may have multiple disability, multiple comorbidities, invisible, hidden and/or undiagnosed disability. • Care and support assessments and planning are conducted in private and in a manner which is comfortable and appropriate to the service user's needs. • Any immediate care and support needs identified in assessment and planning processes are met promptly.
4.3 Service users can access a range of services, workers and other supports to provide holistic, person-centred, culturally appropriate and trauma-informed care and support[10]	• Service users have access to, and receive, care and support that is equivalent to that received by others in the community. • Service users have equal access to care and support services regardless of location, environment, disability, cultural or language needs. • Service users have access to, and receive, care and support services and professionals that meet their individual needs and preferences in relation to disability (including multiple disability), age, culture,

[10] See also expectation 6.1.

	religious or spiritual practice, gender, sex, sexuality, experience of trauma, medical conditions (including comorbidities) and other characteristics. • Service users with intellectual or cognitive disability or dementia have access to care and support services and professionals who are trained to meet their specific requirements. • Service users who have language, speech or comprehension barriers, are non-speaking, or are non-verbal, have access to care and supports services and professionals who are trained to meet their specific requirements. • LGBTIQA+ service users have access to care and support services and professionals who are trained to meet their specific requirements. • Staff understand the differing care and support needs and barriers of service users with inherent variations in sex characteristics (intersex people) compared to transgender service users. • Service users have access to, and are supported to access, care and support services and professionals that meet their social, personal care, cultural and other needs and preferences in all domains of life. These domains include health and wellbeing, family, community, spirituality, work and education, among others. • Service users are enabled to meet their own care and support needs (self-care) to the maximum extent possible and desired by the service user. • Service users' access to care and support includes direct confidential access to a range of appropriately trained professionals to discuss and meet their care and support needs. • Service users can access and use aids, devices, assistive technologies and other forms of assistance and intermediaries they need to meet their sensory, communication and mobility-related requirements. • Service users and supporters are fully informed of the reasons for any referrals to appropriate services and specialists in a timely manner.

	• The service promotes consistency and continuity of care and support (including consistency of care and support personnel) to the maximum extent possible. • Appropriate handover processes are used when shifts or personnel change. These processes include consideration of service users' individual needs, characteristics and preferences. • New staff are introduced to service users before they become involved in providing care and support for that service user. • Staff refer to service user behaviour that presents an actual or perceived risk of harm to themselves or others using humane, compassionate and individually-appropriate language. • Staff address service users' behaviour, including behaviour which may be referred to as behaviours of concern (in disability services) or Behavioural and Psychological Symptoms of Dementia (BPSD) (in aged care services) through humane, individual, and compassionate interventions based on current, evidence-based best practice. • Staff have completed training on, and understand, the relationship between unwanted, undesirable or harmful service user behaviour and the service user's unmet needs. Responses to behaviour consider how to identify and address those needs, as well as how these are best met in the future
4.4 Service users are supported and encouraged to optimise their health and wellbeing through accessing early intervention and rehabilitation	• Care and support planning and provision for all service users should include effective coordination and implementation, including education, of relevant early intervention, prevention and rehabilitation services consistent with their needs and preferences.
4.5 Discharge or transition planning is proactive and comprehensive with a view to ensuring	• Staff understand the necessity of reducing or removing restrictions and deprivations of liberty from service users to the maximum extent possible.

service users are not deprived of liberty, or stay in the service, for longer than is necessary	• Care and support assessment and planning processes include discussion (with service users and supporters) of the service user's preferences, needs and concerns about transitions out of residential care to other services or to the community. • Where relevant, transition or discharge plans are developed, documented, provided to service users in accessible formats and explained in a way they understand. • Transition or discharge plans include facilitation of engagement with required services and supports the service user will require after leaving the service, such as housing, financial and aged care or disability services and supports.

Explanatory note

Users of aged residential care, disability and related services may require care and support to meet their personal needs, carry out daily activities, and fully participate in all aspects of life and community. Rights-based care and support will respect service users' individual needs, dignity, autonomy, safety and privacy, and their right to make decisions and have control over their lives. Without adequate care and support, people with disability and older people deprived of their liberty are at greater risk of torture, ill-treatment and other rights violations.

Article 19(b) of the Convention on the Rights of Persons with Disabilities holds that persons with disabilities should have access to 'a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation and segregation from the community'. It characterises these services as essential for persons with disabilities to enjoy the right to live independently and be included in the community, with choices equal to others. The United Nations Principles for Older Persons similarly encourage governments to ensure that older persons have access to social services that enhance their autonomy, protection and care.[11]

Specific standards and sources

International

- Convention on the Rights of Persons with Disabilities (CRPD) articles 3, 19, 20, 26.
- *United Nations Principles for Older Persons*, GA Res 46/91 (Adopted 16 December 1991) [10], [12]-[14].
- Committee on the Rights of Persons with Disabilities, General Comment No. 5 (2017) on Living Independently and Being Included in the Community (Article 19), UN Doc CRPD/C/GC/5 (27 October 2017).
- Human Rights Council, Report of the Special Rapporteur on the Rights of Persons with Disabilities (on Support Services for Persons with Disabilities), 34th session, A/HRC/34/58 (20 December 2016).

[11] United Nations Principles for Older Persons, GA Res 46/91 (Adopted 16 December 1991) [12].

Topic 5: Connection to the community

Overarching Expectation: Service users are encouraged and supported to be part of the community and maintain contacts and connections that are important to them through a range of measures they freely choose.

Expectations	Indicators
5.1 Service users are connected with and part of the community, and are engaged as citizens	• The makeup of service users' family, kin, community, friend and support networks and expected frequency of visits and outings is determined and documented on arrival and regularly reviewed. • Service users choose whom they want and do not want to see and contact. • Strategies are in place and proactive efforts are made to enable and support service users to maintain contact with friends, family, kin, supporters and wider networks, and to establish new relationships and connections, in line with service users' preferences and needs. • Strategies are in place and proactive efforts are made to enable and support Aboriginal and Torres Strait Islander service users to maintain connection to their Country and community in line with service users' preferences. • All possible efforts are made to encourage and facilitate regular, meaningful contact between children and their parents, carers, siblings and other family members and others close to them. • All possible efforts are made to encourage and facilitate regular peer interaction for children with disability. • Service users are supported to fulfil any parental responsibilities and to engage with their children to the fullest extent possible. • Staff identify service users who self-isolate or do not have supporters or regular contact or visits with others. Staff provide support to promote positive relationships, wellbeing, connection and participation. • Where emergency circumstances necessitate limitations on service users receiving visitors or

