

A comparative review of international monitoring mechanisms for mental health legislation

**Final report to CQC:
Part 1: Evaluation and Part 2: Recommendations**

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Introduction

In October 2012, the Care Quality Commission (CQC) commissioned some research from Bristol University to inform our thinking on how we monitor the use of the Mental Health Act and fulfil our responsibilities under the Optional Protocol to the Convention against Torture (OPCAT).

One of CQC's priorities for the next three years is to strengthen how we deliver our responsibilities in terms of mental health and mental capacity. CQC commissioned this research to understand the experiences of other countries in monitoring their mental health legislation, and enable us to move forward with the development of this function according to international evidence and knowledge about best practice.

The research brief asked the researchers to examine aspects of the monitoring arrangements in place in a number of liberal democratic countries comparable to England. The authors chose New Zealand, Australia, Canada, Denmark, Sweden, the Netherlands, Ireland and other UK jurisdictions for the purposes of this review. Three main areas were considered:

- The methodology of the visits or inspections.
- The process for feeding back the information from visits and how this is integrated with the complaints process.
- How organisations evaluate their effectiveness and the impact of monitoring.

Relevant themes emerging from the study

The qualitative research

Our qualitative research involved a series of semi-structured interviews with a sample (11) of senior representatives from the inspection/visiting bodies in New Zealand, three Australian States, Canada, Denmark and the Netherlands, as well as from monitoring organisations in Ireland and some other UK jurisdictions. We gained ethical approval for the research from the School of Law Research Ethics Committee in advance of the commencement of the study.* On the basis of our discussions with CQC, we identified three aspects of the monitoring role to explore with interviewees including the format and methodology of the visits/inspections; the process for feeding back the information from inspections and links to the complaints process; and how organisations evaluate their effectiveness and the impact of inspections/monitoring.

Rather than focus on particular case studies, we agreed to focus on these key areas with a sample of representatives from relevant jurisdictions and the questions in the interviews were designed to elicit responses focused around these themes. The data has been analysed and a number of key issues have emerged from the interviews, which are outlined and explored below. The comments made by the interviewees are anecdotal and should be treated with caution as we have not been able to verify the accuracy or otherwise of all of their statements.

* We would like to thank Emily Kakoullis and Laura Wills at the University of Bristol for their invaluable help in conducting the interviews and undertaking background research for this project.

General observations

With the exception of the UK, Ireland and New Zealand (via District Inspectors), none of the legislative frameworks would seem to impose a statutory duty on a specific body to monitor the mental health/compulsory detention legislation. In addition, in some jurisdictions there is a lack of agreed national mental health standards (e.g. Canada and Australia). In these, there may be complaints mechanisms of various forms, but no body that regularly monitors mental health legislation, policy or standards on a consistent basis. The complaints mechanisms tend to be responsive, generic and can be complex. In Australia, each state has a diverse range of oversight and regulatory mechanisms, which may overlap and are confusing for patients/consumers. Critics argue that there is a need in Australia for a more 'streamlined' independent commission, which has expertise and a dedicated complaints arm, as well as investigatory functions.¹

It would appear that three different strands are often kept quite distinct in many jurisdictions: monitoring/visits, monitoring/strategic direction and complaints. Often, the same body or indeed the same person/persons does not carry out all three functions and there is considerable variation in how complaints will prompt visits, what happens with information picked up during visits and whether individual complaints will then follow. Some of this appears to depend on whether the body carrying out the visits is doing so on a reactive or proactive/preventive basis. Furthermore, what 'monitoring' entails is interpreted differently by different bodies.

So, one of the interviewees perceived their monitoring role as encompassing not only the visits, but also “national overviews”, namely to report on the state of mental health nationally; and to collect data (e.g. on deaths, restraint, seclusion, ECT), “gossip” and “informal information”, “attendance at events such as academic events”, “an informal, soft way of gathering information”. Indeed, several of the bodies we spoke to identified their ‘monitoring’ role as extending well beyond visiting and will rely on data collected from a range of sources and discussions with a range of external bodies or individuals to help them to fulfil their role: “I suppose we meet informally with all of our disciplines.... Informal information comes in too and we read the papers as well so we try to keep our finger on the pulse of what’s going on throughout the whole of the mental health services”.

