INSPECT!

Inspectorates of Mental Health and Social Care Institutions in the European Union

mdac
mental disability advocacy center

Inside the institution I was given lots
of medication, but I didn't want it.
Sometimes they tied me up.
They wouldn't let me out.
I wanted to build my own life.

MDAC advances human rights.

We respect the privacy of our clients,
so we have chosen models, not clients, to appear in these photographs.

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Inspectorates of Mental Health and Social Care Institutions in the European Union

2006

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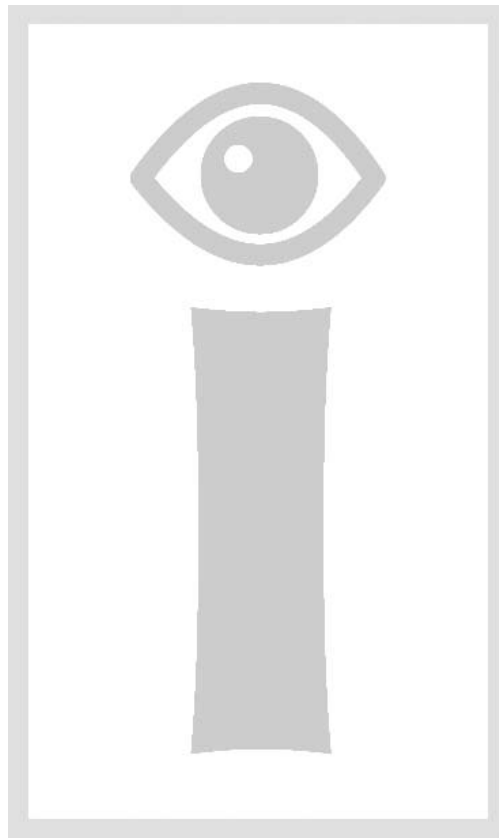

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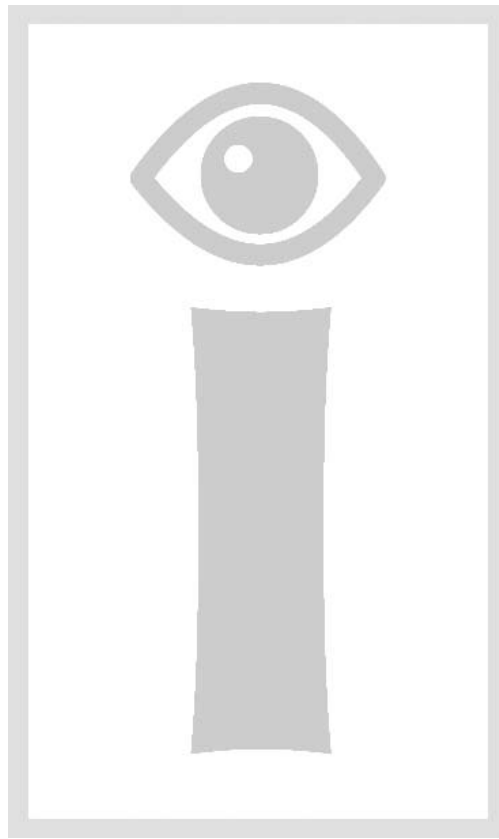

Summary

Inspect! illustrates the fundamental importance of effective inspectorates of mental health and social care institutions. It offers clear guidelines as a framework for establishing and maintaining inspectorates and measures the current practice of six European countries against these guidelines. These six countries are the Czech Republic, Estonia, Finland, Hungary, the Netherlands and the United Kingdom.

Inspect! opens with an explanation as to why effective inspectorates of mental health and social care institutions is so imperative, introducing a tone of urgency into current debates on the issue. The report lays out in point-form Eight Requirements for their establishment and effective functioning. These requirements are based upon international legal standards, agreed following debates in domestic, regional and international forums, with active participation by State, inter-governmental organisations and civil society.

Inspect! reviews the practice of six countries, measured against these Eight Requirements. This review allows an assessment of common or innovative, as well as deficient, practices from which lessons can be learnt.

Inspect! aims simply to raise the profile of mental health and social care inspectorates. In so doing it hopes to stimulate discussion, to facilitate transfer of best practice and to encourage concrete and embedded State action, all geared towards strengthening the effectiveness of inspectorates and thus a reduction of human rights violations.

Methodology and Acknowledgments

THE METHODOLOGY FOR THIS REPORT comprised both desk and field work, which was carried out between January and November 2006. Desk work involved principally internet research, the collation and analysis of national and international legislative provisions, and a review of relevant academic literature. Field work took place in a number of countries, and entailed face-to-face and telephone interviews, with representatives of various governmental departments, inspectorate mechanisms and civil society at the domestic, regional and international level.

Katarzyna Czepelak, an Open Society Justice Initiative Fellow, was the principal researcher. All MDAC staff members and legal monitors commented on earlier drafts. The report was edited by Sarah Green, and proof read by Oliver Lewis. It was designed, laid out and prepared for publication by István Fenyvesi.

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PART I
MDAC's Eight Requirements for Establishing Inspectorates of Mental Health and Social Care Institutions

Introduction

PEOPLE WITH DISABILITIES removed from the protective gaze of society as the result of detention in mental health and social care institutions are particularly vulnerable to neglect and abuse. MDAC defines an institution as

> any place in which people who have been labeled as having a disability are isolated, segregated and/or compelled to live together. An institution is any place in which people do not have, or are not allowed to exercise control over their lives and their day-to-day decisions. An institution is not defined merely by its size. [1]

The consequences of institutionalisation are twofold. First, States must make greater efforts to fulfill their obligations to implement the right of people with disabilities to live in the least restrictive setting. Second, whilst this obligation remains unfulfilled, States must ensure that when inside institutions their human rights are fully respected and protected. The respect and protection of human rights cannot be assured unless and until the cloak of invisibility, so common to institutions, is lifted. The most effective way of removing this invisibility is through the active use of independent inspectorates. Without independent inspectorates, neglect and abuse will continue with impunity, and will continue to be unnoticed and unremedied.

The imperative of monitoring mechanisms in the protection of human rights is recognised in international human rights texts. More specifically, States party to certain international instruments, which will include the United Nations Convention on the Rights of Persons with Disabilities, are obliged to establish national mechanisms to monitor human rights of all people within their jurisdiction wherever they might be accommodated. Nonetheless, even amongst those European countries that do provide for national inspectorate mechanisms, there remain many mental health and social care institutions that continue to avoid meaningful scrutiny.

Regional monitoring, through the European Committee for the Prevention of Torture (CPT) which regularly visits mental health and social care institutions, has led to both concern being expressed at the gap in protection for those within the institutions and an exhortation for the establishment, and full State support, of independent national inspectorates. At the international level, the Optional Protocol to the United Nations Convention against Torture (OPCAT) specifically requires States to establish independent inspectorates, referred to as 'national preventive mechanisms', for all places of detention.

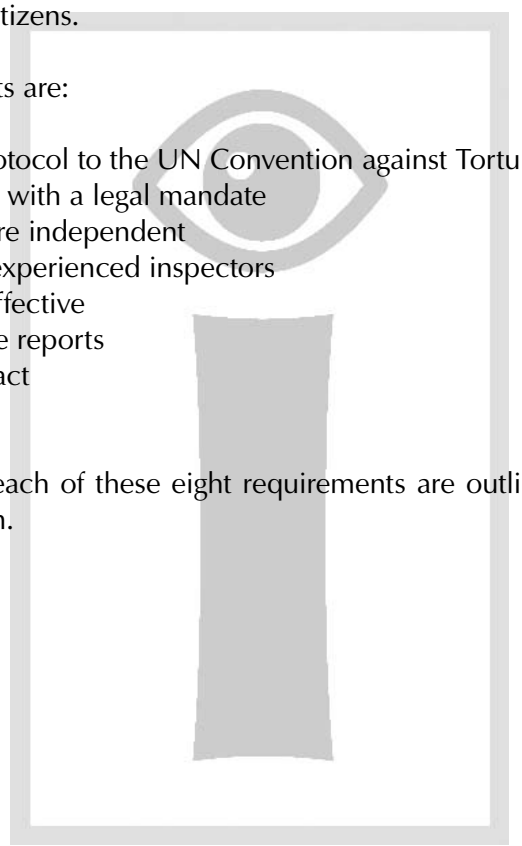
1 Definition from the European Coalition of Community Living, of which MDAC is a member.

MDAC's Eight Requirements for Establishing Inspectorates of Mental Health and Social Care Institutions is a checklist for all States. The effective functioning of such inspectorates will help ensure that people with disabilities and detained in institutions will become less vulnerable to abuse and neglect; they will become more visible to the protective gaze of society, their voices will be heard, services consequently improved and abuses remedied. So too will States themselves benefit. They will be able to rest in the knowledge that they are constructively contributing to the fulfillment of their duty to both respect and protect the human rights of some of their most vulnerable citizens.

The Eight Requirements are:

1. Ratify the Optional Protocol to the UN Convention against Torture (OPCAT)
2. Establish inspectorates with a legal mandate
3. Ensure inspectorates are independent
4. Recruit qualified and experienced inspectors
5. Ensure that visits are effective
6. Publish comprehensive reports
7. Ensure maximum impact
8. Coordinate activities

The key elements of each of these eight requirements are outlined below, followed by a short narrative explanation.



The Eight Requirements

1. Ratify the Optional Protocol to the UN Convention Aagainst Torture (OPCAT)

States should ratify and thereafter effectively implement the OPCAT. Compliance with the OPCAT requires State provision of effective monitoring of places of detention by the establishment of a system of regular visits to such institutions carried out by independent international and national bodies.

2. Establish inspectorates with a legal mandate

States should establish inspectorates by law, with a mandate to:
1. conduct regular unannounced and announced visits to mental health and social care institutions, with the right to speak to patients, residents and their representatives of their own choosing, in private and to view documents;
2. have unobstructed access to all institutions upon demand;
3. react to complaints from people in institutions to the inspectorates;
4. make recommendations to public authorities with the aim of improving protection of human rights, and comment on existing and draft legislation and policy.

3. Ensure inspectorates are independent

States should ensure that inspectorates are independent from the executive and from visited institutions. States should:
1. allow inspectorates to control a budget which is sufficient to effectively carry out its mission;
2. allow inspectorates to hire its own staff, and maintain office space separate from the executive or institutions;
3. ensure that inspectorates adopt policies preventing conflicts of interest.

4. Recruit qualified and experienced inspectors

States should ensure that inspectorates:
1. recruit people with disabilities, including people with psycho-social or intellectual disabilities;
2. recruit people of different professional backgrounds;
3. demonstrate a balanced gender and ethnic minority representation;
4. bring in experts on an ad hoc basis;
5. provide adequate and ongoing training to all inspectors.

5. Ensure that visits are effective

States should guarantee that inspectorates:
1. regularly carry out both unannounced and announced visits;
2. inform institutions and its staff of the objectives of visits;

3. ensure that each institution is visited at least once a year;
4. ensure that they have access to and visit all parts of an institution;
5. conduct interviews in private, with patients, residents and any other person who the inspectorate believes may supply relevant information;
6. establish procedures to prevent perceived or real retribution against patients and residents who communicate with inspectorates;
7. ensure that such people are not subject to sanction;
8. view all documentation without justification or explanation (including health documentation and court records);
9. observe confidentiality and protect privacy of patients and residents.

6. Publish comprehensive reports

States should ensure that inspectorates publicly release detailed reports which:
1. identify root causes of problems;
2. formulate SMART (specific, measurable, achievable, realistic and time-bound) recommendations to institutions and to the authorities which have power to implement them;
3. set priorities and implementation periods;
4. highlight best practice, including promoting alternatives to institutionalisation.

7. Ensure maximum impact

States should:
1. oblige inspectorates to present annual reports to Parliament;
2. ensure that inspectorates enter into dialogue with authorities on implementation of report recommendations;
3. require inspectorates to carry out follow-up visits to ensure recommendations are implemented;
4. respond proactively and appropriately to inspectorate reports and report on actions that they have taken to meet recommendations.

8. Coordinate activities

States should ensure that inspectorates:
1. maintain cooperation and coordination with other bodies responsible for the promotion and protection of human rights, including other inspectorates and complaint mechanisms;
2. guarantee that the cooperation results in effectiveness, coherence of methodology and standards, mutual reinforcement and avoids duplication of work, inconsistency or contradiction;
3. disseminate their reports to civil society stakeholders and relevant international and regional human rights bodies.

Explanation of the Eight Requirements

Requirement 1: Ratify the Optional Protocol to the UN Convention against Torture (OPCAT)

Ratification of the OPCAT is not a prerequisite of the establishment of independent inspectorate systems in mental health and social care institutions. Indeed a small number of such systems already exist in non-State Parties to the OPCAT. For States both with and without such systems however, its ratification will serve as confirmation of formal commitment to the protection of the human rights of all persons within their jurisdiction. Ratification will also serve as a formal commitment to the establishment of inspectorates with a mandate to conduct their activities in an independent and effective way. Comprehensive information about the OPCAT is available on the MDAC website.

Requirement 2: Establish inspectorates with a legal mandate

Inspectorates should be established by an Act of Parliament. This will ensure the stability and continuity of its mandate. With the object of ensuring stability, continuity and, importantly, independence from State authorities, the Act should both specify the duration of, and make provision for, a pluralistic membership.

In order to fulfill its mandate, the inspectorate must have legally guaranteed free access to all institutions. This will minimize the risk of obstruction on the part of institutions and will allow the inspectorates to focus on conducting inspections in places they select rather than on those chosen by the directors of the institutions. A delegation of the inspectorate arriving at and monitoring an institution should be considered a regular feature of mental health and social services.

In order to fulfill its mandate, the inspectorate must have legally guaranteed free access to all institutions

Of similar importance is the legal status of the inspection body, a status which should be clearly defined, as should the rights, obligations, and possible privileges and immunities of its members and staff. Formal clarification and guidance on a number of specific issues is required, particularly those regarding the processing and collection of information. For example, clarification as to the extent information given to the inspection body will remain confidential and both the extent and circumstances of the obligation upon inspectors to pass information on to other bodies (for example. a public prosecutor) is necessary in any mandate.

The inspectorate should be given a mandate to receive complaints. The specific organization of a complaints system may however take different forms:

- ⇨ a system in which each complaint is individually addressed and adjudicated upon;
- ⇨ a system which has no legal mandate to adjudicate upon individual complaints, but uses complaints as information of alleged violations in planning future visits to institutions; or
- ⇨ an inspectorate body with a responsibility to cooperate with relevant adjudicating bodies and to forward complaints to such bodies for further action.

Inspectorates should participate in the process of commenting on draft legislation. Due to their expertise in the area of mental health and social care they should also be automatically consulted by State authorities on relevant policy matters.