	leaving the service (such as lockdowns), restrictions are minimised as far as possible. • During lockdowns or other periods of limitation on visits or movement, service users are able and supported to maintain regular, meaningful contact with family, friends and others in the community through alternative modes of social engagement and other means. • Service users have opportunities to follow the news and keep themselves informed of key events and information they need to participate fully in political and public life. • Service users are encouraged and supported to exercise their right to vote. • Service users are encouraged and supported to join and participate in the activities of political, religious, social, disability and older persons' organisations and other groups and activities of their choice, including groups relevant to other dimensions of service users' identity.
5.2 Service users regularly have time away from their residence	• Service users have the opportunity, and are supported, to regularly leave or have time away from their place of residence. • Staff understand, acknowledge and promote the importance of outside connections and activities. • Where service users can only leave the service with authorisation or when accompanied by others, such leave is actively and regularly considered, and is offered and facilitated to the fullest extent possible. • Service users' wishes, preferences and needs are fully taken into account when planning and supporting spending time away from the service or engaging in outside activities. • Service users are supported to access services, activities, groups and resources of their choice

	outside the service, including those associated with specific cultural, spiritual or other practices.[12] • Service users can be accompanied outside the service for orientation and support by supporters or staff. • Service users' requests relating to leave or other time away from the service are assessed promptly and decisions are clearly explained in a way the service user understands. • Service users' requests to attend significant or time-sensitive events such as weddings, funerals, sorry business and other kinship or cultural obligations, or to visit sick relatives, are facilitated by staff wherever possible. • Service users are not deprived of contact, visits or time outside the service as a punishment. • All efforts are made to mitigate and prevent security or safety risks associated with service users leaving the service.
5.3 Service users live as close as reasonably possible to their community and support networks	• Service users are located as close as possible to their community, family and/or support networks and connections, where this is their preference. • Strategies are in place and proactive measures are taken to prevent and address disadvantages faced by service users located far from their communities, homes and/or support networks.
5.4 Service users can communicate freely, with their privacy respected, and with support where needed. Any restrictions on contact are individually justified,	• Service users have regular and reliable access to telephone calls, correspondence, electronic devices and the internet. • Service users can communicate in privacy and without censorship. • Communication devices can be transported and utilised by service users in private.

[12] See also topic 8.

proportionate and fully explained[13]	• Service users have access to a telephone at any time, independent of staff, unless an authorised restriction is in place. • Staff take reasonable steps to assist or support service users to communicate. • Service users are assisted with making contact with supporters, advocates, substitute decision-makers, legal representatives and others where they so desire. • Foreign nationals, or people whose connections are outside Tasmania or Australia, receive assistance to maintain contact with those connections. • There are no blanket restrictions on access to communication or communication devices. • Service users 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 or to protect other's privacy). • Restrictions on communication are never used as a punishment. • Access to telephones, correspondence, electronic devices or the internet is only restricted if all other less restrictive options have been explored and exhausted and the restriction is authorised in the service user's behaviour support plan. • Any communication restrictions do not interfere with service users' communication with legal representatives or advocates.
5.5 The fullest visiting arrangements possible are facilitated. Visits are as comfortable and easy as possible for service users and visitors.	• Visitors are given information about how to get to the service, any visiting hours, details about what to expect when they arrive, and information on making complaints. • Visitor parking and facilities are available and accessible. • Visitors are made to feel welcome.

[13] See also expectation 2.3.

	• Visits take place in an environment that is private, accessible, safe and comfortable. • Visitors can access a range of refreshments during visits. • Visits take place at any reasonable time and regularity, including evenings and weekends. • Requests for overnight visits from service users' partners are considered and accommodated to the fullest extent possible.

Explanatory note

Connection, contact and participation in community life are essential to the wellbeing and rights enjoyment of people who reside in aged residential care, disability support and related services. These include service users' rights to be free from arbitrary or unlawful interference with privacy, family, correspondence or other communication (ICCPR article 17; CRPD article 22), to be included in the community (CPRD article 19) and to participate effectively and fully in political and public life (ICCPR article 25; CRPD article 29).

To promote and protect these rights, service users must be able to communicate, and interact easily with, family, friends, supporters, independent advocates, legal representatives and others outside the service when they choose. Service users must also be able to participate freely in family, community and public life and pursue their interests and responsibilities outside their residence (addressed further in topic 8, below).

Specific standards and sources:

International

- International Covenant on Civil and Political Rights (ICCPR) article 17, 25.
- Convention on the Rights of Persons with Disabilities (CRPD) articles 19, 21, 22, 23, 29.
- Convention on the Rights of the Child (CRC) articles 13, 16, 23.
- *United Nations Declaration on the Rights of Indigenous Peoples*, GA Res 61/295 (Adopted 13 September 2007), articles 8, 9, 10, 11, 12, 13, 14, 18, 25, 33.
- *United Nations Principles for Older Persons*, GA Res 46/91 (Adopted 16 December 1991), [7]-[9], [12].

- Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, GA Res 43/173 (Adopted 9 December 1988), Principles 15, 19, 20, 28, 29, 33.
- Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), *Prevention of Torture and Ill-treatment of Women Deprived of their Liberty*, 27th session, UN Doc CAT/OP/27/1 (18 January 2016) [31]-[37].
- Claudia Mahler, Report of the Independent Expert on the Enjoyment of all Human Rights by Older Persons on Older Persons Deprived of Liberty, UN Doc A/HRC/51/27 (51st session, 9 August 2022) [61].
- World Health Organization, WHO QualityRights Tool Kit: Assessing and Improving Quality and Human Rights in Mental Health and Social Care Facilities (2012) Standards 1.5, 1.7, 5.3.
- ITHACA Project Group, *ITHACA Toolkit for Monitoring Human Rights and General Health Care in Mental Health and Social Care Institutions* (Health Service and Population Research Department, Institute of Psychiatry, King's College London, 2010) Part 11.
- Council of Europe, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, *Factsheet: Persons Deprived of their Liberty in Social Care Establishments,* CPT/Inf(2020)41, 21 December 2022, 3.
- European Network of National Human Rights Institutions (ENNHRI), *Respect My Rights: An ENNHRI Toolkit on Applying a Human Rights-Based Approach to Long-term Care for Older Persons* (October 2017) Annex 1, 'Right to privacy and family life' and 'Right to participation and social inclusion'.
- *Yogyakarta Principles* (2006), Principles 19, 20, 21, 24, 25, 26, 27.
- Yogyakarta Principles Plus 10 (10 November 2017)

Topic 6: Diversity, equality and non-discrimination

Overarching Expectation: The diversity of the service user group is recognised and welcomed. The distinct and individual needs of service users are identified and fully met in relation to disability, age, Aboriginal and Torres Strait Islander background, culture, gender, sex, sexuality, gender identity, nationality, religion or spirituality, and other grounds. Organisational policies, culture, processes and practices ensure service users are not subject to discrimination, bullying or harassment.