There is evidence of interaction between the different types of bodies e.g. between monitoring bodies undertaking visits and advocacy services and between monitoring bodies and other statutory authorities e.g. in the Netherlands, with agencies such as the Food Authority.² The New Zealand NPM (Ombudsman) works closely with the District Inspectors and Health and Disability Commissioner; and the Chief Psychiatrist in Australian States will also liaise with the Ombudsman/Health Service Commission Visitor Schemes or other bodies in relation to patient complaints and concerns.

Some monitoring bodies e.g. HIW and RQIA carry out joint monitoring and health/social care regulatory functions, in the same way as CQC, and they are attempting to integrate the different aspects of their work, including reviews on governance, service and particular themes. As one interviewee said to us: “there are three different arms. The second arm we have is a review function where we carry out service and thematic governance reviews. The

Mental Health and Learning Disability Programme undertakes some of these also and then this third bit”.

Other monitoring bodies tend to work more independently of the healthcare regulator and/or complaints body, although there is evidence of some interaction/ joint working, but it is often on an informal/ad hoc basis: “it tends to be done informally: pick up the phone, click an email”; “the only formal protocol we have for information exchange is with the public prosecutor” and “it is sort of evolving because it’s fairly new ...it’s likely that a system will evolve of communicating these serious concerns or will continue to evolve”. For example in New Zealand, representatives of the Mental Health Commission will meet informally with the NPM arm of the Ombudsman’s office to feed concerns to the Ombudsman about systemic issues. The Mental Health Inspectors in Ireland work closely with the Mental Health Commission as they occupy the same office. The Chief Psychiatrist in one Australian State will liaise and meet with other regulatory or inspection bodies, as well as with community visitors.

Some have attempted to place joint working on a more formalised footing however. For example, the Community Visitors scheme in South Australia has recently developed a Memorandum of Understanding with other complaints/ regulatory bodies (such as the Health and Community Services Complaints Commission/Office of the Public Advocate) to promote formal information exchange and ensure that complaints/concerns are channelled to the appropriate body. The Chief Psychiatrist in Victoria, Australia has a similar Memorandum of Understanding in place with the Victoria Health Service Commissioner.³ And the Mental Welfare Commission has developed similar Memorandums of Understanding with a number of other organisations including

Healthcare Improvement Scotland, the Ombudsman and the Care Inspectorate, where there are common areas of work.⁴

Visiting methodology

Importance of the visiting function

Those we spoke to recognised the importance of the visiting function and the need for a preventive focus: *“the mere act of having an inspector coming in and staff knowing that they will be inspected and all our inspections are unannounced as well.”* However, the extent to which the impact of visiting (when compared to other methods) had been evaluated appears to be limited, as will be discussed in more detail below.

Need for an independent monitoring body

Some interviewees also emphasised the need for an *independent* monitoring body. As the Principal Community Visitor in South Australia observed: *“We try and highlight that, the fact that we are independent, we’re not part of mental health services, so we’re an independent statutory scheme, so we report directly to the Minister and that’s important”*. Another respondent commented: *“All of our assessments are independent in terms of we’re not aligned to any other organisation”*. Although respondents also recognised the challenges of monitoring and fulfilling this independent role, as highlighted by the Office of the Chief Psychiatrist in Victoria, Australia: *“Ours are such busy services, the churn through them is tremendous but I think monitoring is really hard”* and the difficulties in maintaining that independence from government: *“a lot of people say that [we] should be independent of the department... and I see why people say that. By being in the department we have access to their data, which is very nice, but*

we also have capacity to put our two bob’s worth into policy discussions... I like being in the department but there are people who say you should be independent”. Independence is also a crucial requirement under OPCAT for National Preventive Mechanisms (NPMs).

Training provided

The amount of training provided to inspectors or hospital visitors is extremely variable. In some jurisdictions, where qualified professionals are employed to perform the monitoring function, their professional knowledge and expertise is perceived as sufficient to help them to fulfil their inspection role: *“usually by their background they would have had a lot of experience working in the services. They tend to be quite senior people and are paid at a senior level”*. Some organisations provide inspectors with tailored in-house training, which is on-going, though there is often a lot of ‘on the job training’ – *“the truth is that you learn on the job”*.

The visitor programmes in Australia will rely on individuals/volunteers with a range of backgrounds, often with some experience of mental illness or professional qualifications such as social work. They do receive some initial training, mentoring and support to assist them to perform the visiting role, as well as periodic training sessions.