Requirement 3: Ensure inspectorates are independent

Freedom from State influence or pressure from mental health and social care institutions enables inspectorates to conduct their activities effectively. Sufficient funding and the ability to control its own budget are essential for the fulfillment of its responsibilities. Separate premises from those of the State authorities prevent situations of pressure, and/or conflict of interest, and allow members of the public to speak with inspectorate staff away from the place of an alleged violation. The ability of the inspectorate to select its own staff prevents selection that could be politically motivated or influenced. Conflict of interest policies help to ensure the lack of political motivation or influence.

Requirement 4: Recruit qualified and experienced inspectors

Inspectors should have different professional backgrounds in order to provide a broad range of knowledge and experience. In order to ensure credibility of the inspectorate's work, people who have experienced mental health services and services for people with intellectual disabilities should be actively recruited as inspectors. Inspectorates should identify groups of mental health service users and involve them in their work generally.

The inspectorate should have sufficient resources to be able to invite experts from different fields as necessary. There should be a possibility to create a panel of reference, which could be consulted on an ad hoc basis.

All inspectors should have ongoing training in monitoring methodology, which should be based on international human rights standards

All inspectors should have ongoing training in monitoring methodology, which should be based on international human rights standards. Training should include sensitivity to mental health and disability issues.

Requirement 5: Ensure that visits are effective

In order to fulfill its mandate, inspectorates must conduct systematic visits to mental health and social care institutions, including during the night when abuses are known to be more likely to occur. Inspectorates should, in addition, proactively engage with civil society, to seek and learn from its opinions, knowledge and experiences as they relate to human rights in institutions.

Visits should be a mix of announced and unannounced, with a prevalence of unannounced inspections. Unannounced inspections allow a true examination of every-day experiences within an institution by minimizing the possibility of 'preparation' for inspections. Announced visits are useful in cases where the objective is to obtain a broad understanding of the situation in an institution. To achieve this it may be necessary to meet all the employees of an institution,

and/or relatives of patients and residents or to view documents that need to be prepared in advance. The effectiveness of inspections is proportional to their frequency: the more frequent an inspectorate carries out visits, the more effective its work will be.

An inspectorate must seek to be a credible partner for institutions inspected. An essential element is a proper understanding by institutions of the work done by the inspectorate, as well as the form in which the outcome of a particular inspection is presented. Thus, the scope of any inspection and subsequent reports should be clear to all parties involved (authorities, management, staff) from the very outset. In particular, it should be clarified whether an inspection/report is aiming at a comprehensive human rights assessment or focuses only on specific issues to be addressed by the management of the institution. It should also be clear to the inspected institution whether the report will become public immediately or only upon consultation with its management, and whether or not the report contains comments of the institution concerned.

During each visit, the inspectorate delegation should explain to staff the purpose and methodology of the visit. During visits, inspectors should be allowed access to documents (such as medical records, policies, registers, and administrative/judicial documents). The inspectorate should also bear in mind that relevant information may also be found in establishments other than those to be inspected, including, for instance, other healthcare institutions, local authorities, courts, police stations or prisons.

The inspectorate must ensure the safety and wellbeing of patients and residents of mental health and social care institutions at all times. Consequently, detainees should be treated by them with respect and their physical and emotional privacy ensured. Sensitive documents and information should also be protected. Inspectorates should ensure that potential retribution arising as a consequence of an inspection is minimized.

Requirement 6: Publish comprehensive reports

Releasing detailed and comprehensive reports can alert a particular institution, institutions in general, State authorities, and the public about the true human rights picture of institutions and those detained within them.

All visits should therefore be followed up by publication of a comprehensive report. The reports should contain practical recommendations as to what should be improved, changed or introduced in the operation of the service. Inspectorate reports should encourage alternatives to institutionalization, and should use their power and influence to push forward a broad human rights agenda.

The reports should clearly identify the root causes of any difficulties within an institution. In addition they should contain practical recommendations by way of constructive guidance as to how these might best be addressed. Reports should detail priorities for change and a timeline for implementation. Without timelines, effective monitoring of implementation is weakened. The importance of effective monitoring on the implementation of recommendations is such that the mandate of the inspectorates should include a duty to incorporate the results of such

monitoring in its reports. In addition, the inspectorates should, both during their inspections and in their reports, inform the institutions about available sanctions in case of their non-implementation.

The importance of highlighting best practice, both during inspections and in subsequent reports should not be overlooked. Examples of best practice should be fully acknowledged, as should the institutions practicing them. Indeed the example of these institutions should be used to motivate other institutions to achieve an equivalent standard of care, to facilitate the sharing of best practice and to illustrate that the role of inspectorates is to be constructive at all times.

Requirement 7: Ensure maximum impact

Reporting to Parliament at least annually should be an obligation of all inspectorates. An annual report should list all visits carried out, and summarise observations and recommendations. It should outline difficulties faced and overcome and submit legislative recommendations to Parliament. This will alert legislators to their duties with regard to law reform.

In order to ensure maximum impact, follow-up visits should be a regular and automatic activity, although institutions which have been inspected should, of their own volition and after a set period of time, report to the inspectorate on their progress in implementation of any recommendations made. Inspectorates should conduct follow-up visits to assess for themselves the true extent of such implementation. Inspection reports containing such assessments should be made known and publicly available.

Inspectorates should be mandated to cooperate and enter into dialogue with State authorities. This dialogue should inform authorities about issues raised as the result of their activities and highlight key difficulties within, and faced by, institutions. It should facilitate a holistic view of the institutional system, to allow State authorities to better take into account needs of both detained persons and institutions and plan services accordingly.

Requirement 8: Coordinate activities

In order to maximize their impact inspectorates should identify other organisations working on similar issues, enter into dialogue with them and instigate cooperation. Such cooperation should include that of State authorities as well as civil society organisations, particularly disabled people's organisations and human rights groups. Coordination may take various forms, for example exchange of information, consultation, and creation of a common database or referral procedure among the bodies on the basis of the content of particular problems or complaints. Cooperation will contribute to common standards and consistency, and avoid duplication.

Finally the importance of participation of people with disabilities both within and outside the institutions should be both noted and ensured. They should be given full opportunity to offer feedback and evaluate the work of the inspectorate. Without such participation the effectiveness and credibility of inspectorates' activities will be significantly curtailed.

PART II
Country Reports

Introduction

MOST COUNTRIES IN THE EUROPEAN UNION, the geographical focus of this project, have in place a monitoring mechanism of mental health and social care institutions of some form. Their stage of development, quality and effectiveness, however, differ widely. The 'snapshot' of the practice of the six States below offers an illustration of these differences. So too does it allow a preliminary assessment of common or innovative, and deficient, practices from which those States, willing to further the protection of their citizens, can learn. The 'snapshot' begins with a review of the current situation of the Czech Republic. This is followed by a similar look at Estonia, Finland, Hungary, the Netherlands and the United Kingdom, in that order.

THE CZECH REPUBLIC

Requirement 1: Ratify the Optional Protocol to the UN Convention against Torture

The Czech Republic ratified the OPCAT on 10 July 2006.

Requirement 2: Establish inspectorates with a legal mandate

The 1999 Act on the Public Defender of Rights, was amended in 2005 purportedly to ensure compliance with the OPCAT.[2] The Public Defender of Rights (PDR),[3] is legally authorized to 'systematically visit places where there are or may be located persons whose liberty is restricted by a public authority or as a result of their dependence on care provided'.[4] On 1 January 2006 the PDR established a new detention department with a focus on inspections in the institutions noted above.

Requirement 3: Ensure inspectorates are independent

The PDR him/herself is elected by the parliament for a six year term from a group of candidates of whom two are proposed by the president and two by the senate.[5] Although the office of the PDR is an organizational unit of the State, there is legal provision for the PDR to carry out his duties independently of the State and to dictate and control his day to day activities, such formal

2 Law on the Public Defender of Rights 1999, Act 349/1999, and last amended by Act 342/2006.
3 At the time of writing the Public Defender of Rights is Mr. Otakar Motejl.
4 Law on the Public Defender of Rights 1999, paras. 1.3 and 1.4.
5 *Ibid*, para.2.

control usually being by way of regulations.[6] In addition, although the budget of the office of the PDR is specified in the State budget[7] its actual allocation is, again, dictated and controlled by the PDR. Approximately 10% of the office budget is allocated to the running of the detention department.[8] The law attempts to minimize real or perceived conflicts of interest: the PDR cannot for instance be a member of a political party or a political movement;[9] his/her function is stated as being incompatible with other profit-making activities;[10] and his/her office is located in a building that is separate from other executive or parliamentary premises.[11]

Requirement 4: Recruit qualified and experienced inspectors

In 2005, the PDR employed 91 people of which were 46 lawyers and 13 administrative staff. The application process for legal positions involves tests of legal knowledge, psychological tests and interviews.[12] Of the staff, seven lawyers work in the detention department.[13] People with disabilities are not specifically sought when inspectors are recruited for the PDR office. The PDR hires external experts on an ad hoc basis.[14]

Requirement 5: Ensure that visits are effective

The PDR may conduct inspections in both mental health and social care institutions. The PDR is, in addition, specifically mandated to act on the basis of a complaint or on his/her own initiative.[15] PDR staff may carry out visits to these institutions,[16] and it is usual for visits to be conducted by lawyers from the detention department. The lawyers may be supplemented by experts who are not PDR staff.[17]

Although mandated to conduct both unannounced and announced visits, the current tendency is for announced visits.[18] The choice of institution to be inspected is based on a combination of geographical location, information from the public or the media, complaints and/or results from previous inspections by other bodies. In the first half of 2006, the PDR visited five social care institutions for adults with physical disabilities and five institutions for people with psycho-social disabilities.[19]

6 *Ibid*, para. 25.2.
7 *Ibid*, para. 26.
8 Information from an interview with staff of the Public Defender of Rights in Brno, Czech Republic, 21 August 2006. Interview notes on file with MDAC.
9 Law on the Public Defender of Rights, 1999, para. 3.3.
10 *Ibid*, para. 2.4.
11 Information from an interview with staff of the Public Defender of Rights in Brno, Czech Republic, 21 August 2006. Interview notes on file with MDAC.
12 *Ibid*.
13 *Ibid*.
14 *Ibid*.
15 Law on the Public Defender of Rights, 1999, para. 9.
16 *Ibid*, para. 25.3 in connection with paras 15, 16 and 21a.1.
17 Information from an interview with staff of the Public Defender of Rights in Brno, Czech Republic, 21 August 2006. Interview notes on file with MDAC.
18 *Ibid*.
19 *Ibid*.

Inspections tend to follow a set format with each institution visited being under a duty to assist within time limits prescribed by the PDR.[20] Information is obtained from the institution in advance of the inspection, principally by way of questionnaire.[21] This is followed by the visit itself, which lasts for one or two days, and begins with a meeting with the management of the institution. Specific departments, buildings and areas are then visited, during which private interviews with patients, residents and staff often take place. Visits sometimes include an on-site review of relevant documentation.

The PDR controls and directs the day to day work of his/her staff, including the initiation of inquiries and inspections of places of detention.[22] The decision to carry out inquiries or inspections is often prompted by complaints from residents of institutions, interested third parties, concerned NGOs, or press releases.[23] The complainant and the director of the relevant institution are formally informed of any subsequent inquiry.[24] In practice, if an inspection is considered, the director of an institution is informed a few days before it is to take place. As noted above, the management and staff of the institution are legally obliged to provide the PDR with all requested documents and information.[25] In 2005 there were 25 complaints relating to mental health institutions, of which 15 resulted in the opening of a formal inquiry, followed by an investigation. In the period from January to August 2006, the PDR registered 22 complaints relating to mental health institutions of which ten resulted in a formal inquiry.[26]

In 2005 there were 25 complaints relating to mental health institutions

In contrast to mental health institutions, curiously the PDR does not have a legal mandate to investigate specific complaints arising from social care institutions. In practice however, the PDR apparently uses information from such complaints as a source for planning inspections in these institutions.[27]

20 Law on the Public Defender of Rights, 1999, para. 15.2. The services include, among others, provision of information and explanations, provision of files and other written materials, communication of a written point of view as to the facts of a case and legal matters and provision of evidence.

21 Information from an interview with staff of the Public Defender of Rights in Brno, Czech Republic, 21 August 2006. Interview notes and emails on file with MDAC.

22 Initial inquiries are made in order to decide whether to commence investigation of a case. These may trigger inspections in the institutions as part of an investigation. Investigations are also a freestanding activity carried out on the PDR's own initiative.

23 Information from email correspondence with staff of the Public Defender of Rights on 18 October 2006. Emails on file with MDAC.

24 Although there is no formal requirement of prior notification about any inspection carried out as part of that inquiry.

25 Law on the Public Defender of Rights, 1999, para. 15.2.

26 Information from an interview with staff of the Public Defender of Rights in Brno, Czech Republic, 21 August 2006 and email correspondence with these Officials on 18 October 2006. Interview notes and emails on file with MDAC. There is no specific information about the results or stage of proceedings in any of these inquiries or investigations.

27 Law on the Public Defender of Rights, 1999, para. 1.2, and information from email correspondence with staff of the Public Defenfder of Rights on 18 October 2006. Emails on file with MDAC.

Requirement 6: Publish comprehensive reports

Legal provision is made for each inspection to be followed by a report.[28] Such reports may include recommendations or proposals for corrective measures.[29] Further, each institution is specifically invited by the PRD to comment on the report within a prescribed time limit.[30]

Reports also follow investigations of concrete cases. As noted above, such cases may be initiated by a complaint.[31]

The PDR reports annually to parliament.[32] This report summarizes the activities of the PDR over the previous year, the main issues covered in complaints and the sources of those complaints.[33]

Requirement 7: Ensure maximum impact

The report to Parliament constitutes a parliamentary publication and is formally released to the government, the president and other administrative authorities. The PDR should also inform the public on a 'regular basis' of his or her activities and of any findings resulting from these activities.[34] Each institution is under a duty to inform the PDR, within a specified time limit, about corrective measures undertaken to address issues raised and recommendations made in the report.[35] If an institution fails to respond adequately or at all to a report and its recommendations or if the corrective measures undertaken are insufficient, the PDR may apply sanctions, such as informing a superior authority or the government.[36] The PDR can inform the public and can name and shame the directors of institutions.[37] Unwillingness to comply with requests for information, for access to, and the release of, documents can also be made public.[38]

28 Law on the Public Defender of Rights, 1999, para. 21a.2.
29 *Ibid*.
30 *Ibid*, para. 21a.3.
31 Information from an interview with staff of the Public Defender of Rights in Brno, Czech Republic, 21 August 2006 and email correspondence with these Officials on 18 October 2006. Interview notes and emails on file with MDAC.
32 Law on the Public Defender of Rights, 1999, para. 23.1.
33 See for example the 2005 annual report which is available from the PDR's website: www.ochrance.cz (last accessed 5 November 2006).
34 Law on the Public Defender of Rights, 1999, para. 23.2, informing the public 'on regular basis' may involve monthly press conferences, series of TV documentaries about PDR´s, in practice from 2005, PDR's website. Information from an interview with staff of the Public Defender of Rights in Brno, Czech Republic, 21 August 2006 and email correspondence with these Officials on 18 October 2006. Interview notes and emails on file with MDAC.
35 *Ibid*, para. 21a.3.
36 *Ibid*, para. 20.2(a).
37 *Ibid*, para. 21a.3 in connection with para. 20.2 (b). Evidence suggests that to date this situation has arisen only once.. Information from email correspondence with the staff of the Public Defender of Rights on 18 October 2006. Emails on file with MDAC.
38 *Ibid*, para. 21a.4 in connection with paras. 15, 16 and 20.2. Examples of corrective measures applied in practice can be found at the PDR's website (op.cit.).