Expectations	Indicators
6.1 Service users are respected and valued as individuals; their individual needs and preferences are identified and met	• To the extent they are comfortable to do so, the service user's individual needs, strengths and goals, history and experiences are assessed and discussed on arrival and updated regularly. All prescribed attributes[14] and any other factors that are important to the service user's wellbeing, identity and sense of self are addressed. • Information gathered on arrival is recorded and communicated to staff and kept up-to-date. This knowledge is evident in the care and support provided. • Care plans specify clear actions required to address service users' particular needs and preferences.[15] • Service users have genuine choice about who meets their needs and preferences, and support to make and exercise informed decisions. Planning and commissioning of services is based on an understanding of the diverse backgrounds, identities, needs and goals of service users.
6.2 Aboriginal and Torres Strait Islander service users can exercise their cultural rights and live in a culturally safe service	• Service users' Aboriginal and Torres Strait Islander cultural identity and connections are discussed and understood in a supportive and respectful manner upon arrival at the service, to the extent that the service user wishes to do so. • Respect for Aboriginal and Torres Strait Islander service users' cultural identity and connections are at

[14] *Anti-Discrimination Act 1998* (Tas) s 16.

[15] See also topic 4.

	the centre of all decisions made about their treatment, care and support. • To the extent they wish to do so, Aboriginal and Torres Strait Islander service users are aware of their Country, language groups and nation, and have regular access to cultural mentors and Elders. • Assessment, treatment, care and support provided to Aboriginal and Torres Strait Islander service users is culturally sensitive and safe. • Assessment, planning and provision of care and support to Aboriginal and Torres Strait Islander service users takes into account individual and collective experience of trauma. • Staff have completed Aboriginal and Torres Strait Islander cultural awareness training and have regular access to related professional development opportunities. • Staff are able to demonstrate an understanding of Tasmanian Aboriginal history and continuing culture, and culturally aware and culturally sensitive and safe practices and service provision. • Aboriginal and Torres Strait Islander service users are protected from racism, unfair treatment, harassment, bullying and abuse.
6.3 Service users from culturally and linguistically diverse backgrounds, including Deaf community and culture, can exercise their cultural rights and live in a culturally safe service	• Service users' cultural identity and connections, including Deaf cultural identity, are ascertained in a supportive and respectful manner upon arrival at the service, to the extent that the service user wishes to do so. • Respect for culturally and linguistically diverse service users' cultural identity and connections, including Deaf cultural identity, are at the centre of all decisions made about their treatment, care and support. • To the extent they wish to do so, service users from culturally and linguistically diverse backgrounds, including Deaf service users, are aware of their cultural background and history, and have regular access to cultural mentors and community.

	• Assessment, treatment, care and support provided to service users belonging to culturally and/or racially marginalised groups, including Deaf service users, takes into account individual and collective experiences of trauma. • All staff have completed relevant cultural awareness training (including Deaf cultural awareness) for working with service users from culturally and linguistically diverse backgrounds and have regular access to related professional development opportunities. • Staff demonstrate an awareness of a diverse range of cultural differences and culturally aware and culturally safe practices and service provision. • Service users from culturally and linguistically diverse backgrounds, including Deaf service users, are protected from racism, unfair treatment, harassment, bullying and abuse.
6.4 LGBTIQA+ service users are supported to understand, explore and express their identity in a safe and supportive environment	• Service users' LGBTIQA+ identity and/or status is ascertained in a supportive and respectful manner upon arrival at the service, to the extent that the service user wishes to do so. • Service users are supported to explore or understand LGBTIQA+ identity in a safe, supportive and appropriate manner. • Service users can express their LGBTIQA+ identity or status, and changes or developments to that identity or status, at any time, and staff respond in a supportive and respectful manner. • Respect for LGBTIQA+ service users' identity or status are at the centre of all decisions made about their treatment, care and support. • To the extent they wish to do so, LGBTIQA+ service users are aware of LGBTIQA+ cultures and communities and have regular access to mentors and community. • Assessment, treatment, care and support provided to LGBTIQA+ service users takes into account individual and collective experiences of trauma.

	• Staff have completed relevant awareness training for working with LGBTIQA+ service users and have regular access to related professional development opportunities. Training is tailored to the context and needs of the service setting and service users. • Staff have completed training on, and understand, how to have conversations with service users about LGBTIQA+ identity or status safely, supportively and appropriately. • Staff have completed training on, and understand, the harms of conversion practices or pressures, or other forms of suppressing the expression of service users' LGBTIQA+ identity. • Staff have completed training on, and understand, that service users are entitled to experience and express their LGBTIQA+ identity or status regardless of their legal or decision-making capacity. • LGBTIQA+ service users are protected from unfair treatment, harassment, bullying and abuse.
6.5 Service users live in an environment where tolerance, understanding and respect are actively promoted	• Staff promote and model inclusion in all aspects of their work and show an awareness of equality and non-discrimination principles in their conduct and practices. • Special measures are in place to recruit Aboriginal and Torres Strait Islander staff and staff from other cultural groups, so that staff reflect the diversity of the population of service users. • Regular proactive efforts are made to recognise, raise awareness of, and celebrate the diversity of service users and staff. Service users have opportunities to initiate, lead and/or be involved in these events and activities. • Staff and service users have constructive and positive relationships. • Service users and staff know what behaviours and language are acceptable.
6.6 Service users live in an environment where discriminatory conduct,	• Staff are trained and supported to identify and eliminate discrimination, bullying and harassment in the service.

bullying and harassment are not tolerated and any instances are challenged[16]	• There are clear systems in place, known and used by all staff, to identify and take appropriate action to prevent and act upon all forms of discrimination, bullying and harassment or disadvantage. • There are effective interventions to support service users being discriminated against or subject to bullying or harassment. • There are effective interventions to challenge, educate and support service users who engage in discriminatory, bullying or harassing behaviour. • Service users and supporters feel able, and know how, to raise concerns about discrimination, bullying or harassment through complaint mechanisms. • Complaints about discrimination, bullying or harassment are thoroughly investigated. Responses are timely and take account of the context and individual experience of the service user. • Service users and supporters are aware of, and know how to use, accessible avenues to make complaints about discrimination, bullying or harassment to an external body independent of staff and without fear of negative consequences or reprisals.
6.7 Service users are treated fairly and swift action is taken to address any evidence of discriminatory processes and conduct	• Rules and processes are understood by service users and applied fairly by staff. • There is routine internal monitoring to identify any inequity or discrimination. Monitoring covers all identities and needs, for example in the application of restrictive measures, in access to services, activities, visits or other areas, or in decisions about service users' ongoing tenure in the service. • Results of monitoring are communicated to staff and service users in accessible formats and ways they understand. • Where inequity or discriminatory practice is identified or suspected, timely action is taken to address this.

[16] See also expectation 2.4.

	• Data on discriminatory incidents and allegations is routinely analysed for patterns and trends to identify issues requiring action and for continuous improvement purposes. • Aspects of a service user's identity or characteristics that may lead to bullying or discrimination are kept confidential except to the extent desired by the service user.
6.8 Reasonable adjustments and other accommodations are made to ensure equality of access and treatment of people with disability	• Individualised supports, resources and aids are provided to meet service users' mobility, sensory and other disability- or impairment-related needs, aligned with individual preferences. • Reasonable adjustments are made to ensure that service users with disability, including service users with multiple disability, multiple comorbidities, invisible, hidden and/or undiagnosed disability, have access to the full suite of mainstream programs, activities and facilities. • Where reasonable adjustments are not possible, the reason is explained in a way the service user understands and alternatives of equivalent quality are offered.