In one jurisdiction we were informed that there is a two-day intensive training workshop focusing on interviewing and communication skills. Thereafter, for example, within the Community Visitor programme in South Australia: *“we provide regular support and updates and information to the community visitors on a regular basis but we also invite them in for special sessions that we might do. We had one on report writing and undertaking requested visits earlier this year”*. And in another Official

Visitors scheme in Western Australia: *“new Official Visitors have an initial three days training in house. This involves taking them through the Mental Health Act and our own procedures and policies. We also have a number of guest speakers who take part in the training including a psychiatrist and consumers who talk about their experiences having been made involuntary, what it is like to hear voices and so on. We also had a carer at the last training, they go out on a number of visits with experienced Official Visitors. All new Official Visitors are allocated a mentor from amongst the experienced Official Visitors who have a checklist to work through. New Official visitors do not handle individual advocacy matters until we, and they, feel they are ready to do so. They also receive training from lawyers at our mental health law centre on how to prepare for a mental health review board hearing. In addition there is regular and on-going training for all Official Visitors”*. Where those undertaking the visits are part of a more generic body, the training does not always include specific training on mental health issues.

Background and experience

With regard to the background and experience of those undertaking the visits, in jurisdictions with a statutory monitoring function, most Inspectors are qualified and experienced professionals drawn from mental health nursing, social work, psychiatry, psychology and law. There may also be some service user/advocacy involvement. Visits tend to be carried out by groups of two or more multi-disciplinary teams: *“we represent all of the disciplines normally found in a multi-disciplinary mental health team”*. There was considerable variation in the employment status of the visitors/inspectors: some were full-time staff and others were employed on a part-time/sessional basis.

Expertise and experience

The expertise and experience of other visiting or inspection bodies varies considerably. For example, the Visitor Scheme in South Australia has been fortunate *“to recruit an exceptional community visitor team, people who have got many, many years of experience”* such as lawyers, social workers, teachers, former service users and carers/relatives of people who have suffered from mental illness/disability. In New Zealand, the NPM arm of the Ombudsman employs a full-time inspector with a mental health nursing background, and co-opts a psychiatrist to help with the visits to mental health and learning disability units. Similarly, in Denmark, the NPM involves members of a specialist body such as Dignity to provide appropriate medical/psychiatric expertise to accompany ombudsmen on visits to mental health places of detention. Other generic ombudsmen, for example in Nova Scotia, recognise the importance of ensuring that staff with a social work background will visit individuals who may be considered to have psychiatric or mental health issues. Some jurisdictions find it helpful to use a roster of experts from which they can draw to conduct certain visits.

Duration of inspections

The duration of inspections varies considerably from half a day to two to three days and in some cases a total of five days in duration, depending on the nature and size of the unit as well the type of inspection: *“it will be two or three people for two or three days at each centre”*; *“the inspection takes place over a two day period”*; *“They do two visits a month, yeah, and that should be around about four hours. Some do more”*; *“They can go on all day, they can be done in half a day. So it’s however long it takes and if it requires a follow up visit, a follow up visit would be established for them”*.

Types of visit

Visits may be routine annual inspections or themed inspections focusing on particular issues. One jurisdiction undertook regular 'quality' visits, themed visits and visits which responded to specific incidents or concerns. Northern Ireland has carried out themed reviews during 2011-12 based on human rights issues and the Healthcare Inspectorate in the Netherlands has a similar thematic approach. New Zealand's Ombudsman carries out focused visits (i.e. routine and thematic inspections) as well as scoping visits.

Methodology for visits

The methodology adopted on the visits varies. For some, visits were flexible in terms of format: *"We don't have any hard and fast rules". "I think it's a lot of custom and practice was developed over the last 200 years". "[I]t's patient driven so there could be a lot of time spent with patients or a lot of patients want to speak to the inspectors". The key is to get an atmosphere of how well the place is run from talking to staff, asking staff to point out aspects of the regulations that are being looked for in documentation and generally just having a discussion, but a lot of it is documentation"*.

For others, there were reporting templates, checklists, pro-formas and action lists to complete. For example the Community Visitors' Scheme in South Australia *"developed a reporting template and a reporting prompt sheet"* and the Ombudsman in Canada has *"an internal policy manual that outlines [sic] and all staff are required to read that and go through it and ask questions before they commence an investigation, and it's an on-going document that's revised regularly"*. Where the body conducting the visit was more generic, such as an ombudsman, they did not always have a policy manual that was tailored to mental health institutions or to mental health issues.