Requirement 8: Coordinate activities

The PDR has no official cooperation with NGOs, there being no legal basis for such cooperation. The 2005 amendment to the 1999 Act on the PDR originally included a provision on the basis of which NGOs and external experts could be included in the inspections. This provision was however omitted from the final version of the amendment.[39] Nonetheless, in practice there is evidence of informal cooperation.

Comment

The Czech Republic has recently demonstrated an increased commitment to the development of inspectorates of its mental health and social care institutions. Such commitment is evidenced by its ratification of the OPCAT, the reform and broadening of the mandate of the PDR and legislative provision for its increased independence and effectiveness. Although it is clearly premature to assess the functioning of the PDR's new detention department and the adequacy of resources provided, these measures are to be welcomed.

Nonetheless, attention should be drawn to a number of instances where its inspection mechanisms fail to fulfill the requirements of a fully effective inspectorate system. The most notable of these is the failure to ensure that each institution is visited annually, as regular visits are imperative to the effectiveness of any inspectorate system. Added to this is the failure to specifically recruit people with disabilities, to provide for formal dialogue and cooperation with NGOs. Of most urgent need of legislative attention is the PDR's formal inability to act on complaints emanating from social care institutions. These failures to put in place such important protections serve to undermine the effectiveness of the positive and welcome steps already taken.

39 'Governmental proposal number 751/0 of 27 July 2004. See also: Jiři Kopal, *Nové právní předpisy a zkušenosti s jejich aplikací* 7 December 2005, published in Via Juris, an online legal journal that can be found at: http://viaiuris.pilaw.cz (last accessed 5 November 2006).'

ESTONIA

Requirement 1: Ratify the Optional Protocol to the UN Convention against Torture

Estonia signed the OPCAT on 21 September 2004. On 18 October 2006, the Parliament agreed to its ratification and the country will submit its ratification upon completion of formal procedural steps.[40] The Chancellor of Justice (CJ) will be designated as the 'national preventive mechanism' for the purposes of the OPCAT.[41]

Requirement 2: Establish inspectorates with a legal mandate

The CJ, currently Mr. Allar Joks, acts as an Ombudsman and carries out a range of activities, inspections of institutions being just one. His assumed role in relation to mental health and social care institutions is that of the protection of human rights of residents. There is however no legal basis for this activity.[42] The Chancellor of Justice Act 1999 (the 1999 Act) provides only for his unrestricted access to documents and other materials which are in the possession of the mental health and social care institutions that are to be, or have been, visited.[43] An amendment to the 1999 Act, scheduled to enter into force following ratification of the OPCAT, provides a legal basis for 'regular and unannounced inspections to places of detention', which are defined as including mental health and social care institutions.[44]

Requirement 3: Ensure inspectorates are independent

The Estonian Constitution establishes the CJ as an independent official[45] and Parliament appoints the office-holder for a term of seven years.[46] Candidates for the post must both have completed

40 This information was received on 1 November 2006 in a letter to MDAC by Mai Hion, Head of the Human Rights Division of the Estonian Ministry for Foreign Affairs. Also, letter on file with MDAC dated 19 October 2006 by the Estonian Minister for Foreign Affairs which states that 'The draft of the Ratification Act of the Optional Protocol was handed over to the Parliament on 29 May 2006, where it was taken into proceeding. On 14 June 2006, the draft successfully passed the first reading in the Parliament. The second reading and the passage of the ratification act took place on the 18 October 2006. The Instrument of Ratification of the Optional Protocol is scheduled to be deposited with the Secretary-General of the United Nations by the end of the present year.'

41 Information from Mai Hion, Head of the Human Rights Division in the Ministry for Foreign Affairs in a letter received by MDAC on 1 November 2006.

42 Although the Chancellor of Justice is not currently legally authorised to conduct inspections in mental health and social care institutions, his activities in this area have not, at least openly, been questioned. Source: Email correspondence with Mari Amos, Adviser at the Chancellor of Justice, 31 October 2006. Email on file with MDAC.

43 Chancellor of Justice Act, 1999, para. 27.

44 Para. 27 of the Amendment to the Chancellor of Justice Act 1999. Information from interview with Mari Amos, Adviser at the Chancellor of Justice conducted on, 6 July 2006. Notes of the interview on file with MDAC. Para. 27 mandates the Chancellor of Justice to 'carry out regular and unannounced inspections to … detention institutions, …, psychiatric hospitals, special care homes, special schools, general care homes, orphanages, youth homes.' This wording is used also with regards to filing of complaints in para. 24 of the Chancellor of Justice Act 1999.

45 Constitution, 1992, para. 139.

46 Constitution, 1992, para. 140. See also Chancellor of Justice Act, 1999, paras. 37.1 and 31.5.

an academic education in law and be an experienced and recognised lawyer.[47] Provision is made for real or perceived conflicts of interest to be minimized. The CJ may not for instance participate in activities of political parties[48] or hold another State or local government office or other public office.[49] He may not belong to the management of a commercial undertaking and cannot engage in business, other than by way of personal investments.[50]

The CJ's staff is selected by the CJ[51] with the office being located on premises separate from those of State authorities.[52] Although the CJ's budget is part of the State budget and is negotiated with Parliament[53] its actual allocation is dictated and controlled by the CJ.[54] In 2005 his Office expenditure reached 18.9 million Estonian kroons (approximately 1,200,000 Euro), some 6.4% less than 2004. The reason for the decrease has been explained as being caused by the high 2004 familiarization and training costs involved in the PHARE foreign aid project.[55]

Requirement 4: Recruit qualified and experienced inspectors

The CJ's office employs 44 full-time staff, 33 of whom are lawyers and the remainder administrative staff. The salaries of the staff are in accordance with national legislation which dictates the salary conditions for State and public servants. The CJ may increase the salary rates by up to 50%,[56] and in practice, the salaries of legal staff tend to be higher than the average salaries in the public sector.[57] Ongoing training is determined at the start of each year.[58] Such training includes seminars on general legal issues by experts from abroad.[59] People with psycho-social or intellectual disabilities are not specifically sought as inspectors.[60]

47 Chancellor of Justice Act, 1999, para. 6.2. This paragraph does not specify the meaning of the word 'recognized'.
48 *Ibid*, para. 12.1.2.
49 *Ibid*, para. 12.1.1.
50 *Ibid*, para. 12.1.3-4.
51 *Ibid*, para. 36.2.
52 Information from Mari Amos, Adviser at the Chancellor of Justice on 10 August 2006. Email correspondence on file with MDAC. See also the brochure of the Chancellor of Justice at: http://www.oiguskantsler.ee/.files/97.pdf (last accessed 5 November 2006).
53 Chancellor of Justice Act, 1999, para. 42.
54 Information from Mari Amos, Adviser at the Chancellor of Justice on 2 October 2006. Email correspondence on file with MDAC.
55 The National Audit Office of Estonia, Audit report No. OSI-2-2/06/30 of 23 May 2006, which is available on the internet: http://www.riigikontroll.ee/fake_index.php?lang=en&uri=%2Faudit_en.php%3Flang%3Den%26audit%3D544 (last accessed 5 November 2006).
56 Chancellor of Justice Act, 1999, para. 40.1.
57 Information from Mari Amos, Adviser at the Chancellor of Justice on 10 August 2006. Email correspondence on file with MDAC.
58 Chancellor of Justice Annual Report for 2004, available from: http://www.oiguskantsler.ee/.files/36.pdf, last accessed 5 November 2006.
59 Information from Mari Amos, Adviser at the Chancellor of Justice on 2 October 2006. Email correspondence on file with MDAC.
60 *Ibid*.

Requirement 5: Ensure that visits are effective

The CJ, although currently without a specific legal mandate as noted above, carries out both unannounced and announced visits to mental health and social care institutions. The current tendency is for announced visits.[61] In 2005, all 15 visits to mental health institutions were announced.[62] The CJ makes unannounced visits if there is an urgent need on the basis of information received by way, for example, of specific or individual complaints or from the media. Visits are planned annually. For 2006 this plan included inspections in two psychiatric hospitals and one in a prison psychiatric department, all of which have been carried out.[63]

The CJ makes unannounced visits if there is an urgent need on the basis of information received by way of specific or individual complaints or from the media

There is only one lawyer in the CJ Office who carries out inspections of mental health institutions,[64] although always accompanied by the CJ himself. In addition, this lawyer reviews legislation and makes recommendations about legal issues to the executive and legislature. Social care institutions are inspected by two other lawyers from the CJ's office. In 2005 there were two visits to such homes.[65] There are no plans to visit social care homes in 2006.[66]

The CJ generally informs an institution, by way of letter, of an intended visit six weeks before the inspection is to take place. The letter includes confirmation of the date and purpose of the visit, a request for the release of certain documents (e.g. internal rules, rules concerning involuntary care and rules regulating seclusion) and a detailed questionnaire.[67] The CJ is

61 The current Chancellor of Justice considers announced visits to be more effective as in his opinion they guarantee the presence of all management and staff during a visit and compilation in advance of all the documents requested. Information from Mari Amos, Adviser at the Chancellor of Justice on 6 June 2006. Interview notes on file with MDAC.

62 Information from Mari Amos, Adviser at the Chancellor of Justice on 2 October 2006. Email correspondence on file with MDAC.

63 *Ibid*.

64 Information from Mari Amos, Adviser at the Chancellor of Justice on 30 October 2006. Email correspondence on file with MDAC.

65 Sillamäe Social Care Home and Kernu Social Care Home.

66 According to Mari Amos, Adviser at the Chancellor of Justice, the reason for the lack of inspections in social care institutions in 2006 is staff shortages. Information received via email on 6 October 2006. Email correspondence on file with MDAC.

67 The questionnaire includes questions about number of employees; number of patients/residents; statistics on types of diagnosis; whether there any other persons than health care workers who participate in providing health care services (such as security guards etc); guarantees of security of employees (also, if there is a possibility for them to visit psychologist or psychiatrist at their workplace); number of cases of involuntary care and length of stay; how many cases there are of continuation of therapy on a voluntary basis; whether an institution provides involuntary care for children; use of police; procedures to prevent the use of excessive force; informed consent; consultation of relatives or representatives; whether patients are informed about their rights; how the right to representation is ensured; how a person is informed about a court's decision and appeal; whether there is a complaints mechanism and how complaints are handled; use of ECT; forced feeding; restraints; numbers of suicides and suicide attempts; procedures for examination of documents by patients and their representatives; use of personal belongings; procedures for re-examination of involuntary care after the treatment in an institution; return home; procedures for

mandated to demand the release of all information that he considers necessary.[68] The institution must respond to these demands within a period set by the CJ to allow the preparation of a detailed plan of inspection.[69] In practice, this period is approximately four weeks.[70]

During the visit, the delegation meets with the management of the institution, its staff and/or residents. Such meetings are in private. Tours of the entire premises take place and access to all requested documentation should be arranged.[71] In some cases the CJ gives a press conference on site immediately following the inspection, with the express purpose of bringing to public attention the main identified problems in the institution.[72]

Any person can submit a complaint to the CJ.[73] Although the CJ's office responds to each complaint it cannot formally provide legal advice or initiate court cases.[74] There is specific legislative provision to protect complainants from possible retribution: if a complaint to the CJ is filed by a person in a mental health or social care institution, that institution should promptly forward the petition to the CJ without examining its contents.[75] The confidentiality and privacy of patients is protected by general laws on privacy and data protection.[76] There is also specific provision for the CJ not to disclose information of which he becomes aware concerning the family or private life of individuals or other information.[77] However, the CJ may disclose the content of a complaint or the final result of the proceedings in the media or through other channels without disclosing any information which would allow the persons involved to be identified.[78]

Requirement 6: Publish comprehensive reports

The CJ prepares a report after each inspection. Reports include recommendations to the inspected institution and to relevant authorities.[79] There has been a recent initiative to publish

homeless people, aftercare and rehabilitation. Information from Mari Amos, Adviser at the Chancellor of Justice on 10 August 2006. Email correspondence on file with MDAC.

68 Chancellor of Justice Act, 1999, paras. 27 and 28.
69 *Ibid*, para. 28.
70 Information from Mari Amos, Adviser at the Chancellor of Justice on 10 August 2006. Email correspondence on file with MDAC.
71 Chancellor of Justice Act, 1999, para. 27.
72 Such a situation took place after the visits to the Jämejala psychiatric hospital. This is the only psychiatric hospital in Estonia with an involuntary treatment unit for for people who have commited a criminal offence. Information from Mari Amos, Adviser at the Chancellor of Justice on 30 October 2006. Email correspondence on file with MDAC.
73 Chancellor of Justice Act, 1999, para. 19.1 in connection with para. 23.
74 *Ibid*, paras. 15 and 19.
75 *Ibid*, para. 24.
76 Information from Mari Amos, Adviser at the Chancellor of Justice on 10 August 2006. Email correspondence on file with MDAC.
77 Chancellor of Justice Act, 1999, para. 13.
78 *Ibid*, para. 32.
79 Information from Mari Amos, Adviser at the Chancellor of Justice on 10 August 2006. Email correspondence on file with MDAC.

these reports on the CJ's website.[80] The CJ submits an annual report to Parliament. These are published on the CJ's website.[81]

Requirement 7: Ensure maximum impact

Within the CJ's annual report to Parliament, several issues are outlined, including the main problems encountered in institutions, any specific responses from those inspected and measures taken to remedy rights violations.[82]

The CJ may make inquiries concerning implementation of his recommendations, with an institution being under a duty to detail steps taken in compliance with such recommendations or general enquiries promptly. Failure to comply will result in a report from the CJ to the supervisory body[83] of the institution in question, to the government and/or the parliament. In addition the CJ may take the matter to the public.[84]

Requirement 8: Coordinate activities

The CJ cooperates on an informal basis with other statutory bodies. An example of such cooperation is that with the Health Care Board, which also inspects other health care institutions.[85]

The CJ cooperates with non-governmental organizations but, in the absence of specific legislative provision, again, on unofficial bases.[86]

At the international level, the CJ is in contact with the Danish and Finnish Ombudsmen. In September 2006, for example, the CJ invited representatives of the Finnish Ombudsman to inspect Estonia's Jämejala psychiatric hospital.[87]

80 This is a recent initiative of one member of staff. According to the received information, these reports should be soon available on the website of the CJ. Information from Mari Amos, Adviser at the Chancellor of Justice on 31 October 2006. Email correspondence on file with MDAC.