Explanatory note

Equality and non-discrimination are fundamental human rights principles. International instruments including the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, and the Convention on the Rights of Persons with Disabilities (CRPD) seek to establish equality and prohibit discrimination based on various factors.

The Committee on the Rights of Persons with Disabilities has explained that 'inclusive' equality under the CRPD requires both acceptance of disability as part of human difference and diversity and positive measures such as the provision of accessibility and accommodations. It also necessitates recognition that the needs and experiences of persons with disability, including experiences of discrimination, may vary depending on multiple and intersecting dimensions of difference.

For users of aged residential care, disability support and related services who are deprived of their liberty, equality and non-discrimination measures require that services recognise and respond to individuals' attributes, needs, experiences and preferences. These include attributes, needs, experiences and preferences related to faith or religion, spirituality, gender, sex, sexuality, gender

identity, nationality, Aboriginal and Torres Strait Islander background, age, or other grounds, including the 'prescribed attributes' in the Tasmanian anti-discrimination legislation.

Service users must also enjoy robust protections to prevent and, where necessary, respond to discrimination, bullying or harassment from any source. Service users who are members of a particular group or demographic, such as children, service users from culturally and linguistically diverse backgrounds, including Deaf community and culture and LGBTIQA+ service users, may have particular care and support needs and experiences which do not apply to other groups, requiring tailored and appropriate services to protect and promote their rights.

In light of the comparatively high incidence of disability among Aboriginal and Torres Strait Islander people in Tasmania, and the ongoing effects of individual and collective trauma associated with colonisation and dispossession, it is also imperative that the history, experiences and needs of Aboriginal and Torres Strait Islander service users are understood and met in a culturally safe manner.

Specific standards and sources:

International

- International Covenant on Economic, Social and Cultural Rights (ICESCR) articles 2, 3.
- International Covenant on Civil and Political Rights (ICCPR) articles 3, 26, 27.
- Convention on the Rights of Persons with Disabilities (CRPD) articles 3, 5, 6, 7, 15, 16.
- Convention on the Rights of the Child (CRC) articles 2, 30.
- International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) articles 2, 5, 6
- Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) articles 12, 15.
- *United Nations Declaration on the Rights of Indigenous Peoples,* GA Res 61/295 (Adopted 13 September 2007) (2 October 2007) 1, 2, 5, 9, 15, 18, 22.
- Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, GA Res 43/173 (Adopted 9 December 1988), Principles 5, 33.
- *United Nations Principles for Older Persons*, GA Res 46/91 (Adopted 16 December 1991), [10], [18].

- Committee on the Rights of Persons with Disabilities, Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities (2015), [17]-[18].
- Committee on the Rights of Persons with Disabilities, *General Comment No. 6 on Equality and Non-Discrimination (Article 5)*,19th session, UN Doc CRPD/C/GC/6 (26 April 2018).
- Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), *Prevention of Torture and Ill-treatment of Women Deprived of their Liberty*, 27th session, UN Doc CAT/OP/27/1 (18 January 2016) [24]-27].
- *Yogyakarta Principles* (2006) Principles 1, 2, 3, 9, 10, 19, 20, 21, 26.
- *Yogyakarta Principles Plus 10* (10 November 2017) Principles 30, 31, 32, 37, 38.

Topic 7: Safety, order and restrictive practices

Overarching Expectation: Service users feel safe and are free from all forms of harm or maltreatment. Service users' safety is secured, and their needs met, via alternatives to restriction to the maximum possible extent. All aspects of safety and security are informed by an understanding of individual needs, characteristics and experiences, including experiences of trauma.

Expectations	Indicators
7.1 The service takes a holistic, trauma-informed, person-centred and proactive approach to maintaining a safe environment for all service users[17]	• Staff and service users interact in a manner that fosters positive, warm and professional relationships. • Staff have completed training, and understand how, to support positive and safe relationships with service users. • No service user is subject to physical, sexual, financial, economic or other exploitation. • No service user is subject to verbal, physical, sexual or mental violence or abuse. • No service user is subject to unlawful coercion. • No service user is subject to physical or emotional neglect. • The service has adequate resourcing (such as adequate time and staff numbers) to ensure service user safety. • Staff take appropriate action to protect service users from exploitation, violence, abuse, coercion, neglect or other harm. • Staff have completed training on, and understand, the range of practices that may constitute exploitation, violence, abuse, coercion, neglect and other forms of harm or maltreatment, including practices within the service. • Staff training on forms of harm and maltreatment is specific to the characteristics and needs of the service user group (such as gender-specific, age-sensitive and culturally-specific training).

[17] See also expectation 8.3.

	• Staff have completed training on, and understand how, to recognise indicators of exploitation, violence, abuse, coercion, neglect or other harm or maltreatment. • Staff training on indicators of harm or maltreatment addresses indicators that may be particular to the service user or situation, and indicators of present (not only historical) harm. • Staff have completed training on responding effectively to issues of service user safety and wellbeing and support colleagues who disclose exploitation, violence, abuse, coercion, neglect or other harm. • Staff, including any security staff, have completed training on, and understand, the impact of, life experiences such as trauma and abuse on service users' needs and behaviour. • Staff, including any security staff, have completed training on, and understand, how to provide trauma-informed services as relevant to their role. • Staff, including any security staff, have completed training on, and understand, how their own experiences of trauma may affect their responses to service users and others. • Service users who have been subjected to trauma, including in the service, are assisted to access support and services of their choice to respond to that trauma. • The service has a protocol in place that enables service users, supporters and others to provide information to the service about service users who may be at risk of harm and may require additional supports.
7.2 The service responds promptly and appropriately to concerns or allegations (including potential concerns or indications) about exploitation, violence,	• Service users, supporters and others can approach staff to discuss safety or maltreatment concerns, issues or incidents, and they are taken seriously. • Service users, supporters and others can raise concerns in confidence with a range of people and services outside the service.

abuse, coercion, neglect or other forms of harm to service users[18]	• Where allegations or concerns about exploitation, violence, abuse, coercion, neglect or other harm have been raised, service users are supported and protected and proactively enabled to access an independent advocate for assistance. • Where allegations or concerns about exploitation, violence, abuse, coercion, neglect or other harm have been raised by someone other than the service user, immediate support is given to that person. • All concerns (including potential concerns or indications) about exploitation, violence, abuse, coercion, neglect or other harm are promptly documented, investigated and reported to the appropriate authority for investigation. • Staff meet mandatory reporting obligations and have completed the necessary training and support to do so. • Alleged criminal acts are reported to the Police. • In determining how to respond to incidents between service users, independent supports are engaged to determine whether it is appropriate and safe to make a referral to Police. • Investigations into allegations or suspicions of exploitation, violence, abuse, coercion, neglect or other harm are shared with the appropriate agencies and handled fairly, quickly and in accordance with statutory guidance. • Service users and any person who alleges harm against a service user are given a written response that sets out the action that has been, or will be, taken. Responses respect the privacy and confidentiality of the service user and others. • Disciplinary and/or legal action is taken against any staff member or other person found to be engaged in exploitation, violence, abuse, coercion, neglect or other maltreatment of service users.