Professional codes of conduct and organisational values

Some inspectors were required to operate through their own professional codes of conduct and the organisation's core values. Other organisations, such as the Community Visitors Scheme in South Australia required the inspectors/visitors to sign a specific Code of Conduct *"which outlines the sort of dos and don'ts"* whilst carrying out the role. An interviewee from the Dutch Healthcare Inspectorate commented that *"[w]e have a code of conduct for the inspectorate but it's rather general"*. There was some evidence of the approach being more systematic when it is carried out by a body that has been designated as a NPM under OPCAT (see e.g. New Zealand NPM), under which the Ombudsman conducts visits to health and disability places of detention and where a template on monitoring standards is used. This may be in part due to the specific requirements of OPCAT.

Announced and unannounced inspections

Most jurisdictions with a monitoring body in place will carry out a combination of announced and unannounced inspections, however, there was a general recognition of the need to move towards a greater proportion of unannounced inspections. As New Zealand's Chief Inspector of COTA (Crimes of Torture Act Team) in the Office of the Ombudsman observed: *"if you know that the Ombudsman can turn up at any time of the day or night to carry out an inspection of your site I'm sure that that's a bit like knowing that the boss might have a hidden camera on you so that you're not going to do some of the silly things that you might have done not being aware of that"*.

Frequency of visits

In terms of the frequency of visits, once a year was mentioned by several we spoke to as the minimum: *“we actually think that you need to go at least once a year to different sites. Once every four years doesn't cut it”; ‘I presume probably once a year and being unannounced I think keeps people on their toes, it's probably a good balance’; and ‘we try to do them at least once a year in the big institutions so I think we have about let's say 40 large mental health institutions and we visit them at least once a year”*. For some it depended on risk: so, if, as one interviewee from the Dutch Healthcare Inspectorate told us, *“we trust the institution because of previous experiences or information we have we tend to visit them less than if we have some doubts about what's going on”*.

For advocacy systems, however, the regularity is much more frequent, usually every few weeks or once a month. The regularity of the visits is important for bodies with an OPCAT NPM function to ensure that their visits are sufficiently preventive in nature. What ‘regular’ should mean is difficult to measure, as the interviewee from the Dutch Healthcare Inspectorate said to us: *“it's very difficult to say what is enough in this field. If there are a lot of serious incidents everyone screams that there should be more inspections and we should do more and if it's more quiet then the field starts to complain that we do too much and that they lose too much time working at that. It's a balance always. Basically it's a political charge how much money or persons you attach to this kind of quality assessment”*.

Patient advisors and advocacy services

Patient advisors and advocacy services would seem to offer some monitoring function. They tend to visit frequently (sometimes on a weekly basis), meet patients, inspect facilities and assess records. In one jurisdiction we

were informed that concerns raised by patients’ advocates with the monitoring body led the latter to conduct a visit to the relevant institution. However, the advisor or advocate’s role tends to be advisory: to inform patients of their rights and they cannot arbitrate on patient complaints. In Canada, in Nova Scotia for example, a Patient Advisor informs patients of their rights and takes applications for legal aid. The background of patient advisors varies depending on the jurisdiction. So in some circumstances, such as in Nova Scotia, they need to be knowledgeable of mental health and illness and have previous experience of dealing with individuals with mental illnesses and have knowledge of the procedure for reviewing detention and obtaining legal services.

Rights advice provides some protection to individuals who are experiencing a loss of freedom to make their own decisions. The Patient Advisor is independent of the health authority and will have completed a specific training programme. Similarly, in Ontario, the Psychiatric Patient Advocate Office (PPAO) provides advocacy services to in-patients at the 10 major mental health facilities in the province on a daily basis. The PPAO frequently addresses concerns with privacy rights/patient records and the use of restraints and liaises regularly with other bodies such as the Consent and Capacity Board and Public Guardian & Trustee.

Official and community visitors

Official or community visitors can also meet patients on a regular basis, assist with patient complaints and act as conduits of information. In Victoria, Australia, the Mental Health Act 1986 provides for Community Visitors to conduct visits to detained patients in mental health units. They are volunteers who monitor the adequacy and appropriateness of accommodation, care and

support services. They do not monitor the operation of the legislation or advise on patient rights however. During 2012, 360 community visitors in Victoria made 5104 visits to 1,309 residents.⁵ The Community Visitors programme has made recommendations to parliament, which has led to some improvements in the standards of services and treatment of detained patients. Western Australia has a Council of Official Visitors to assist 'affected persons' under the Mental Health Act 1996.