81 Annual reports can be found on the Chancellor of Justice's website: http://www.oiguskantsler.ee (last accessed 5 November 2006).

82 Chancellor of Justice Act, 1999, para. 4, and Constitution, 1992, para. 143.

83 Chancellor of Justice Act 1999 does not provide a definition of the 'supervisory body' referring to such bodies in para. 35 as the 'authority which exercises supervision over the agency'. According to the information received via email from Mari Amos, Adviser at the Chancellor of Justice, on 30 October 2006, the supervisory body for mental health hospitals is the Health Care Board and the supervisory body for social care homes is the Head of the county where an institution is located. Email correspondence on file with MDAC.

84 Chancellor of Justice Act, 1999, para. 35.

85 Information from interview with Mari Amos, Adviser at the Chancellor of Justice conducted on 6 July 2006. Notes of the interview on file with MDAC.

86 *Ibid*.

87 Information from Mari Amos, Adviser at the Chancellor of Justice on 31 October 2006. Email correspondence on file with MDAC.

Comment

Inspectorates of mental health and social care institutions can clearly exist without ratification of the OPCAT, as is demonstrated in Estonia. Genuine commitment, including that of resources, to their effectiveness and quality however is more likely to be ensured if formal steps are taken toward both legislative compliance with its provisions and ratification. Estonia has taken some concrete steps in this direction and it would appear that ratification of the OPCAT is imminent. Until ratification actually occurs and implementation of legislative proposals actually takes place, however, their true extent and potential impact remain uncertain and therefore preclude conclusive assessment.

Nonetheless, notable in the current system is the low number of staff dedicated to inspections: other than the CJ himself just one lawyer for mental health institutions and two for social care. The number of mental health or social care institutions visited remains low, suggesting that the requirement for annual visits remains unfulfilled. These facts alone implicate inadequate resourcing or inadequate internal management. Also notable in the current system is the absence of formal provision for the recruitment, and thus participation, of people with disabilities in the inspection process together with the absence of formal provision for participation of NGOs.

Attention should be drawn however to the welcome practice and extent of unofficial collaboration, both on a national and international level, with bodies of varying standing. Such is the potential for the transfer of information and best practice that such cooperation must be encouraged in Estonia and elsewhere.

FINLAND

Requirement 1: Ratify the Optional Protocol to the UN Convention against Torture.

Finland signed the OPCAT on 23 September 2003 but has not yet ratified it. It is probable that the Office of the Parliamentary Ombudsman will be appointed as the 'national preventive mechanism' for the purposes of the OPCAT in Finland. [88]

Requirement 2: Establish inspectorates with a legal mandate

The Parliamentary Ombudsman is a body established by law, which carries out, among others, an inspectorate function in Finnish mental health and social care institutions.[89] The present Parliamentary Ombudsman is Mrs. Riitta-Leena Paunio.

Requirement 3: Ensure inspectorates are independent

The constitutional law committee of parliament screens applicants, who should have an outstanding knowledge of law,[90] for the posts of the Parliamentary Ombudsman, who is appointed by the parliament for a period of four years. Although the Parliamentary Ombudsman must report to parliament on her activities and observations, this must not impact on any specific individual case handled by her.[91] The Parliamentary Ombudsman's budget is included in the parliament's budget and is approved by the parliament. Nonetheless, she puts forward her own budgetary proposals. She has full control over the budget allocated,[92] and has, to date, received all funds requested.[93] Although the Parliamentary Ombudsman's office is located in the parliament building and its staff are considered civil servants, the Parliamentary Ombudsman selects her own staff.[94]

88 On 27 September 2006 MDAC sent a letter inquiring about the OPCAT ratification process in Finland to the Minister for Foreign Affairs, Mr. Erkki Tuomioja. On 6 November 2006, MDAC received information from Mia Spolander, Secretary at the Ministry for Foreign Affairs that in the last week of September 2006, an inter-ministerial working group on the ratification of OPCAT was established by the Ministry for Foreign Affairs. This group's mandate is to prepare for the ratification of OPCAT, including the designation of the national preventive mechanism. The mandate of the working group expires on 30 November 2007. The current schedule for the ratification of the OPCAT is spring 2008. Most members of the working group have taken the preliminary view that the Parliamentary Ombudsman would be the most appropriate institution to carry out the functions of the National Mechanism. Email correspondence on file with MDAC.

89 Parliamentary Ombudsman Act 2002, Act 197/2002, para. 5.

90 Constitution, 1999, para. 38.

91 Website of the Parliament: http://www.eduskunta.fi/efakta/eoa/eoa1e.htm#what (last accessed 5 November 2006).

92 Information received via email from Håkan Stoor, Senior Legal Adviser at the Parliamentary Ombudsman on 25 September 2006. Email correspondence on file with MDAC. 25 September 2006. Email correspondence on file with MDAC.

93 Information received via email from Håkan Stoor, Senior Legal Adviser at the Parliamentary Ombudsman on 4 September 2006. Email correspondence on file with MDAC.

94 Information received via email from Håkan Stoor, Senior Legal Adviser at the Parliamentary Ombudsman on 15 October 2006. Email correspondence on file with MDAC.

The Parliamentary Ombudsman and deputies may not serve as members of parliament or other public officials. Should they hold a public office when elected, they are granted a leave of absence.[95] There is further provision to prevent actual or perceived conflicts of interest including the requirement of a Parliamentary Ombudsman to declare specifc interests to the parliament.[96]

Requirement 4: Recruit qualified and experienced inspectors

The Parliamentary Ombudsman's 55 staff members are, as noted, selected by the Parliamentary Ombudsman and are civil servants. They are all full time employees. They include lawyers, inspectors, legal assistants, a public relations officer and clerical staff. People with psycho-social or intellectual disabilities are not specifically sought when the Parliamentary Ombudsman recruits inspectors.[97] All staff receive on-going training, including for the legal staff four sessions annually on human rights, and most staff have attended accredited courses on human rights.[98]

Requirement 5: Ensure that visits are effective

The Parliamentary Ombudsman is responsible for overseeing the treatment of detainees in closed institutions.[99] Her inspections are chosen with the aim of covering as many institutions and as large a geographical area as possible. She may make specific interventions on her own initiative when shortcomings are brought to her attention.[100] Although prior notification is not a legal requirement, in practice the director of an institution tends to be informed about a planned visit and its purpose approximately four weeks in advance.[101] In 2003, the Parliamentary Ombudsman inspected four mental health institutions,[102] in 2004 six, in 2005 three and in 2006 four.[103] The Parliamentary Ombudsman may access any institution at any time and receive all requested documents.[104] Preparation for the visits includes checking previous reports, including, importantly, those of the European Committee for the Prevention of Torture, and specific complaints, including those from residents of institutions.[105] Additional useful sources of information is that collected by

95 Website of the Parliament (op cit).
96 Parliamentary Ombudsman Act 2002, para. 13.
97 Information received via email from Håkan Stoor, Senior Legal Adviser at the Parliamentary Ombudsman on 25 September 2006. Email correspondence on file with MDAC.
98 *Ibid*.
99 Parliamentary Ombudsman Act, 2002, para. 5.
100 Op cit, para. 4.
101 Information received via email from Håkan Stoor, Senior Legal Adviser at the Parliamentary Ombudsman on 4 September 2006. Email correspondence on file with MDAC.
102 The term 'mental health institutions' refers to psychiatric hospitals or psychiatric units in general hospitals or prisons. Information received via email from Håkan Stoor, Senior Legal Adviser at the Parliamentary Ombudsman on 13 October 2006. Email correspondence on file with MDAC.
103 There were in addition four planned inspections in institutions for people with intellectual disabilities. Information received via email from Håkan Stoor, Senior Legal Adviser at the Parliamentary Ombudsman on 12 October 2006. Email correspondence on file with MDAC.
104 Constitution, 1999, para. 111. Parliamentary Ombudsman Act, 2002, para. 5.2.
105 The following data is collected beforehand: annual reports of the institutions including data on the number of beds, patients and staff, the rules of the institution on the use of force, reports from the institutions to the State Provincial Offices on the use of seclusion and restraint, and the units' records on the use of force.

the National Research and Development Centre for Welfare and Health (STAKES) and the State Provincial Offices.

During inspections, the Parliamentary Ombudsman is usually accompanied by one or two lawyers. The general practice is for her and her team to conduct a general tour, inspect specific buildings or areas and to hold discussions with management.[106] The team will also consider documentation, including registers and individual medical files whilst on site. The standard of care in each institution is measured against CPT standards.[107]

A complaint about alleged unlawful action or neglected duties in institutions may be filed with the Parliamentary Ombudsman by anyone at any time

A complaint about alleged unlawful action or neglected duties in institutions may be filed with the Parliamentary Ombudsman by anyone at any time.[108] Two Ombudsman lawyers assist potential complainants through the complaints process. In addition, provision has been made for specific access for residents of such institutions to an individual complaints procedure within the State-funded legal aid system.[109]

Although acting upon complaints forms a formal part of the work of the Parliamentary Ombudsman, there are in place no special procedures to prevent potential retribution when such complaints are made, procedures particularly pertinent to resident complainants. To date, although the Parliamentary Ombudsman has received allegations of retributive measures (for example: 'my outdoor exercise was cancelled because I made a complaint'), no such complaint has been substantiated.[110] Confidentiality issues are covered by general laws on privacy and data protection.

Requirement 6: Publish comprehensive reports

A report is drawn up after every visit. Such reports include both general observations and recommendations.[111] Before reports are finalised the institution in question is given the opportunity to comment on it.[112] The Parliamentary Ombudsman submits an annual report to parliament.[113]

106 The issues covered during an inspection include the institution's internal rules and records on the use of force, the facilities for seclusion and/or restraint, the patients' rooms and lockers, the availability of daily outdoor exercise, the facilities for receiving visitors. Information received via email from Håkan Stoor, Senior Legal Adviser at the Parliamentary Ombudsman on 2 October 2006. Email correspondence on file with MDAC.

107 Information received via email from Håkan Stoor, Senior Legal Adviser at the Parliamentary Ombudsman on 2 October 2006. Email correspondence on file with MDAC.

108 Parliamentary Ombudsman Act, 2002, para. 2.

109 In general, individual complaints may be sent to the following authorities: the Ombudsman for Justice, the State Provincial Offices, and the National Authority for Medico-Legal Affairs.

110 Information received via email from Håkan Stoor, Senior Legal Adviser at the Parliamentary Ombudsman on 2 October 2006. Email correspondence on file with MDAC. The Parliamentary Ombudsman does not consider such allegations as an issue in Finland.

111 Parliamentary Ombudsman Act, 2002, para. 11.

112 *Ibid*, para. 9.

113 Constitution, 1999, para. 109.

Recommendations cover issues pertinent to institutions, as well as ambiguous legislation.[114] The reports are not posted on the Parliamentary Ombudsman's internet site, but the public has a right to ask for copies of reports with confidential data removed. Only annual reports and the most substantial decisions in individual complaints are published on the web in Finnish or Swedish (depending on the language of the applicant) with confidential data removed. In addition there has, in the past, been a presentation of thematic reports: on the use of seclusion and restraint in social care institutions in 1996 and in mental health institutions in 1998, since which time there have been no thematic reports.[115]

Requirement 7: Ensure maximum impact

The annual report to parliament often contains general observations relating to defects in legislation, with special attention paid to fundamental and human rights.[116] The Parliamentary Ombudsman has not published any information on the impact of recommendations contained in previous reports.[117] However, although it has been suggested that there is no direct evidence of antagonism from those implicated in the reports, recommendations contained within them are not always acted upon. One example is the failure to follow through a recommendation about mental health law for a period of over ten years. It is only recently that the government has initiated relevant reforms.[118]

The Parliamentary Ombudsman asks institutions to report on measures undertaken to comply with her recommendations. The Parliamentary Ombudsman can reprimand non-compliers, or give an 'opinion'.[119] Reprimands may contain criticism or guidance for the future. An 'opinion' may include information of what is considered to constitute a proper observance of the law or draw attention of a relevant authority to considerations of human rights.[120]

114 The Ombudsman has drawn attention to the necessity of detailed written guidelines in a hospital about restrictions of the right to self-determination. She has also pointed out that the conditions for restraint and isolation that are demanded by law differ from each other. See for example, http://www.oikeusasiamies.fi/Resource.phx/eoa/english (last accessed 5 November 2006).

115 'Although there have been no thematic reports on psychiatric care since 1998, there have been reports from other sectors, e.g. a report in February 2006 on activities of public authorities to combat domestic violence towards children.' Information received via email from Håkan Stoor, Senior Legal Adviser at the Parliamentary Ombudsman on 2 October 2006. Email correspondence on file with MDAC.

116 Parliamentary Ombudsman Act, 2002, para. 12.

117 Information received via email from Håkan Stoor, Senior Legal Adviser at the Parliamentary Ombudsman on 4 September and 2 October 2006. Email correspondence on file with MDAC.

118 *Ibid*.

119 Parliamentary Ombudsman Act, 2002, para. 10.

120 If a case involves an action that has only slightly transgressed the law, the matter is assessed from a different perspective. The Parliamentary Ombudsman may issue a reprimand to the official in question. Rebukes by the Parliamentary Ombudsman usually attract significant media attention. In practice the mechanism has proven to be an effective way of preventing mistakes from reoccurring. Source: Speech of Ikka Rautio, Deputy Parliamentary Ombudsman of Finland delivered in Guatemala on 18 April 2002, "*The Ombudsman's work in safeguarding economic, social and cultural rights in Finland*".

The Parliamentary Ombudsman is reportedly planning to review the system of follow-up to recommendations.[121]

Requirement 8: Coordinate activities

The Parliamentary Ombudsman does not officially coordinate with other bodies. However, there is an unofficial collaboration with several organizations, for example, with the Provincial State Offices (local government) or with the National Authority for Medico-Legal Affairs.[122]

The five Provincial State Offices, each of which includes a full time psychiatrist,[123] supervise mental health and social care institutions in their region and are authorized to receive official complaints from patients, residents or their relatives.[124] In addition, mental health institutions have to report all coercive measures applied to their respective Provincial State Office.