[18] See also expectations 2.4, 9.3

7.3 Alternatives to restriction are prioritised and implemented effectively	• The service is actively working to reduce and eliminate restrictive practices, including seclusion and restraint. These efforts are evidenced in policies, procedures and practices. • External service providers such as general practitioners, geriatricians, occupational therapists, paediatricians, psychologists and psychiatrists are informed of, involved in and support the service's efforts to reduce and eliminate restrictive practices. • Individualised de-escalation and restraint and seclusion avoidance planning is conducted for every service user on arrival and aligns with positive behaviour support planning as appropriate. • De-escalation and restraint and seclusion avoidance planning involves service users and supporters and takes into account any advance directives. • De-escalation and restraint and seclusion avoidance planning identifies relevant aspects of service users' individual needs, history (including history of trauma), potential triggers, effective and/or preferred de-escalation strategies, and effective and/or preferred alternatives to restraint and seclusion. • Agreed de-escalation and restraint and seclusion avoidance strategies are subject to necessary approvals (such as inclusion in a behaviour support plan), recorded, communicated to staff, readily available in a crisis, and updated regularly. • Blanket restrictions on all service users, or blanket consent for all types of restrictive practices, are not used. • Access to shelter, warmth, a comfortable environment, water, food, fresh air, exercise, leave, confidentiality or reasonable privacy are never restricted as a punishment or used as a 'reward' or 'privilege' dependent on a service user's behaviour.
7.4 Staff are trained in trauma-informed practice and least restrictive practice, and have adequate	• Staff, including any security staff, have completed training in, and understand the purpose of, restraint and seclusion avoidance. Training includes de-escalation techniques for intervening in crises and preventing harm to service users, staff and others.

resources, to respond to potentially harmful or risky incidents and behaviour	• Staff, including any security staff, have completed training on, and understand, the potential for restrictive practices and other practices to cause or exacerbate service user trauma. • Behaviour support, de-escalation and restraint and seclusion avoidance planning is conducted by suitably trained, qualified and specialised personnel. • Where potentially harmful events or behaviour occur, staff respond compassionately and implement ant agreed de-escalation, restraint and seclusion avoidance strategies.
7.5 Any use of restraint or seclusion is conducted with proper legal authority, used only as a last resort and for the shortest time possible, and causes the minimum interference with the person's autonomy, dignity and privacy[19]	• Staff, including security staff, have completed training on, and understand, the range of practices that may constitute restraint and seclusion, and the harms of restraint and seclusion. • Staff have completed training on, understand, and follow legal authorisation or consent processes required for the lawful use of restraint and seclusion. • Staff have completed training on, understand, and follow monitoring, safeguarding, reporting and review requirements that apply during and following every use of restraint and seclusion. • Staff and leadership foster and demonstrate a culture of continuously questioning and reassessing the appropriateness of authorisation and use of restrictive practices for individual service users. • Any staff, including security staff, who may be involved in applying restraint or seclusion have completed training on how to do so as safely as possible. • Restraint and seclusion are never used to punish, or with the intention of inflicting pain, suffering or humiliation. • Restraint and seclusion are never used to manage service users as a substitute for adequate staffing or facility design.

[19] See also expectation 2.1.

	• A service user's actual or perceived diagnosis of a disability or mental health condition is never treated as sufficient reason for administering restraint or seclusion. • Informal seclusion is never used. • Solitary confinement (confinement alone in a space the person cannot leave for 22 hours or more a day without the opportunity for meaningful human contact) is never used. • Any restraint or seclusion is only used where there is a real possibility of harm to the person, staff or others if the restriction is not imposed. • Any restraint or seclusion is only used as a last resort after all available alternatives have been explored and applied. • Any restraint or seclusion is the least restrictive option and causes the minimum interference to a person's autonomy, privacy and dignity. • Decisions about authorising or applying restraint or seclusion take into account, and respect, service users' dignity of risk. • Any restraint or seclusion is imposed for no longer than absolutely necessary. • Where the use of restraint or seclusion is authorised, the service user's needs, views and preferences (such as preferences about modes of restriction and gender of staff involved) are identified, documented and followed to the maximum extent possible. • All efforts are made to mitigate the potential harm of restraint or seclusion. • The nature of the techniques used to restrain are proportionate to the risk of harm and its seriousness. • Every incidence of restraint or seclusion has an exit strategy and target end point that is known and understood by the service user to the fullest extent possible. • Service users in seclusion have access to appropriate sensory stimuli.

	• Every incidence of restraint or seclusion is formally and transparently documented and audited in accordance with legal requirements. • Documentation of restraint or seclusion incidents includes a report of what happened, the reasons for the use of restraint or seclusion, efforts made to avoid it, its authorisation and any reviews, how it was implemented, how the service user's needs were met, and the service user's response. • Use of restraint or seclusion is reported to the appropriate authority. • There is a debrief with staff, the service user and supporters following any incidence of seclusion or restraint. The events that led to the use of seclusion or restraint, what actually happened to the service user during the seclusion or restraint, and the rationale for the use are explained in a way the service user understands. • During debriefing, service users are offered the opportunity to communicate their perspective on the restraint or seclusion incident and the service's explanation of it. • Debriefing includes discussion of ways the service and service user can avoid future incidences of restraint or seclusion and provision of support. • Policies concerning use, and efforts to minimise and eliminate use, of restraint and seclusion are kept under ongoing review to ensure consistency with best practice and human rights standards.
7.7 The service provides a safe and secure environment which reduces the risk of self-harm and suicide. Service users at risk of self-harm or suicide are identified at an early stage and given the necessary support	• The environment minimises to the fullest extent possible the risk of self-harm and suicide. • Service users are assessed regarding their risk of self-harm and suicide at appropriately regular intervals. This information is recorded and communicated to staff. • Services provide and use preventative measures such as sensory regulation tools, behaviour support, de-escalation and restraint and seclusion avoidance

	strategies, in responding to risks of self-harm and suicide. • Staff receive training on, and understand, that the use of restraint or other restrictions to prevent self-harm or suicide may be traumatic even when it is considered necessary . • Staff regularly check on service users according to their assessed risk of self-harm and suicide, particularly in more private areas of a service, while being mindful to minimise intrusion into a service user's privacy as much as possible. • Personal possessions are only removed in well documented, exceptional circumstances to reduce risks to the service user.
7.8 Any searches are undertaken with proper legal authority, are proportionate to an identified risk and carried out with due regard to, and respect for, dignity and privacy	• Where personal or property searches of service users or visitors are considered necessary and proportionate to identified risk, this is referred to a body with lawful authority to conduct the search.[20] • Where relevant, service users, staff and visitors are informed there is a policy on searching and are provided with its details in readily available and accessible formats. • Searches of people or their property respect the person's privacy and dignity and are carried out in the least intrusive way possible. • Searches are respectful of a person's gender, culture and faith. • Searches are respectful of a person's actual or potential experiences of trauma. • Service users can access a supporter, including an independent advocate, in relation to searches. • Searches of people who experience pain or have sensory, bodily or other needs that vary from others in

[20] In relation to searches of children and young people, see also expectation 11.5 of Tasmanian NPM, *Expectations on the Treatment of Children and Young People* (Version 1, October 2023) <https://npm.tas.gov.au>

	the community take into account and accommodate their needs. • The consent of the person to be searched is sought before the search is conducted. • The person is kept informed, in a way they understand, as to what is happening and why throughout the search. • Records of all searches are documented and audited. Any items taken are appropriately logged and stored securely. Service users' items are transferred with that service user if they move to another service. • Support is available for people who are distressed or otherwise affected by the process of searching.