Official visitors are members of the general community who have an understanding of mental illness. Their role is to provide an independent advocacy service for individuals who are being treated under the MHA 1996. There are currently 33 Official Visitors in addition to the Head of Council, who in 2010-11 visited 1,201 consumers and dealt with 3,518 issues raised by those consumers.⁶ The Council carries out routine Inspection Visits which are planned on a monthly basis, and which can occur at any time without prior notice. The Council also responds to requests for visits by patients or their families/guardians.

The Council's strengths are perceived to be its independence, responsiveness, accessibility and the 'frank and fearless' visitors. However it lacks the powers to enforce major change.⁷ South Australia has a similar Community Visitor scheme in place, which was introduced in the Mental Health Act 2009. The visiting role relies on volunteers to carry out two visits per month to each unit. The visitors recruited to date have come from a variety of professional backgrounds, particularly social work and education, as well as former service users and carers. Part of the visitors' role is to assist with the complaints process for patients. However they have the same powers as the Health Inspector to visit units, meet with patients and look at case notes or

documentation to investigate issues of concern to patients. The scheme has identified issues of a systemic nature and led to referrals to the Ombudsman in South Australia who, in turn, can carry out a formal investigation.

Role of advocates

Where advocacy services have been evaluated, some concerns raised by interviewees included the need for them to be more independent and that advocates should be appropriately trained in human rights.⁸ For example: *"the roles for advocates and the independent need for advocates will increase and we will have a role to undertake some scrutiny of their effectiveness and the quality of the service"*. This has implications under OPCAT. However, there is also a sense of an increased need for advocates and there are examples of good practice: in one jurisdiction, there is regular and close liaison between the Inspectors and the advocacy service *"we approach advocates who are on the ward when we visit and sometimes we jointly interview the patients"*. In addition, *"we also worked very closely with the advocacy service, if there was an advocacy service on the wards. We would have spoken to the advocates and the advocates would have met with us. We have a forum where we meet with the advocates from across [the country] and that has been helpful"*.

The way in which information from advocates is shared with the monitoring body varies. It can include being provided with reports from the advocates, or meetings with them *"we get a report from the advocates in each approved centre as part of our visit... on an annual basis we meet with the service user families that are advocates... it sort of fills out and gives us a rounder more national view"*. Given the unique position of advocates and the regularity of contact they have with patients and ward staff on an

almost daily basis, this approach offers a valuable opportunity to gather insights and useful information about the day-to-day experiences of detained patients. It would also serve to augment a more formalised and less frequent visiting regime.

Capturing the voice and experiences of patients

Most of the monitoring bodies we looked at make some attempt to capture patients' voices and experiences routinely as part of the inspection/visit. This may be via direct meetings with individual patients or discussions that take place at some stage during the visit to the ward/unit, perhaps during meal times for example in the Netherlands the Healthcare Inspectors *"will lunch on the ward with the patients to see how the atmosphere is"*. One jurisdiction took this a step further by conducting patient experience reviews prior to an announced inspection. Patients will be sent a template of questions, to assist Inspectors to identify areas of concern in advance of the inspection: *"there are informal discussions with patients before we undertake inspections. A lot of the time patients would have directed us to areas where we really needed to drill down more which was helpful... but we also sent questionnaires to patients, to relatives, to carers and staff on the wards."* This approach was perceived to be particularly beneficial in highlighting issues of concern to the Inspectors.

Other monitoring bodies will capture service users/consumer views through **regular meetings and events**: *"on an annual basis or a two yearly basis, we meet with a [service user group]. We met with them last year, we'll probably will meet with them again, just to get their perspective and to get their intelligence as well as to what's happening in various places, which we will use then on our inspection."*

Views of relatives and carers

The views of relatives/carers and other family members are also given increased weight in the inspection methodology in some jurisdictions. For example, in New Zealand, the NPM monitoring body values the input of relatives in the inspection process: *"what we started doing is interviewing the family members because a lot of the family members come to the hospital and spend most of the day and every day there..... We started talking to the visitors and they've been giving us some good information about some of the bad dementia sites."*