A second potentially important collaborative body is the National Authority for Medico-Legal Affairs, a subsidiary body of the Ministry of Social Affairs and Health. This body promotes safety by supervising healthcare professionals.[125] The Parliamentary Ombudsman liaises with this body and when investigating complaints can request from it a medical opinion or other information. The Parliamentary Ombudsman is also in regular contact with national mental health NGOs.[126]

At the international level, the Parliamentary Ombudsman is in contact with the Estonian Chancellor of Justice (for more information, see Estonia country report, above).

121 Information received via email from Håkan Stoor, Senior Legal Adviser at the Parliamentary Ombudsman on 4 September 2006. Email correspondence on file with MDAC.
122 Information received via email from Håkan Stoor, Senior Legal Adviser at the Parliamentary Ombudsman on 25 September 2006, 4 September 2006 and from the STAKES Officer on 16 October 2006. Email correspondence on file with MDAC.
123 Information received via email from Håkan Stoor, Senior Legal Adviser at the Parliamentary Ombudsman on 16 October 2006. Email correspondence on file with MDAC.
124 Mental Health Act, 1990, para. 2: 'In the territory of a province, the planning, direction and supervision of mental health work is the responsibility of the State Provincial Office. The State Provincial Office shall, in particular, supervise the use of the limitations on the right of self-determination.'
125 See the Website of the National Authority of Medico-Legal Affairs: http://www.teo.fi/uusi/engl_1.htm (last accessed 5 November 2006).
126 Information received via email from Håkan Stoor, Senior Legal Adviser at the Parliamentary Ombudsman on 4 September 2006. Email correspondence on file with MDAC.

Comment

It is disappointing to note that despite Finland signing the OPCAT three years ago, it remains unratified. Nonetheless, the fact that there is an apparent intention to designate the Parliamentary Ombudsman, as the 'national preventative mechanism' for the purposes of the OPCAT, is a clear indication that ratification is being actively considered. Even in the absence of ratification, the Parliamentary Ombudsman incorporates a number of examples of good practice which could be shared elsewhere: the ongoing training; the ability to act upon complaints irrespective of their source and to apply sanctions; the presentation of thematic reports; the ability to comment and make specific recommendations on legislative provisions and active collaboration on international, state and local levels and with NGOs (albeit, for the latter, without legal mandate).

Nonetheless, there is no place for complacency. Simple designation of existing institutions without accompanying reform may in fact be evidence of a minimalist approach to compliance with the OPCAT. It neither follows, nor ensures, that resources dedicated to the inspectorate are adequate and allow, for instance, regular visits to each institution. Indeed it is clear from the figures provided by the office of the Parliamentary Ombudsman that annual visits to mental health institutions do not take place in Finland, despite the imperative of this requirement for an effective inspectorate system.

HUNGARY

Requirement 1: Ratify the Optional Protocol to the UN Convention against Torture

Hungary has neither signed nor ratified the OPCAT.[127]

Requirement 2: Establish inspectorates with a legal mandate

The Parliamentary Commissioner for Civil Rights ('the Commissioner'), who acts as Ombudsman, is the national body with a legal mandate to conduct inspections in mental health and social care institutions.[128] The Commissioner carries out a range of activities, such inspections being only one of them.[129]

Requirement 3: Ensure inspectorates are independent

The Constitution and the 1993 Act on the Parliamentary Commissioner for Civil Rights establishes the Commissioner as an independent official. The Commissioner is appointed by the parliament for a term of six years with a possibility of re-appointment.[130] The Commissioner is responsible to parliament. There is provision for the Commissioner to act independently and on the basis of the Constitution and the law. A prerequisite for the post-holder is that he/she should enjoy public prestige and not have performed a public function in the previous four years.[131] The current Commissioner is Mr. Barnabás Lenkovics.

The Commissioner's staff is selected by the Commissioner. The office is located on premises separate from those of the other State authorities.[132]

The operational costs of the Commissioner and of the office, as well as the number of employees are determined within the State budget.[133] Although this budget is determined and

127 A letter inquiring about the OPCAT ratification process in Hungary was sent to the Minister for Foreign Affairs, Dr Kinga Göncz, on 29 September 2006. On 26 October, MDAC received a letter from the Head of the Global Organisations Unit of the International Organisations Division of the Ministry of Foreign Affairs indicating that Hungary is considering ratification of the OPCAT. According to the letter, the Ministries of Foreign Affairs and Justice 'are examining the harmonization of existing laws and mechanisms with the regulations of the Protocol' as a first step. The government is considering that the Public Prosecution Service be the 'national preventive mechanism'. In addition, the prosecution 'already conducts regular and thematic examinations in places of deprivation of liberty'.

128 Law on Parliamentary Commissioner for Civil Rights, 1993, para. 2.

129 There are two Commissioners whose mandate is to protect civil rights. They are the Parliamentary Commissioner and the Deputy Commissioner for Civil Rights. The relationship between them is not regulated by law.

130 Constitution, 1949, para. 32/B; and Law on Parliamentary Commissioner for Civil Rights, 1993, paras. 4.3 and 5.

131 Law on Parliamentary Commissioner for Civil Rights, 1993, paras. 3.2-3.

132 Information received via email from Dr. Laura Góg, Lawyer and International Rapporteur at the Parliamentary Commissioner on 20 October 2006. Email correspondence on file with MDAC.

133 Act on the Parliamentary Commissioner for Civil Rights, 1993, para. 28.1.

submitted to the parliament for approval, by the government,[134] its actual allocation is controlled by the Commissioner.[135] The Commissioner's 2006 budget 2006 amounted to 1,282,300,000 Hungarian forints (approximately 4,800,000 euro).[136] The budget does not specify the amount to be allocated for inspections.[137]

Requirement 4: Recruit qualified and experienced staff

The Commissioner employs 150 staff, who are all civil servants: eighty-eight are lawyers, the remainder doctors, social workers, economists and administrative staff. There are no special gender requirements, although women predominate.[138] People with psycho-social or intellectual disabilities are not specifically sought as inspectors .[139] Professionals in other fields are involved on an ad hoc basis.[140]

Requirement 5: Ensure that visits are effective

The Commissioner carries out announced and unannounced visits to mental health and social care institutions,[141] approximately one third of which are unannounced.[142] The timing and geographical location of the institutions visited are based principally on complaints and information from the media and non-governmental organizations. Unannounced visits are, in turn, principally conducted as a response to information indicating a direct threat to human rights.[143] The source of such information tends to be individual complaints of residents of the institutions themselves.

Evidence suggests that to date no visiting delegation has been denied entry to an institution.[144] Generally, an inspection team consists of two persons, although the number increases when

134 Annual Report 2006, available from www.obh.hu/allam/eng/cover.htm (last accessed 5 November 2006).
135 Information received via email from Dr. Laura Góg, Lawyer and International rapporteur at the Parliamentary Commissioner on 20 October 2006. Email correspondence on file with MDAC.
136 The budget is regulated in Chapter IV of the Appendix 1 of the Act CLIII of 2005 on the State budget.
137 Information received via email from Dr. Laura Góg, Lawyer and International rapporteur at the Parliamentary Commissioner on 20 October 2006. Email correspondence on file with MDAC.
138 *Ibid*.
139 *Ibid*.
140 *Ibid*.
141 In 1995 the Commmissioner dealt with only one case related to mental health, 17 cases in 1996; 15 cases in 1997; 18 cases in 1998; 25 cases in 1999, 24 cases in 2000, 8 cases in 2001, 8 cases in 2002, 23 cases in 2003, and 15 cases in 2004, 12 cases in 2005. Information received via email from Dr. Laura Góg, Lawyer and International rapporteur at the Parliamentary Commissioner on 20 October 2006. Email correspondence on file with MDAC.
142 It has been suggested that the Commissioner is of the view that the announcement or otherwise of inspections do not influence the effectiveness of the inspections. Information received via email from Dr. Laura Góg, Lawyer and International rapporteur at the Parliamentary Commissioner on 17 October 2006. Email correspondence on file with MDAC.
143 Information received in a form of a questionnaire filled out by an Official of the Parliamentary Commissioner and received by MDAC on 17 October 2006.No specific examples have been provided.
144 *Ibid*.

an inspection is anticipated to raise particularly complex and/or serious issues.[145] It used to be the case that external experts (for instance psychiatrists and/or sociologists) were regularly included within inspection teams. Financial constraints currently limit this practice, to the disappointment of some of the Commissioner's staff, which has expressed its belief that its own limited staffing levels in the area of inspections in mental health and social care institutions justifies their regular inclusion.[146]

Background research is conducted prior to visits[147] with institutions being under a duty to provide the Commissioner with any information sought either prior to or during the inspection.[148] The visiting team may request information from the institutions. Such information might include reports, protocols (in cases when a complaint alleges a physical abuse of patients), statistics, or simply a verbal report from the director of the institution. The inspectors usually conduct a tour of the entire premises and offer both staff and residents the opportunity for a private interview.[149]

As noted, the Commissioner may receive complaints.[150] Although the Commissioner does not generally investigate anonymous complaints, mental health and social care institutions constitute an exception to this rule.[151] The Commissioner's role in any subsequent action is limited in view of his inability to offer legal advice or bring cases to court. Further, he is considered to lack competence to investigate complaints under judicial investigation or where court proceedings are pending.[152]

The Commissioner may however direct a complainant to the most appropriate authority or alternatively inform that authority of the complaint on the complainant's behalf. In the case of complaints emanating from mental health or social care institutions, the Commissioner can instigate a formal inquiry, including an on-site investigation in the form detailed above, although, again as indicated above, only in cases where legal remedies are not being pursued.[153]

Requirement 6: Publish comprehensive reports

A report should be prepared following each inspection. It should include the date of the inspection, details of both general observations and recommendations, and the names of

145 Inspections of the Juridical and Observations Psychiatric Institute (the Igazságügyi Megfigyelő és Elmegyógyító Intézet – IMEI) is given as an example of an institution that might require larger teams of inspectors.
146 Information received via email from Dr. Laura Góg, Lawyer and International rapporteur at the Parliamentary Commissioner on 17 October 2006. Email correspondence on file with MDAC.
147 *Ibid*.
148 Law on Parliamentary Commissioner for Civil Rights, 1993, para. 18.
149 Information received via email from Dr. Laura Góg, Lawyer and International rapporteur at the Parliamentary Commissioner on 17 October 2006. Email correspondence on file with MDAC.
150 Law on Parliamentary Commissioner for Civil Rights, 1993, para. 16.
151 Information received via email from Dr. Laura Góg, Lawyer and International rapporteur at the Parliamentary Commissioner on 17 October 2006. Email correspondence on file with MDAC.
152 1993 Law on Parliamentary Commissioner for Civil Rights, para. 18, Section 1.
153 *Ibid*.

participating inspectors and staff.[154] The Commissioner also produces various thematic reports. These may for instance be issued in cases of individual complaints or following any previous inquiries and inspections.[155]

In addition to individual and thematic reports the Commissioner reports to parliament annually.[156] The Commissioner has a legal mandate to release all reports as and when considered appropriate.[157]

Approximately one third of visits are announced

Requirement 7: Ensure maximum impact

The annual reports to parliament include recommendations to relevant authorities, details of issues and cases considered to be particularly significant, and initiatives concerning legislation.[158] Annual reports are posted on the Commissioner's website.

Follow-up activity depends on the form of right at stake. In cases of great urgency the Commissioner may invite other relevant bodies to conduct a follow-up investigation.[159] Where urgency is less apparent, the Commissioner requests details of measures taken to implement any recommendations made and obstacles faced in such implementation.[160] However, it is not unknown for a detailed examination of measures taken to take a number of years to complete, owing for instance to their dependency on 'standard' follow-up inspections, which can occur some two to three years after the initial inspection.[161] If, in the view of the Commissioner, an ambiguous, superfluous, absent or inadequate legal provision is the direct cause of a violation of human rights within an institution he may suggest legal measures to remedy those provisions. [162]

154 Information received via email from Dr. Laura Góg, Lawyer and International rapporteur at the Parliamentary Commissioner on 17 October 2006. Email correspondence on file with MDAC.

155 An example given to MDAC by Dr Laura Góg, Lawyer and International rapporteur at the Parliamentary Commissioner is the preparation of a thematic report covering an entire institution after a visit specifically limited to one ward. Information received via email from Dr. Laura Góg at the Parliamentary Commissioner on 17 October 2006. Email correspondence on file with MDAC.

156 Annual reports can be downloaded from www.obh.hu (last accessed 5 November 2006).

157 Law on Parliamentary Commissioner for Civil Rights, 1993.

158 2005 Annual Report to the Parliament, available from www.obh.hu/allam/eng/cover.htm (last accessed 5 November 2006). Previous reports are available in Hungarian.

159 An illustrative example is the investigation of the National Public Health and Medical Office (Állami Népegészségügyi és Tisztiorvosi Szolgálat – ANTSZ) in the IMEI where the nurses refused to care for a patient with HIV. ANTSZ is the National Public Health and Medical Officer Service responsible for the direction, coordination and supervision of public health.

160 Information received via email from Dr. Laura Góg, a Lawyer and International rapporteur at the Parliamentary Commissioner on 17 October 2006. Email correspondence on file with MDAC.

161 *Ibid*.

162 1993 Law on Parliamentary Commissioner for Civil Rights, para. 25.

Requirement 8: Coordinate activities

The Commissioner cooperates on an informal basis with other statutory bodies. An example of such cooperation is that with the National Public Health and Medical Officer Service (ÁNTSZ). The Commissioner also cooperates with non-governmental organizations, for example Association of Asthmatic Patients, Downs Syndrome Association, the Mental Health Interest Forum (PÉF) but, in the absence, of specific legislative provision, again on unofficial bases.

Comment

The framework for inspections of mental health and social care institutions in Hungary gives rise to a number of concerns, reflected by the tone of urgency in this comment. Not only has Hungary made no significant move towards either signature or ratification of the OPCAT, but so too has it made no significant move to amend its dated legislative framework to reflect international standards on inspectorates.

Granted the current system of inspections does have a legislative basis, and contains a number of welcome practices: purported independence of the Commissioner from government, the ability to initiate inspections, the involvement of staff with different professional backgrounds and continuous training and the publication of reports are examples. Nonetheless, the difficulty in gaining access to information on matters as simple, but vitally important, as the identity and number of institutions visited annually, together with institutional and governmental response to observations and recommendations contained in reports, is troubling.

The review of State practice prior to this point indicates that the failure to make provision for formal participation of people with disabilities and NGOs in the inspection process is common. Unfortunately this observation is affirmed in this instance.

A final note is made here of the proposal to designate the Public Prosecution Office as the national preventative mechanism under the OPCAT should ratification eventually take place. The independence of the Public Prosecution Service from State authority is currently being questioned and consequently there is a possibility that the independence of any inspectorate body under its auspices will be compromised.