Explanatory note

Users of aged residential care, disability support and related services must enjoy safety in all aspects of life. Services must develop and effectively implement processes to prevent safety risks and respond to allegations (including potential concerns or indications) about exploitation, violence, abuse, coercion, neglect and other forms of maltreatment or harm to service users.[21] This is necessary for the protection and promotion of many human rights, including the rights to liberty and security of the person (ICCPR article 9, CRPD article 14), health (ICESCR article 12, CRPD article 25), life (ICCPR article 6, CRPD article 10), freedom from exploitation, violence and abuse (CRPD article 16) and freedom from torture, or cruel, inhuman or degrading treatment or punishment (ICCPR article 7, CRPD article 15).

Users of these services may at times behave in ways that create, or are perceived to create, a risk of harm to themselves or others. Services might respond to these and other circumstances by imposing restrictive practices such as physical, mechanical, environmental or chemical restraint, or seclusion, on service users. These restrictive measures, while legally permitted in certain specified circumstances, cause harm and raise serious human rights concerns themselves. Multiple human rights bodies, including the Committee on the Rights of Persons with Disabilities, have expressed the view that their use can

[21] *Convention on the Rights of Persons with Disabilities*, Preamble, articles 16,23; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Nature and Extent of Violence, Abuse, Neglect and Exploitation* (Final Report, vol. 3).

and must always be avoided through the provision of appropriate environments and support.[22] Some other human rights bodies have characterised restraint and seclusion as permissible in international law where they are necessary as a last resort for safety reasons, if accompanied by appropriate safeguards including authorisation, supervision, monitoring, review and appeal processes.[23]

Both perspectives set a clear direction towards the reduction and elimination of restraint and seclusion and require demonstrable steps to be taken towards this aim. There is a growing body of evidence to support the implementation of alternatives to restrictive practices. Effective steps include individualised de-escalation and restraint and seclusion avoidance planning, as well as training, resourcing and support for staff to implement alternative practices in a manner that maintains safety and security for all.

Specific standards and sources

International

- *International Covenant on Civil and Political Rights* (ICCPR) articles 6, 7, 9, 10, 16, 17, 26.
- *International Covenant on Economic, Social and Cultural Rights* (ICESCR) articles 12.
- *Convention on the Rights of Persons with Disabilities* (CRPD) articles 3, 5, 10, 12, 14, 15, 16, 17, 22, 25.
- *Convention on the Rights of the Child* (CRC) articles 16, 19, 24, 37.
- *United Nations Declaration on the Rights of Indigenous Peoples*, GA Res 61/295 (Adopted 13 September 2007), articles 1, 2, 7, 22.
- General Assembly, *Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring*

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[22] E.g., Committee on the Rights of Persons with Disabilities, *Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities* (2015), [12]-[15]; General Assembly, Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court, 30th session, UN Doc A/HRC/30/37 (6 July 2015) [38], [103]; • Human Rights Council, Report of the Special Rapporteur on the Rights of Persons with Disabilities (on Disability-Specific Forms of Deprivation of Liberty), 40th session, A/HRC/40/54 (11 January 2019) [44]-[56].

[23] E.g., Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), Approach of the SPT Regarding the Rights of Persons Institutionalized and Treated Medically Without Informed Consent, 22nd session, UN Doc CAT/OP/27/2 (26 January 2016) [6]-[9]; Human Rights Committee, General Comment No. 35: Liberty and Security of Person, 112th session, UN Doc CCPR/C/GC/35 (16 December 2014) [19].

Proceedings Before a Court, 30th session, UN Doc A/HRC/30/37 (6 July 2015) [38], [103].

- Committee on the Rights of Persons with Disabilities, *Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities* (2015), [12]-[15].
- *Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment*, GA Res 43/173 (Adopted 9 December 1988), Principles 6, 7.
- *United Nations Principles for Older Persons*, GA Res 46/91 (Adopted 16 December 1991) [17].
- General Assembly, *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 Re37/194, Principle 5.
- Committee Against Torture, *Ninth Annual Report of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment of Lesbian, Gay, Bisexual, Transgender and Intersex Persons)*, 57th session, UN Doc CAT/C/57/4 (22 March 2016) [60]-[70], [74], [76]-[82].
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- World Health Organization, *Strategies to End Seclusion and Restraint: WHO QualityRights Specialised Training Course Guide* (2019).
- *Yogyakarta Principles* (2006) Principles 2, 3, 5, 7, 9, 10, 11, 18,
- *Yogyakarta Principles Plus 10* (10 November 2017) Principle 30.

Topic 8: Daily life

Overarching Expectation: The living situation in the service promotes dignity, respect, autonomy, wellbeing and rights of all service users; service users have choice and control over their everyday lives to the fullest extent possible, and care and support facilitates this.

Expectations	Indicators

8.1 Service users are welcomed and well-oriented when they arrive at the service	• Before and on arrival at the service, service users are welcome and treated with dignity and respect.
	• The environment and processes when service users arrive at, first use, or are admitted to the service make service users feel safe, supported and comfortable.
	• Service users can choose to involve supporters in arrival, admission and/or orientation processes.
	• Upon arrival at the service and periodically during the service user's time with the service:
	  ○ any immediate needs of the service user are identified and met.
	  ○ any safety risks are identified, considered, assessed and addressed.
	  ○ service users and supporters are informed of service users' rights and how to access support.[24]

8.2 Service users are the primary decision-makers in relation to day-to-day life decisions, and their dignity, autonomy and wellbeing is fostered	• Service users and supporters are consulted about service users' interests and preferences as to how they spend their time. • Service users have the maximum possible control over daily decisions, such as what to wear, personal grooming, where to spend time and with whom, entertainment and daily routine (such as when to shower and when to get up and go to bed). • If a service user's choices cannot be honoured, the reasons why are explained to the service user and supporters (in a way they understand), documented and regularly reviewed.

[24] See also expectations 2.3-2.6.