THE NETHERLANDS

Requirement 1: Ratify the Optional Protocol to the UN Convention against Torture

The Netherlands signed the OPCAT on 3 June 2005, but has not ratified it.[163]

Requirement 2: Establish inspectorates with a legal mandate

The Dutch Healthcare Inspectorate was created in 1995 upon amalgamation of the Medical Inspectorate of Health, the Medical Inspectorate of Mental Health and the Inspectorate of Drugs.[164] Its role is to monitor public health and to promote and enforce safety, quality and accessibility of healthcare by means, among others, of inspections in healthcare institutions. 'Health care institutions' are held to specifically include mental health and social care institutions.[165] In early 2006 the Healthcare Inspectorate underwent reform. As a consequence, the section responsible for mental health and social care institutions was divided into three departments and now comprise: mental health hospitals for adults, mental health hospitals for children and hospitals for drug and alcohol addicts; institutions for people with intellectual disabilities; and nursing homes for elderly people.[166]

The 1994 Psychiatric Hospitals (Compulsory Admissions) Act (PH(CA)A) purports to protect rights of persons who suffer from mental disorders[167] in the event of and during involuntary admission not only in the general psychiatric hospitals, but also in psychiatric departments of general hospitals, nursing homes or institutions for people with intellectual disabilities. Under the PH(CA)A, inspectors are specifically designated as being responsible for the protection of the interests of all persons with psycho-social disabilities.[168]

Requirement 3: Ensure inspectorates are independent

The Healthcare Inspectorate works within the Ministry of Health, Welfare and Sport. Its activity plan should be annually approved by the Minister of Health, Welfare and Sport (the

163 On 29 September 2006, MDAC sent a letter to the Dutch Minister for Foreign Affairs, Mr. Bernard Bot, inquiring about the OPCAT ratification process. In response to this inquiry, the Ministry for Foreign Affairs stated that the process of ratification of the Protocol had been on hold since the signature on 3 June 2005. One reason given was the nature of ongoing discussions about judicial reform in the Netherlands. A review of the current functioning of the judicial system coincides with deliberation among the Ministries of Health, Justice, Defence and Internal Affairs about the monitoring system required under the OPCAT. The main issue in these deliberations is whether the OPCAT introduces the need for any new measures than those already in existence.

164 These inspectorates were based on several laws dating from the nineteenth and twentieth centuries.

165 Information received in a telephone interview with an Inspector at the Healthcare Inspectorate on 13 October 2006.

166 For the purpose of this paper, these types of institutions will be referred to as mental health and social care institutions.

167 Term used in the PH(CA)A, paras. 60-63. In the introduction to the PH(CA)A the term 'mental illness' is also used.

168 Psychiatric Hospitals (Compulsory Admissions) Act, 1994, para. 63.1.

Minister) and parliament. The minister is responsible before the parliament for realisation of the annual activity plan. The minister has power to issue instructions to the head of the Healthcare Inspectorate – the Inspector General.[169] The budget in 2005 of the Healthcare Inspectorate was approximately 40,600,000 euro.[170]

Requirement 4: Recruit qualified and experienced staff

There are 353 employees of the Healthcare Inspectorate (133 men and 220 women) of whom 236 (116 men and 120 women) are full time employees of the ministry. [171] Of these 13 are employed as inspectors by the department responsible for mental health hospitals for adults, mental health hospitals for children and hospitals for drug and alcohol addicts. The department responsible for institutions for people with intellectual disabilities employs seven inspectors, and that responsible for nursing homes for elderly people, ten inspectors. In total, these 30 inspectors are responsible for monitoring of the various institutions nationwide.[172] Among them, there are two psychiatrists and the remainder are psychologists and psychiatric nurses. In addition, there are also ten trainees[173]

Inspectors receive initial training upon appointment, consisting of eight hours a week for a period of one year. The emphasis is on relevant legal issues and legislation, although appropriate attitudes and specific duties in respective areas of inspections are also covered. In addition, each inspector is entitled to four days of training a year on, among others, writing reports and current monitoring techniques. As part of the on-going training, inspectors participate once a week in discussions about their individual cases.[174]

External experts in mental health and social care are involved in the Healthcare Inspectorate's activity. They may be used for example in cases of suicides or deaths in mental health or social care institutions. Additionally, there are experts in methodology to provide specific assistance

169 See the website www.igz.nl (last accessed 5 November 2006) Two illustrative examples are the request by the Minister to inspect all the nursing homes in the period 2005 to 2006 and a request to comprehensively inspect institutions for people with intellectual disabilities in the period 2006 to 2007. There was one situation in 1973, when an inspector insisted on using his powers against the will of the Ministry. The inspector disagreed with the Ministry about closing an institution for people with intellectual disability. In consequence of this disagreement, the inspector was dismissed. Information received during a telephone interview with Inspector at the Healthcare Inspectorate on 12 October 2006.

170 Information received in a telephone interview with an Inspector at the Healthcare Inspectorate on 12 October 2006.

171 *Ibid*.

172 There are approximately 800 nursing homes and departments for people with dementia in the Netherlands, 47 institutions for people with intellectual disabilities, 100 mental hospitals and 90 psychiatric departments of general hospitals.

173 Information received in a telephone interview with an Inspector at the Healthcare Inspectorate on 12 October 2006.

174 *Ibid*.

with thematic research [175] and more general assistance with, for instance, the formulation of electronic questionnaires used in the first stage of inspections.[176]

There is neither special gender balance regulation in the Healthcare Inspectorate nor recruitment of people with psycho-social or intellectual disabilities.

Requirement 5: Ensure that visits are effective

There are four forms of supervision over mental health and social care institutions which are:

1. general supervision which incorporates three formal stages (described below);
2. crisis-supervision that generally involves an immediate inspection;
3. thematic supervision;
4. investigation of cases of forced treatment.

Inspectors of all three departments, listed under requirement 2 above, may freely enter mental health and social care institutions.[177] They are also entitled to free access to any data required and may conduct interviews in private with residents.[178] General supervision, which is the main form of inspection, comprises three stages. The first stage involves an institution being asked to complete an electronic questionnaire. This may be followed by a formal institutional inspection if responses to the questionnaire raise concerns. The use of these questionnaires, and subsequent action based upon the institutional responses, indicates that their use serves to reduce the frequency of inspections.[179]

If the Healthcare Inspectorate decides on the basis of the questionnaire response that an inspection is warranted, it carries out the second stage of general supervision, namely the inspection itself. This usually begins with a meeting with the institution's board of directors and the medical director, during which the aim of the inspection is explained. Specific concerns are raised and discussed before a meeting is held with the institution's advisory committee composed of psychiatrists and nurses. During this meeting inspectors check issues including restraint and control practices. A third meeting with the team responsible for medical treatment follows, at which treatment plans for each patient is considered. The Healthcare Inspectorate

175 Each year, the Healthcare Inspectorate conducts research on approximately 25 different themes. Coercive treatment in mental health institutions in respect of both adults and children are two examples. Information received in a telephone interview with an Inspector at the Healthcare Inspectorate on 19 October 2006.

176 Information received in a telephone interview with an Inspector at the Healthcare Inspectorate on 19 October 2006.

177 Health Care Quality Act, 1996, para. 8; PH(CA)A, 1994, para. 63.2.

178 PH(CA)A, 1994, para. 63.3-5.

179 There are various operational instruments used in the first and second stages of inspections. They include, among others, a checklist for seclusion rooms, a checklist for the safety of restraints, a list of questions to ask in a meeting with treatment team, a list of questions to ask in a meeting with the medical director of an institution, a checklist on forced admission and treatment and a checklist on protocols concerning isolation. Information received in a telephone interview with an Inspector at the Healthcare Inspectorate on 18 October 2006.

is mandated to review the basis for compulsory admissions to a mental health or social care institution, during which process inspectors may request information from the medical director and, if any irregularities are found, they may inform the public prosecutor. Each inspection is generally concluded with a final meeting with all of the institution's staff, during which inspectors make general comments and raise concerns.[180]

The third stage of the supervision begins only upon failure by the institution to comply with recommendations made.[181]

There are several avenues of complaint available to patients and residents in the Netherlands

As noted, 'monitoring' may also take the form of crisis-supervision. This may be triggered by a single serious incident in a specific institution, for example the sudden death of a resident.[182]

Thematic inspections on the other hand, are pre-planned and usually conducted in several selected institutions. They may be triggered by information from any source alleging poor quality of care.[183]

There is a provision under the PH(CA)A on the basis of which all institutions are obliged to report on each case of compulsory detention and forced treatment. The Healthcare Inspectorate must investigate every reported case. There are approximately 2,500 such cases annually and of these about 10% involve a formal inspection, an examination of medical records, and discussions with treatment teams, a patient and/or his or her representative.[184] In 2005, there were no inspections in mental health hospitals or institutions for people with intellectual disabilities. In contrast, there were 46 visits to social care homes,[185] during which inspectors examined compliance with the PH(CA)A.[186] This, as noted above, purports to protect rights of persons detained in a list of specified institutions.[187]

There are several avenues of complaint available to patients and residents in the Netherlands. The 1995 General Complaints in Healthcare Act (GCHA) offers one such avenue. Under the GCHA, every health care institution is required to appoint a complaints committee which should be composed of at least three people. Its chairman must be independent of the institution. If

180 Information received in a telephone interview with an Inspector at the Healthcare Inspectorate on 13 October 2006.
181 Information received in a telephone interview with an Inspector at the Healthcare Inspectorate on 20 October 2006.
182 *Ibid*.
183 *Ibid*.
184 Information received in a telephone interview with an Inspector at the Healthcare Inspectorate on 20 October 2006. In cases of detention on basis of the PH(CA)A, there were 8,737 long term and 7,774 short term detentions reported in 2005. Of the 8,737 long term detentions, 1,267 were provisional, i.e. the patient could stay at home if he or she agreed and complied with a prescribed treatment (only valid for patients with mental health problems).
185 These were nursing homes for people with dementia.
186 Information received in a telephone interview with an Inspector at the Healthcare Inspectorate on 13 October 2006.
187 *Ibid*.

a complaint relates to a member of the committee, s/he will be replaced although will be given an opportunity to formally challenge the complaint during a hearing. The complainant has a right to be represented by an attorney or another trusted person. Possible outcomes of this procedure include a finding that the case is legitimate, partially legitimate or unfounded. Although the committee may issue recommendations on the basis of its findings there is no obligation on the part of the person to whom the recommendation is directed to comply on the committee's decision. In every case, a complainant receives a reasoned decision after the procedure is finished.

A second avenue of complaint is available to residents detained under the PH(CA)A. Under this act, they have the right to complain about various issues that frequently arise during the course of detention. These include decisions taken by an institution on the use of forced treatment and the use of means of restraint. A complaint committee should hold a hearing in the presence of a psychiatrist (or another expert in the nursing homes and institutions for people with intellectual disabilities) and a lawyer. In direct contrast to the procedure under the GCHA, an institution under the PH(CA)A must comply with any findings of the committee, against which there is no appeal. The complainant is assisted free of charge by an attorney when filing a complaint with a judge. Again, possible outcomes are a finding that a complaint was legitimate, partially legitimate or unfounded. The judge will issue instructions to an institution how to remedy the situation complained about.

A complaint may be also filed directly with the Healthcare Inspectorate, although this cannot serve as an appeal from the findings of the committee. If considered sufficiently serious, the Healthcare Inspectorate will file a complaint with either the medical disciplinary tribunal or a criminal court. The medical disciplinary tribunal is composed of four medical doctors and one lawyer. This tribunal does not handle requests for damages.

In mental health institutions, patients can ask an independent patients' advocate (a 'person of trust') for help or advice. Patients' advocacy is required by the PH(CA)A. There is no similar requirement in nursing homes and/or homes for people with intellectual disabilities.[188]

Requirement 6: Publish comprehensive reports

The reports on general inspections include general findings, conclusions and recommendations. There may be a different deadline for each recommendation depending on the gravity of an issue in question. On receipt of such reports, each institution is requested to submit, again within a given time period, a timeframe or a strategy of implementation.[189]

Healthcare Inspectorate thematic reports, which number annually approximately 20 to 30,[190] are forwarded to the parliament and, as with the reports prepared following crisis interventions,

188 See Pandora Foundation, especially its website at: www.stichtingpandora.nl (last accessed 6 November 2006).

189 Information received in a telephone interview with an Inspector at the Healthcare Inspectorate on 3 October 2006.

190 *Ibid.*

they should be sent to municipalities (city councils) or to parliament. The Healthcare Inspectorate's annual reports are both forwarded to the parliament and released to the public.

Requirement 7: Ensure maximum impact

If an institution does not comply with recommendations or implementation is delayed, the Healthcare Inspectorate may start a procedure requesting a ministerial directive. This procedure, which has been followed approximately four times a year,[191] is initiated by the Healthcare Inspectorate sending a letter to the Ministry. This will contain an explanation of the situation, give reasons for starting the procedure and formally seek a ministerial directive aimed towards the implementation of recommendations by an institution. This letter will usually be followed by a discussion between the Ministry and the institution in question, the latter being under an obligation to explain its reasons for non-compliance. It is not unknown for hospital departments to be closed down following the conclusion of this procedure.

In cases of extreme urgency and severity, for example when there were several deaths in a short period of time in the same institution, the Healthcare Inspectorate may issue an order for immediate closure of a hospital department. This order is valid for one week and the Healthcare Inspectorate immediately informs the Ministry. In those cases where grounds for these measures remain, he must inform the Ministry accordingly. In cases when the Healthcare Inspectorate has reasonable grounds to suspect that a criminal offence was committed, it may also report the case to a prosecutor attorney to commence criminal proceedings.[192]

In 2000, the Netherlands Court of Audit audited the activities of the Healthcare Inspectorate. The report submitted by the Healthcare Inspectorate for audit was criticised on grounds of lack of clarity of the legal provisions providing for assessment of the institutions nationwide. The Court of Audit also pointed out that a follow-up activity took place in less that one third of inspected institutions.[193] A further audit carried out two years later noted certain improvements.[194]

Requirement 8: Coordinate activities

The Healthcare Inspectorate informally cooperates with the NGO Patients' Advocates Foundation by means of discussions and exchange of opinions and information. The Healthcare Inspectorate collaborates also with various patient and family organizations by way of meetings, discussions about priorities and activities and mutual support before State authorities.[195]

191 *Ibid*.
192 *Ibid*.
193 Algemane Rekenkamer, Healthcare Inspectorate, See their website at www.rekenkamer.nl (last accessed 5 November 2006).
194 Information received in a telephone interview with an Inspector at the Healthcare Inspectorate on 20 October 2006.
195 *Ibid*.