	• Service users are afforded the dignity of being able to change their minds about daily decisions and choices without explanation or justification. • Staff understand the significance of service users having control over daily decisions when other elements of their life are constrained. • Staff recognise, and are supported by management to respect, dignity of risk. They enable and support service users to choose to take risks in their daily lives. • Support for service users to make positive choices which contribute to their health and wellbeing is provided through engagement, education and encouragement, not coercion. • Service users receive support to live and mobilise with the greatest possible independence through measures such as access to personal mobility and communication aids, devices, assistive technologies and other forms of assistance and intermediaries.[25] • Service users can access regular physical rehabilitation or exercise.
8.3 Service users are treated with dignity and respect[26]	• Staff support the creation of a daily lifestyle that is as similar as possible to the lives of others in the community in the same stage of life. • Staff take time to build relationships with service users, show genuine interest and listen to them. • Communication with and about service users is empathetic, constructive, humanising and respectful. • Staff encourage and support empathetic engagement between service users and staff, other professionals, volunteers and community members. • All service users have the opportunity for meaningful human contact – contact that is of sufficient quality and duration – every day.

[25] See also topic 4 and expectation 6.6.

[26] See also expectations 7.1 and 7.2.

	• Staff know how and feel confident to raise concerns about colleagues' behaviour or interactions with service users, without recrimination. • Staff listen to and act on service users' wishes, views and preferences about daily life to the fullest extent possible. • There is a comprehensive and sensitive handover of information between staff to ensure continuity of care and support in the service.
8.4 Service users have access to meaningful activities and are encouraged and supported to engage in activities of their choice[27]	• Service users have the opportunity, and are encouraged and supported as necessary, to participate in recreational, sporting, leisure, religious and cultural activities within and outside the service aligned with their preferences and wishes. • Service users have the opportunity, and are supported and encouraged as necessary, to participate in activities to foster and develop their autonomy, dignity and other rights, aligned with their preferences and wishes. These may include education, employment and public participation. • Suitable and meaningful activities are offered and available for service users throughout the day and throughout the week. • The needs of specific service user groups in relation to activities, including spiritual and cultural needs, are identified and supported. • Service users are able, and supported, to spend active and meaningful time with other people and form meaningful relationships with those around them. • Service users' sexuality and sexual and romantic lives and relationships are acknowledged, respected and facilitated as appropriate to the individual. • Where service users request or seek to be isolated, efforts are made to identify the reasons for this and address the root causes.

[27] See also expectations 5.1 and 5.2.

8.5 Service users can freely practice their culture, religion and spirituality[28]	• Service users have access to people who can provide cultural and/or spiritual support. • Service users are provided with appropriate materials, opportunities and private space to engage in cultural and/or religious practices to the fullest extent possible.
8.6 Service users have access to adequate amounts of water and nutritious food which promote their health and wellbeing	• Safe drinking water is freely available to all service users at all times. • Nutritious food of sufficient quality and quantity is available to all service users. • Service users can access dietary advice that takes into account their individual health needs and is meaningful to them in their individual context. • Service users have a varied, healthy and balanced diet which meets their individual needs (including dietary, cultural and religious needs) and personal preferences. • Service users have choice and input about what, when and where they can eat, include outside of mealtimes. • Service users have opportunities to provide feedback on the food and drink available to them. • Meals and food are served at appropriate temperatures and times, unless there is a justifiable and proportionate reason that this is not possible.
8.7 Service users have access to appropriate clothing and laundry facilities	• Service users are able to wear their own clothes and make choices about the clothing that they wear. • If service users are unable to wear their own clothing, they are provided with options of good quality clothing that meets their needs and preferences and is suitable for the climate. • There are adequate laundry facilities and practices. • Items that need to be washed, such as clothing and bedding, are kept clean and in good condition. Items are labelled and returned correctly to their owner.

[28] See also topic 6.

8.8 Service users have access to personal possessions and property	• Service users can have possessions that are familiar or important to them, especially in their bedroom. • Respect and appropriate care are shown for service users' personal possessions. • Clear, timely and effective processes are in place for the dignified storage and transfer of service users' possessions. • Service users can access their stored possessions on request.

Explanatory note

The experience of daily life for residents of aged residential, disability support and related services engages a range of human rights standards and principles. In order to prevent torture and ill-treatment, service users must be treated with dignity and respect at all times. This encompasses admission processes, all interactions with staff, and access to adequate and good quality food, water and clothing, and service users' own possessions.

Service users' autonomy in daily life, including the freedom to make their own choices and to enjoy full and effective participation and inclusion in society on an equal basis with others, must also be supported. The choices and forms of participation valued by service users will differ from person to person but may include having control over daily routines and experiences, forming and fostering relationships with others, and being involved in a range of activities and pursuits within and outside the service (including religious, cultural, recreation, leisure and sporting activities, as well as education, employment and public participation).

Specific standards and sources

International

- International Covenant on Civil and Political Rights (ICCPR) articles 7, 10, 17.
- International Covenant on Economic, Social and Cultural Rights (ICESCR) articles 11, 12.
- *Convention on the Rights of Persons with Disabilities* (CRPD) articles 3, 4(3), 5, 12, 14, 15, 16, 17, 19, 22, 24, 25, 26, 27, 28, 29, 30, 33(3).
- United Nations Declaration on the Rights of Indigenous Peoples, GA Res 61/295 (Adopted 13 September 2007), articles 20, 21
- *United Nations Principles for Older Persons*, GA Res 46/91 (Adopted 16 December 1991) [1]-[5], [10], [12]-[18].
- Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, GA Res 43/173 (Adopted 9 December 1988), Principles 1, 6.
- Human Rights Council, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (on the Right to Health in the Context of Confinement and Deprivation of Liberty), 38th session, A/HRC/38/36 (10 April 2018).
- *Yogyakarta Principles* (2006), Principles 2, 12, 16, 20, 24, 26.

Topic 9: Leadership, culture and staffing

Overarching Expectation: The leadership, culture and staffing of residential services promotes and protects the rights of service users.

Expectations	Indicators
9.1 Service users and representative organisations are involved in governance and decision-making processes[29]	• Governance and decision-making processes at all levels involve meaningful consultation and effective communication with service users, supporters and other stakeholders. • Services and leaders make proactive efforts to secure diverse representation, provide necessary accommodations and accessibility measures, and involve representative organisations and advocates for service users, in order to facilitate service user representation and participation to the fullest possible extent. • Stakeholder consultation and involvement includes representative and advocacy organisations of persons with disability, older persons, and persons with dementia (including, as relevant, groups representing persons with multiple dimensions of identity), those who have experience of the aged care sector or disability support sector, and civil society.[30] • Leaders proactively seek engagement with Aboriginal and Torres Strait Islander service users, their families and communities with the aim of building trust and improving service delivery and co-design practices.
9.2 Leaders and staff promote, operationalise and demonstrate a human rights-based approach to providing the service to service users	• There is a demonstrable commitment from leaders to treating all service users with dignity and respect. • Leaders and staff understand and share the aim of delivering a human rights-based approach to providing care and support and other aspects of the service. • Leaders and staff have completed training on relevant human rights standards, including the prohibition against torture and other forms of cruel and inhuman and degrading treatment, the right to equal recognition

[29] See also expectation 2.6.

[30] See also topic 6.

	before the law (including supported decision-making), and other rights of persons with disabilities and older persons. • Leaders and staff demonstrate knowledge and understanding of the needs and rights of children, persons with disability, older persons and/or persons with dementia (as appropriate to the service user group). • Leaders and staff understand and are confident to respond in a rights-based manner to situations where two or more service users' rights, preferences or needs are (or appear to be) in conflict. • Staff training emphasises how human rights fundamentally underpin the provision of a safe, high quality, person centred, trauma-informed service.
9.3 Leaders are committed to and take responsibility for promoting and providing high quality care and support, and continuous quality improvement[31]	• Leaders communicate a shared and ambitious vision for the service. • Leaders and staff foster a culture where feedback and complaints are welcomed and taken seriously. • Leaders are in touch with what happens on a day-to-day basis in the service, including issues raised through complaints and the challenges faced by staff. • The service gathers and analyses sufficient information to ensure leaders can monitor conditions and treatment of service users, are aware of any concerns, and address them. • Leaders monitor and understand the legal and factual basis on which service users are subject to restrictive practices or other deprivation of liberty. • Leaders monitor and follow-up changes to policies and practice to ensure they are implemented. • Senior management has the experience and skills necessary to improve outcomes for service users.

[31] See also expectations 2.1, 2.2, 2.4 and 7.2.

	• Leaders develop successful working relationships with partners and stakeholders to deliver the service's aims. • Best practice models and up-to-date research are used to improve the service and service users' experience. • Quality improvement strategies are used to assess and improve the service and service users' experience. • Strategic and operational plans, including those relating to staffing, resourcing and quality improvement, show how the service realises, maintains and progresses best practice. • There are processes to ensure that staff, service users and supporters and can influence and contribute to quality improvement initiatives. • The organisation has a range of tools, including policies, systems and processes to assess, monitor, manage, mitigate and report incidents and risks. • External scrutiny is welcomed and encouraged by those in leadership positions. • Recommendations made by external bodies, professionals and groups inform changes to practice and service improvement. • Staff have completed training on, and understand, their obligations regarding information collection, sharing and recordkeeping. • Leaders ensure effective, accurate reporting in relation to all safety (including sexual safety and restrictive practices) incidents and provide rigorous management scrutiny and oversight of the same. • Whistleblowing procedures are known, understood and trusted by staff.
9.4 Leaders are committed to, and promote, policies, practices, strategies and behaviours which respect diversity and	• A workforce diversity and inclusion strategic plan has been developed with clear targets, and its implementation is tracked. • Leaders and staff model non-discriminatory attitudes and behaviours.

create an inclusive service and organisational culture[32]	• Fair and non-discriminatory policies and processes are developed and deployed at all levels within the service.
9.5 The service emphasises its commitment to service users' rights, safety and wellbeing when advertising for, recruiting and screening staff and volunteers	• Recruitment, including advertising, referee checks and staff and volunteer pre-screening, emphasise the rights, safety and wellbeing of service users. • Staff and volunteers are conscientiously selected, recognising that the service users' safety and wellbeing depends upon the staff members' integrity, humanity, knowledge, skills, and personal suitability. • Relevant staff and volunteers have current working with vulnerable people checks relevant to the sector they work in and the service users they work with. • Appropriate screening is conducted of staff and volunteers from external providers delivering services or activities to service users. • All staff and volunteers, including agency staff, receive an appropriate induction and are aware of their responsibilities to service users, including record keeping, information sharing and reporting obligations. • New part-time or full-time staff undergo formal supervised probation scaffolded by a variety of supports and supervision by suitably selected experienced and trained managers, supervisors, and peers. Issues identified during probation are addressed with opportunities given for improvement. • Probation is only signed off when new staff meet all requirements for permanency and are deemed suitable for ongoing work with service users.
9.6 Staff are equipped with the resources, knowledge, skills and awareness to protect and promote service users' rights	• There are appropriate levels of staffing and other resources to provide a rights-based, safe, culturally safe, high quality, person-centred and trauma-informed service. • Leaders readily identify resource constraints and take measures to resolve them.

[32] See also topic 6.

	• The service employs and trains staff with sufficiently diverse skills to promote and protect service users' human rights. • Staff understand and share the aims and priorities of the service. • Staff complete regular training to ensure they have the knowledge, skills and attitudes necessary to provide a rights-based, safe, culturally safe, high quality, person-centred and trauma-informed service. • Staff complete regular training to maintain and upgrade their skills (and qualifications where relevant) and can access professional development activities. • Staff complete regular training on safety and wellbeing policies and procedures and evidence-based best practice. • Staff have completed workplace training on 'soft skills' (such as communication and facilitation skills) and workplace-specific skills and knowledge (such as behaviour support, de-escalation, seclusion and restraint, incident reporting and other work health and safety practices and procedures). • Staff have completed training to increase disability awareness, Aboriginal and Torres Strait Islander cultural awareness and safety, child and adolescent development, child and youth safe standards and practices, emergency management, anti-discrimination and other areas relevant to the service user group. • Staff are trained and aware of their responsibilities toward service users who are deprived on their liberty. • The regular performance appraisal process includes updating staff professional development needs and interests. • There is a formal training plan to coordinate the training of staff. Accurate and up-to-date records are kept of all staff training.
9.7 Ongoing supervision and people management is	• Staff are provided with appropriate supervision and management.

focused on promoting the safety, dignity, rights and wellbeing of service users	• Ongoing staff support, supervision and performance management policy and processes involve safety and quality elements. • Line managers and supervisors support their staff, including challenging or managing where necessary and providing suitable professional development opportunities. • The organisation maintains suitable record keeping systems and protocols for staff and volunteers. • Robust retention strategies are in place. • Leaders prioritise maintaining consistency of staffing and rosters. • Regular performance appraisal is undertaken for all staff. • There are robust codes of conduct, performance management, investigation and standing down policies and procedures to identify, respond to, manage and report on staff underperformance and incidents, including allegations of abuse. These policies and procedures are strictly adhered to, actions are taken (including reporting) and outcomes are recorded. • Timely action is taken when unsuitable staff are identified. • Use of leave and overtime is monitored as part of the regular review of staff morale.

Explanatory note

The quality of leadership, staffing and organisational culture are essential to the prevention of torture and ill treatment in all places of detention, including aged residential care, disability support and related environments. This requires the commitment of leaders (meaning anyone with leadership or management responsibility in the service or wider system) and staff to providing a human rights-based service through adequate resourcing, appropriate recruitment, training and oversight processes, and ongoing monitoring and quality improvement.

Governance and decision-making at all levels should be informed by meaningful consultation and involvement of service users, supporters and their representative organisations (CRPD articles 4(3), 33(3)). The evidence base for effective governance and decision-making processes in this context is an evolving field and it is crucial that services understand best practice and undertake ongoing improvement.

Specific standards and sources

International

- Convention on the Rights of Persons with Disabilities (CRPD) articles 4(3), 33(3).
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- *Convention on the Elimination of All Forms of Discrimination Against Women*, opened for signature 1 March 1980, 1249 UNTS 13 (entered into force 3 September 1981).
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