Comment

The Netherlands is not alone in, having signed the OPCAT, failing to take the further step of ratifying it. Neither is it alone in having a functioning monitoring system of places of detention which contain a number of positive aspects: in this instance, for example, a number of options for making complaints, formal continuous training and, notably, multidisciplinary participation.

It is disappointing to note however the continuing debate as to the relevance of ratification, especially considering the solid history of Dutch inspectorates. The implication is a belief that the current monitoring system provides adequate and effective protection to persons in detention. It does not. Independence of the monitoring system is questionable and recent reforms may reduce the frequency of inspections which are now targeted to more serious/ urgent situations. This clearly undermines the effectiveness, and indeed purpose, of a monitoring system.

Finally, and as not unanticipated but regretful all the same, note is made of the failure to formally include people with psycho-social disabilities and people with intellectual disabilities and civil society generally in its monitoring activities.

THE UNITED KINGDOM

Requirement 1: Ratify the Optional Protocol to the UN Convention against Torture

The United Kingdom ratified the OPCAT on 10 December 2003.[196]

Requirement 2: Establish inspectorates with a legal mandate

The Mental Health Act Commission (MHAC) is one of a range of bodies, which monitors mental health and social care institutions in England and Wales.[197] It is a body established by the Mental Health Act 1983 and is responsible for several aspects of the Act's implementation as it relates to patients who are detained or are liable to be detained in mental health institutions. Inspections of these institutions form part of the MHAC's remit.[198]

The Commission for Social Care Inspection (CSCI) regulates social care institutions including care homes and domiciliary care agencies in the public, private, voluntary and charitable sectors. The CSCI was created by the 2003 Health and Social Care (Community Health and Standards) Act.[199]

The Healthcare Commission was established by the Health and Social Care (Community Health and Standards) Act 2003 'to promote improvements in the quality of healthcare and public health in England and Wales'.[200]

Requirement 3: Ensure inspectorates are independent

The MHAC is an arms-length body of the Department (Ministry) of Health upon whom it relies solely for its funding and to whom it is accountable. The MHAC does not have full financial autonomy.[201] Its expenditure is unable to exceed its funding and it is subject to

196 Ratification of the OPCAT did not result in the UK creating a new inspectorate body. Ongoing discussions amongst NGOs, academics and various inspectorates remain as to how best to incorporate the OPCAT requirements into the existing system of inspectorates. See John Kissane, UK Department of Constitutional Affairs, Speech delivered at a seminar on implementation of the OPCAT in the Baltic States, Riga, 27-28 April 2006.

197 The MHAC is a body, which operates in England and Wales. For the purposes of this paper, only its remit in England will be described.

198 See website of the MHAC at: http://www.mhac.org.uk/Pages/about.html.

199 See website of the CSCI at: http://www.csci.org.uk/.

200 In England, the Healthcare Commission is responsible for assessing and reporting on the performance of both NHS and independent healthcare organisations, to ensure that they are providing a high standard of care. It also encourages providers to continually improve their services and the way they work. In Wales, its role is more limited and relates mainly to working on national reviews that cover both England and Wales. For more information, see its website: www.healthcarecommission.org.uk (last accessed 5 November 2006).

201 It has been suggested that the apparent financial dependence on the Department of Health does not prevent adequate freedom in the allocation of resources. Information from a telephone interview with an Official of the MHAC on 18 January 2006.

regular governmental audits.[202] Commissioners are selected by the Secretary of State on the recommendation of the MHAC following an open competition and interviews.[203] The MHAC's offices are separate from any premises of the executive branch.

The Commission for Social Care Inspection comprises the Chair and five Commissioners appointed by the National Health Service (NHS) Appointments Commission. Commissioners may be removed by a decision of either the CSCI as a body or the Secretary of State. The CSCI has a responsibility to appoint and monitor the performance of its chief executive and other senior staff.[204]

The budget of the CSCI in 2004-2005 was 157 million British pounds (approximately 235 million euro), 82% of which was allocated to social care regulation, 9% on performance assessment of councils and 4% on inspections of council services.[205] There are special provisions against corruption which include, among others, declarations of interests.[206] The CSCI headquarters is located outside the premises occupied by the executive.[207]

The Healthcare Commission was established as the principal assessor of healthcare and to be independent of direct government control. It has the status of a non-departmental public body. In exercising its functions it must however have regard to government policy. The Secretary of State for Health is answerable to parliament for its policies and performance.[208]

The Healthcare Commission's activities involve three principle elements: inspecting, informing and improving

The Healthcare Commission's activities involve three principle elements: inspecting, informing and improving. 'Inspections' are carried out by way of assessment of performance measured against governmental standards. 'Informing' is principally by way of preparation and publication of annual ratings of healthcare providers and other relevant information. Its aim is to facilitate decision making by the public. 'Improving' takes place, in the main, by way of independent reviews of complaints and by carrying out investigations

202 Financial information of the MHAC is available at http://www.mhac.org.uk/Pages/finance.html (last accessed 5 November 2006).

203 See MHAC's website: http://www.mhac.org.uk/Pages/composition.html (last accessed 5 November 2006).

204 See: CSCI Standing Orders, Point 3, available at: http://www.csci.org.uk/Docs/Standing_orders_revised_edition_4.doc (last accessed 5 November 2006).

205 Annual Report 2004-2005 available at: http://www.csci.org.uk/PDF/annual_report_2004-05.pdf.

206 Source: CSCI Standing Orders, Point 5. See further at: http://www.csci.org.uk/Docs/Standing_orders_revised_edition_4.doc.

207 Source: http://www.csci.org.uk.

208 The Healthcare Commission is perceived by some commentators as 'a heavy-handed weapon of central control'. They suggest that 'there is no clear boundary between the inspection of a service and the implementation of a government policy.' If the Commission is to implement the government policy on health services, therefore it will be seen in time if this has a positive impact on the health and observing the rights of patients. As the power of appointment of the Commissioners is delegated by the Secretary of State, the nature and purpose of appointments is set at a political level. See Adrian James, Adrian Worrall & Tim Kendall (Eds.) *Clinical Governance in Mental Health and Learning Disability Services, A Practical Guide*, (2005, The Royal College of Psychiatrists, London), pp. 70-71.

into allegations of serious service failings, particularly when there are concerns for the safety of patients.[209]

Senior staff have regular meetings with senior governmental officials. The accounts are audited in the standard way for governmental bodies.

The Chair and the majority of the Commissioners must be lay people. They cannot be healthcare professionals or in paid appointment or office within the NHS.[210]

Requirement 4: Recruit qualified and experienced staff

A priority of the Mental Health Act Commission is the involvement of users of psychiatric services in all areas of its work. To this end a Service User Reference Panel has been initiated, as has the maintenance of a wider list of service users, whom it contacts for consultations or other activities in which their involvement is particularly relevant.[211] There are approximately 100 self-employed, part-time Commissioners who are recruited from among laypersons, lawyers, doctors, nurses, social workers and psychologists. They are paid for two days work a month. The MHAC is divided into regions with a director managing each region. It employs approximately 40 people at its headquarters.[212] Continuous training of all staff begins upon initial appointment and continues throughout the term of employment.[213] There are indications of a view within the MHAC that an increase in both human and financial resources would increase the effectiveness of its monitoring activities.[214]

The Commission for Social Care Inspection is far larger than that of the MHAC: in 2005, it had 2,548 staff. Of these 2,400 people worked in the regions delivering and supporting inspection, performance and regulatory work and 250 in headquarters in policy and corporate functions.[215] Guiding the work of the CSCI, and indeed government policy, are five Service Improvement Boards. Their composition includes service users, carers, service providers, commissioners of social care and policy officers. These boards meet four times a year. Ad

209 See: About the Healthcare Commission, on its website at: http://www.healthcarecommission.org.uk/_db/_documents/04021261.pdf (last accessed 5 November 2006).

210 Source: HC 2005/2006 Annual Report. See further at: http://www.healthcarecommission.org.uk/_db/_documents/Annual_Report_English_Version_200609180843.pdf.

211 See MHAC's website: http://www.mhac.org.uk/Pages/serviceuser.html (last accessed on 5 November 2006).

212 See MHAC's website: http://www.mhac.org.uk/Pages/composition.html (lst accessed on 5 November 2006).

213 An illustrative example of such training is the *Mental Health Act Commission: Equalities and Human Rights Case Study Project* funded by the Department of Constitutional Affairs and the Department of Health. The purpose of the training was to demonstrate how a public sector organisation uses knowledge and understanding about human rights to improve the way in which it carries out its day to day business. The project provided for training for various MHAC staff in equality and human rights, and opportunities to put this training into practice and then to reflect on the experiences.

214 Information from a telephone interview with an Official of the MHAC on 27 April 2006.

215 See Annual Report 2004-2005 available at: http://www.csci.org.uk/PDF/annual_report_2004-05.pdf (last accessed 5 November 2006).

hoc experts or service users are invited for specific activities. For instance inspection teams of learning disability services will often include a person with a learning disability.[216] CSCI applies an ethnic equality policy by monitoring its racial composition and relevant training needs and provision[217] and established a Training and Development Plan in 2005 in order to address regular training requirements. The expenditure on training in 2005 was 1,190,000 British pounds (approximately 1,800,000 euro).[218]

Finally, note is made of the investigations committee. This provides strategic and operational advice to the CSCI on investigations into potential failures in NHS services in England.

The Healthcare Commission comprises a Chair and 14 Commissioners who are appointed by the Secretary of State for Health to work for two and a half days a month.[219] The Commissioners are recruited from among lawyers, economists, lay persons, medical doctors and psychologists.[220]

Requirement 5: Ensure that visits are effective

As noted, the Mental Health Act Commission is mandated to conduct inspections of institutions where patients are detained in law. The costs of and related to these inspections constitute approximately 60% of its budget.[221] The frequency of visits is partly dependent on the size and composition of the institution, with the larger institutions being visited monthly.[222]

Since 2004 Commissioners have conducted visits alone rather than as part of a team. Visits may be announced, with short notice or unannounced. Unannounced visits are the current norm and can take place at any time of the day on any day of the week.[223] Commissioners are entitled to go to any part of the hospital premises. During a full day's visit a Commissioner might interview up to six patients with institutions being under a dual duty to facilitate such interviews, particularly when sought by a patient, and to allow access to medical records. Interviews are in private, often based on questionnaires used for the purposes of the interview.

216 See www.csci.org.uk/about_csci/who_we_are.aspx (last accessed 5 November 2006).
217 See the website of the CSCI and the Race relations Act. www.csci.org.uk/about_csci/who_we_are/about_the_diversity_of_our_sta.aspx (last accessed 5 November 2006).
218 See the CSCI's Standing Orders, Point 2, at: www.csci.org.uk/Docs/Standing_orders_revised_edition_4.doc (last accessed 5 November 2006).
219 See www.healthcarecommission.org.uk/aboutus (last accessed 5 November 2006).
220 See www.healthcarecommission.org.uk/aboutus/whoarewe/thecommissioners.cfm (last accessed 5 November 2006).
221 Calculated on basis of the financial statement for 2004-2005, see http://www.mhac.org.uk/Pages/finance (last accessed 5 November 2006).
222 The MHAC created a list of indicators for 2004 to 2007. The plans of the MHAC include conducting 9,000 private interviews with residents per annum. There should be 9,000 second opinions given and 10,000 document checks per annum. Every hospital unit with detained patients should be visited at least once a year and every department with a detained patient should be visited at least once every 18 months.
223 The view presented on the website has been confirmed in an interview with an Official of the MHAC on 27 April 2006. The Official believes that a burden of inspection on the part of the visited hospital is light. Staff and management often welcome a visit as an opportunity to raise concerns or seek advice.

Confidentiality is considered paramount.[224] Verbal and handwritten feedback can, and often is, given on the day of a visit and can lead to the resolution of issues, particularly those at hospital department level.[225]

Confidentiality is considered paramount

The MHAC may investigate complaints but only in relation to detention.[226] In the vast majority of cases it advises and supports detained patients to take complaints through the well-established NHS complaint process, advising them of their rights and corresponding with the hospitals on their behalf.[227]

The MHAC complaints procedure is triggered by way of letter. This in turn, and only with the patient's consent, is forwarded to the institution which is given four weeks to respond in accordance with the NHS complaints procedure. In those instances where it is felt that the NHS complaints procedure has proved inadequate, the MHAC carries out its own investigation.[228]

There is formal coordination between the MHAC and the Healthcare Commission in this procedure as the MHAC can pass complaints it cannot resolve satisfactorily to the HC,[229] which will then carry out its own investigation. These might involve gaining access to medical records and input from independent and multidisciplinary advisers including health professionals, clinicians and service users.

Reasoned decisions of the Healthcare Commission are conveyed to both the complainant and the institution against which the complaint is made.[230] Possible results and courses of action at this stage include: taking no further action, referring the issue back to the institution, and/or making specific recommendations as to what further action it might take to resolve the complaint or review its procedures and services. In particularly serious cases, of for instance, non-compliance with requests for information, a case may be referred to the Health Service Ombudsman. In such a case the latter's power to compel witnesses to answer could be the lever needed to resolve or answer the complaint.[231] There are special policies of ensuring the privacy

224 Information from a telephone interview with an Official of the MHAC on 18 January 2006.
225 *Ibid*.
226 The Commission's remit to investigate complaints is set out in Section 120 (1)(b) of the Mental Health Act 1983.
227 Between April 2004 and March 2005 the Commission supported 275 people through the complaints process and offered advice to a further 663 people whose concerns fell outside its remit to investigate. See http://www.mhac.org.uk/Pages/complaints.html (last accessed 5 November 2006).
228 Source: http://www.mhac.org.uk/Pages/complaints.html (last accessed 5 November 2006).
229 In 1999, a national evaluation of the NHS complaints procedure revealed that the public did not think the procedure was sufficiently independent or consistent, and that complaints took too long to be processed. As a result, the Department of Health decided that a new complaints system should be set up, with a second stage run by an independent organisation – the Healthcare Commission.
230 See www.mhac.org.uk/Pages/complaints.html (last accessed 5 November 2006).
231 See www.healthcarecommission.org.uk/contactus/complaints/handlingcomplaints.cfm (last accessed 5 November 2006).

and confidentiality of patients.[232] The MHAC has issued an equal opportunities statement[233] and initiated an ethnic equality scheme and action plan.[234]

The Commission for Social Care Inspection is permitted to inspect any premises that are used, or which it has reasonable cause to believe may be used, as a care home or for the purpose of a domiciliary care agency.[235] From April 2006, all institutions are assessed according to their quality and safety. A component of these assessments is inspections, which take three forms: key, random and thematic. Key inspections tend to be unannounced, are comprehensive, invariably call for the release of detailed information from the institution and take into consideration complaints or issues raised and brought to the attention of the CSCI since a previous inspection.[236]

Random inspections are, again, usually unannounced. They can take place at any time or day, are short, targeted and focus on specific issues, such as complaints and implementation measures. On occasions they can quite simply be random. There are also thematic inspections that focus on a specific issue, such as medication, or a specific area or region so that trends can be assessed. Visits take place approximately twice a year.[237] Inspectors will seek the opinion of service users and relatives in all three forms of inspections.

As noted, investigations of the CSCI can be initiated on the basis of complaints and there is now an established complaint procedure within it. This includes provisions minimising the risk of retribution together with rules on strict confidentiality.[238]

Residents of care homes must follow a specified procedure if they have a complaint about the service they receive in social care institutions, services provided by local councils and/or also about the activities of the CSCI.[239] The CSCI acknowledges receipt of a complaint, and initiates an investigation to assess the standard of care provided by the institution. The investigations might be carried out, at the request of CSCI, by the institution, or by the CSCI itself. Any inquiry should be completed within 20 working days. Subsequent action might involve making recommendations or even, in more serious cases, the CSCI may consider taking legal action.[240] The Healthcare Commission conducts investigations in response to specific concerns of which it is made

232 See www.mhac.org.uk/Pages/privacypolicy.html (last accessed 5 November 2006).
233 See http://www.mhac.org.uk/Pages/documents/internal_policies/EQUAL%20OPPORTUNITIES.pdf (last accessed 5 November 2006).
234 Source: http://www.mhac.org.uk/Pages/race.html (last accessed 5 November 2006).
235 Care Standards Act 2000, section 31. In 2005 the Commission conducted a survey about the best way to inspect care home and care services. It found that the best way of inspecting is to focus on the services which had the most problems. Children's services are inspected without such a distinction.
236 See www.csci.org.uk/about_csci/our_inspections.aspx (last accessed 5 November 2006).
237 Calculated on basis of the inspections reports available at: http://www.csci.org.uk/registeredservicesdirectory/rsquicksearch.asp (last accessed 5 November 2006).
238 See www.csci.org.uk/complain/share_concerns_and_complaints.aspx (last accessed 5 November 2006).
239 A full description of this procedure is available at the website: www.csci.org.uk/complain/share_concerns_and_complaints.aspx (last accessed 5 November 2006).
240 *Ibid*.

aware.[241] An investigation involves obtaining evidence on, and developing an understanding of, the reasons for a serious failing in the provision of healthcare and making subsequent recommendations to prevent repetition.

The system of inspections[242] has been recently modified with inspections being less frequent and concentrated on institutions which do not fulfill necessary minimum standards or implement recommendations. The Healthcare Commission offers specific tools for self assessment for independent/private healthcare institutions, including a self-assessment questionnaire. [243] These serve an additional purpose of allowing the HC to pre-plan and target inspections with 'less breadth and more depth.'[244]

Requirement 6: Publish comprehensive reports

Although no formal report is prepared following a Mental Health Act Commission visit, a Commissioner will forward to an institution details of his/her findings, recommendations and target dates for the fulfillment of those recommendations. Issues considered to be of extreme importance are 'fast tracked'. Material from individual visits is collated to inform a biennial report which is presented to parliament, although institutions are given prior opportunity to comment on their content. A component of the policy of openness of the MHAC is the publishing of its annual and thematic reports and their free availability on its web site.[245] This occurs despite the absence of a mandatory duty to do so.

In contrast, the Commission for Social Care Inspection prepares and publishes a formal report after each inspection. These identify the institution, its positive aspects and areas of required improvement.[246] The standards against which institutions are measured are the government's

241 Investigations are conducted in order to promote improvements in provision of healthcare. Source: www.healthcarecommission.org.uk/aboutus/whatisthehealthcarecommission/whatis.cfm (last accessed 5 November 2006).

242 Inspections are made to assess performance of healthcare providers. See the website www.healthcarecommission.org.uk/aboutus/whatisthehealthcarecommission/whatis.cfm (last accessed 5 November 2006).

243 The provision of healthcare is assessed by the Healthcare Commission on basis of standards and guidance provided by the Ministry of Health. See the website for more details: www.dh.gov.uk/PolicyAndGuidance/fs/en (last accessed 5 November 2006). An example of such assessment may be the 2006 Performance Rating, available at: http://annualhealthcheckratings.healthcarecommission.org.uk/annualhealthcheckratings.cfm (last accessed 5 November 2006).

244 This reduction in the number and breadth of inspections has raised practical issues. For instance, institutions which have not been inspected face a comprehensive review and will be measured against all applicable national minimum standards. In contrast, previously inspected institutions will only undergo an annual review if they have demonstrated a failure to meet the minimum standards. If an institution provides sufficient evidence of compliance, the frequency of inspections will decrease. See the website for more details: www.healthcarecommission.org.uk/serviceproviderinformation/independenthealthcareprivateandvoluntary/independenthealthcaredetail.cfm?CONTENT_ID=4016921 (last accessed 5 November 2006).

245 For more information see www.mhac.org.uk/Pages/publications.html (last accessed 5 November 2006).

246 See inspections reports available at: www.csci.org.uk/find_a_report/what_is_an_inspection_report.aspx (last accessed 5 November 2006).

National Minimum Standards.[247] The institution however has 28 days to comment on the report prior to its publication on the CSCI website.[248] Preparation of child-friendly reports on children's services is currently underway.[249] In addition CSCI posts its annual reports on its website.[250] The Healthcare Commission is required to write an annual report,[251] and issues a range of thematic reports. It publishes all reports on its website.[252]

Requirement 7: Ensure maximum impact

The Mental Health Act Commission presents a report to parliament every two years. Its statutory powers of enforcement are limited in that it can neither enforce implementation of its recommendations nor impose sanctions.[253] It can however refer non-compliant bodies to the Healthcare Commission which has both a broader remit and the power to impose sanctions. In the past these have included closures of hospital departments.[254]

The Commission for Social Care Inspection sends its annual report to both parliament and the Secretary of State.[255] Implementation of recommendations made following each visit is facilitated by repeat visits, carried out approximately six months later and again by a Commissioner.[256] Cooperation to improve services is the general tenor of these repeat visits, although lack of required improvements can result in formal sanctions. Where residents or patients are considered to be at serious risk, these might for instance include cancellation of service agreements. The 2006 Enforcement Policy provides a clear outline of steps that can be taken by the CSCI during the implementation process.[257] The CSCI contributes to government policy principally by responding to its reports and

There is a formal coordination of monitoring mechanisms

247 The National Minimum Standards are described at: www.csci.org.uk/care_professionals/service_providers/national_minimum_standards.aspx (last accessed 5 November 2006).
248 See: www.csci.org.uk/find_a_report/what_is_an_inspection_report.aspx.
249 See: www.csci.org.uk/about_csci/news/children_get_inspection_report.aspx.
250 Health and Social Care (Community Health and Standards) Act, 2003, section 29.
251 Annual Report for 2005-2006, published 24 July 2006, can be downloaded from www.healthcarecommission.org.uk/_db/_documents/Annual_Report_English_Version_200609180843.pdf (last accessed 5 November 2006).
252 See: www.healthcarecommission.org.uk/nationalfindings/publications.cfm and www.healthcarecommission.org.uk/serviceproviderinformation/reviewsandinspections/investigations.cfm (last accessed 5 November 2006).
253 The practice of the MHAC is to repeat a request for information on implementation. Information from a telephone interview with an Official of the MHAC on 18 January 2006.
254 An illustrative example can be found at this website: news.bbc.co.uk/2/hi/uk_news/england/norfolk/4460284.stm (last accessed 5 November 2006).
255 CSCI's Standing Orders, Point 2.5. See further at: http://www.csci.org.uk/Docs/Standing_orders_revised_edition_4.doc (last accessed 5 November 2006).
256 Reports are all available on the CSCI's website www.csci.org.uk (last accessed 5 November 2006).
257 Policy and Guidance: Enforcement Policy, July 2006, Quality, Performance and Methods Directorate. Available from: http://www.csci.org.uk/Docs/enforcement_policy_csci.doc (last accessed 5 November 2006).

consultations,[258] one illustrative example being its response to a call for consultation by the Department for Education and Skills on proposals to create a single inspectorate for children and learners.[259]

The Healthcare Commission presents its annual report to parliament and to the Secretary of State for Health. Recommendations made are followed up, and its website contains details of both the investigations themselves and the progress of the implementation of recommendations.[260]

Requirement 8: Coordinate activities

The current variety and number of monitoring mechanisms of mental health and social care service institutions and providers has led to the development of formal coordination of activities of the various bodies involved. This coordination is led by the Healthcare Commission, which has sought to initiate working agreements and so minimize potential confusion and overlap.[261]

A formal code of objectives and practices agreed by bodies auditing, inspecting, and regulating healthcare and known as 'the Concordate' was initiated by the Healthcare Commission and published in June 2004. Both MHAC and CSCI are signatories.[262] Its aims are coordination of inspections with other reviews and data; a focus on the experience of patients, other services users and carers; and supporting general and continuous improvements in quality and performance of working methods of inspecting bodies. Specifically, inspections should be independent, consistent and fair, targeted and proportionate. They should be transparent and accountable. Inspectors should be suitably qualified, trained and skilled and the inspecting bodies should continuously monitor their own practices against Concordant standards. In addition its signatories commit to maximizing information sharing, minimizing administration costs, and avoiding repetition.[263] A dedicated hotline, maintained by the Healthcare Commission, is open to all NHS staff where concerns, general or specific about the planning and handling of inspections, can be raised. The role of the various monitoring and inspecting bodies, including the CSCI and MHAC, is to be gradually consolidated into one body, the Healthcare Commission. The role of MHAC following this consolidation remains uncertain.[264]

258 A list of publications contributing to policy development can be found at: http://www.csci.org.uk/about_csci/using_our_expert_voice_in_soci/how_we_contribute_to_governmen.aspx (last accessed 5 November 2006).

259 See: http://www.csci.org.uk/PDF/dfes_csci_response.pdf (last accessed 5 November 2006).

260 Source: An exemplary report of the Healthcare Commission on Abbey Caldew Hospital (2005/2006) can be found at: http://www.healthcarecommission.org.uk/_db/_documents/04022135.pdf (last accessed 5 November 2006).

261 The homepage of the Concordate, which explains in detail the objectives of this document, is: www.concordat.org.uk/homepage.cfm (last accessed 5 November 2006).

262 See further: http://www.concordat.org.uk/signatories/fullsignatories.cfm (last accessed 5 November 2006).

263 A useful element of the Concordate website which might serve to minimize overlap and confusion between the bodies, is a section where all 'notable practices' of the signatories within the Concordate objectives are highlighted.

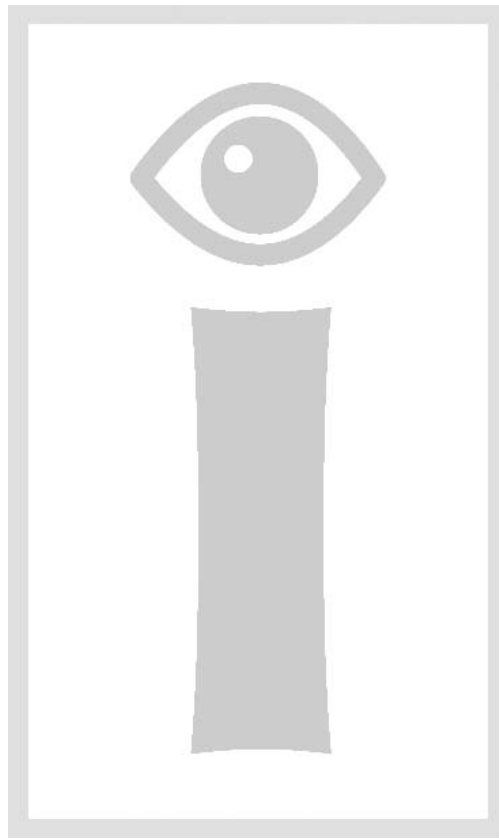
264 The Healthcare Commission's website states, 'it is expected that most of the functions of MHAC will transfer to the HC and that MHAC will be abolished, though not before April 2007. In the meantime, each organisation will maintain its separate statutory responsibilities but work together on a coherent overall program for the assessment of the provision of care in the field of mental health.' at: http://www.healthcarecommission.org.uk/aboutus/whatisthehealthcarecommission/whatis.cfm (last accessed 5 November 2006).

Comment

The United Kingdom clearly has a well developed system of monitoring mental health and social care institutions. This, combined with its ratification of the OPCAT, demonstrates a commendable commitment to the principle of inspectorates. Nonetheless it exhibits weaknesses from which States, willing to develop their own systems, can learn.

The most obvious of these weaknesses is the potential for overlap and confusion both within the system itself and for those trying to access it. That this has occurred and effective measures to counteract this confusion are elusive, is demonstrated by the continuing debate between academics, NGOs and governments as to how the system might be reformed.

It is however not only their effectiveness that is implicated but so too is the wastage of finite resources. Unfortunately, in common with each State reviewed in this paper, the inadequacy of resources dedicated to the development of an effective, coordinated inspectorate system, is once again apparent. Where the UK differs significantly from the other reviewed states is in the widespread involvement of users and user groups in its inspectorate mechanisms.



CONCLUSION

THE AIM OF **Inspect!** is quite simple: to raise the profile of mental health and social care inspectorates. In so doing it hopes to stimulate discussion, to facilitate transfer of best practice and to encourage concrete and embedded State action, all geared towards strengthening their effectiveness.

That most States already have in place a monitoring mechanism of mental health and social care institutions, of some form, is both accepted and welcomed. Their stage of development, quality and effectiveness differ to such an extent however that formal comparison at this early stage has a limited role. Comparisons should be viewed as a tool to assess common or innovative, and of course, deficient practices and to allow lessons to be learnt from these.

MDAC hopes that by providing a clear structure, its Eight Requirements, against which these practices can be measured, it will further this process by encouraging focused debates. The summaries of individual State practice noted in this paper perhaps point to the most obvious starting place for any such debate: inadequate resourcing; a lack of both perceived and actual independence from government control; and inadequate formal participation of persons with disabilities and civil society generally. All of these are the result of, and contribute to, the pervasive invisibility and vulnerability of persons with disabilities removed from society. Effective inspectorates can contribute to social reform by ensuring that States respect and promote the right to live independently and to be included in the community.

Mental Disability Advocacy Center (MDAC)

The Mental Disability Advocacy Center (MDAC) advances the human rights of adults and children with actual or perceived intellectual or psycho-social disabilities. Focusing on Europe and central Asia, we use a combination of law and advocacy to promote equality and social integration. We have participatory status at the Council of Europe and are a cooperating organisation of the International Helsinki Federation for Human Rights.

Our vision is for a world that values emotional, mental and learning differences, and where people respect each other's autonomy and dignity.

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