Several monitoring bodies will ensure that posters are placed on wards either permanently or in advance of an announced inspection to alert family members in advance that Inspectors will be available to meet with them: *"We would try on every occasion to involve relatives and carers in terms of their views about what's happening... the people who visit relatives on the ward know we are visiting in and make a point of seeing us and we welcome that obviously."* Similarly, another interviewee from a generic Ombudsman in Canada opined that: *"it's important for family members or friends to have access to it as well in case someone is unable to speak on their own behalf.... there are posters ...I guess the patients themselves or a family member is seeing our poster and feels open to contacting us with a concern."* Another monitoring body will *"meet with service user families that are advocates, we have a national meeting where we invite them up to our offices and we meet to discuss their perspective on the mental health services and we write reports on that as well... It sort of fills out and gives a rounder more national view."*

Relationships with other bodies

Some monitoring bodies have developed good relationships with other bodies, such as NGOs and rely on them, as well as other sources, such as the media and health commissions to provide them with information about units/sites or particular individuals where there may be concerns or 'likely trouble spots'. As the Chief Inspector of COTA from the Office of the Ombudsman in New Zealand responded: *"we've set up quite a good communication process with these NGOs...because you see we get information from the NGOs and like patient advocacy services ...and they tell us what their concerns are"*, which might prompt an unannounced inspection/visit.

Adequacy of resources

A few representatives of the organisations that we spoke to mentioned the inadequacy of the resources at their disposal and how this impacts negatively on their complaints handling/inspection work. They would welcome the opportunity to be more proactive and increase the regularity of visits, but their current limited resources and capacity makes this difficult or impossible. As highlighted by one of the Canadian Ombudsmen: *"We're only 17 people in our office and we cover the entire province and it's all municipal government so we don't really have a lot of resources to be honest with you... we're trying to get funding from the government to have enough people to be able to go and do all of the visits and that type of thing."* Another interviewee from the Office of the Chief Psychiatrist in Victoria, Australia made a similar observation: *"one of the things you need to know is that we're small so if I had twice as many staff I could do twice as much. As long as you know we're restrained by our resources but I'm sure that's not unusual.... The number of actual visits for investigation purposes is very, very small."*

Enforcement powers and sanctions

A number of bodies do have enforcement powers and sanctions to impose on failing units/institutions. Some interviewees, however, felt that a collaborative approach, based on building strong relationships with and respect from providers, as well as other informal methods of persuasion are often perceived to be more effective in influencing practices and, particularly, in bringing about changes to 'culture' – *"even when you've got a stick it is still more effective to try to work collaboratively in the first instance."* For example, the Chief Psychiatrist in Victoria, Australia observed: *"We have powers to direct but I've used those powers once, nearly all the time we can persuade or cajole or add a bit of money here and a bit of love there and try to get things through... It was all done through relationships really... culture was what had to change and that's sort of how we did it by that sort of talking and watching and persuading."*

Other inspection bodies echoed this view. The Principal Community Visitor in South Australia felt that it was crucial for inspectors to develop good working relationships with particular units to enhance the inspection process: *"what we try and do is get them consistency and regularity from our visitors going to the same units so they're not chopping and changing and they do build up relationships and they get to know the staff and the staff get to know them and if there are clients in there for longer periods of time then, that's important as well".* In his view: *"the scheme is not about trying to catch them out, so that if there are any issues or concerns that our community visitors pick up and report back to me then they will be the first ones to know about it, we will give them an opportunity to respond to issues of concern at the earliest possible time that we can do so, and try and resolve it at that level wherever possible."* And one representative

from the New Zealand Office of the Ombudsman (a NPM body) remarked: *“I’ve always found informally is the best. It’s all about prevention, it’s all about fixing stuff. ...it’s not about catching people out and thinking we’re getting brownie points for all the stuff that we find wrong. I’d rather say at the end of the year no it’s been a really good year and the agencies have worked well with us and things that needed to be done have been addressed.”*

Some generic ombudsmen bodies, such as the Nova Scotia Office of the Ombudsman, also recognised the value of *“informal resolution of a complaint”* unless *“the issue is significant and has an impact on a great number of people, it would then*

automatically go up to the Ombudsman’s level.” For many years, the Healthcare Inspectorate in the Netherlands *“has operated on the principle of a ‘soft approach where possible and a hard approach where necessary’, largely relying on authority and trust”* and a range of informal measures, such as consultations, advice and encouragement.⁹ This ‘informal’ resolution approach seems to be preferred by many of the bodies that we spoke to, however, it does make it even more difficult to evaluate the precise impact and effectiveness of their inspection/monitoring work.

Feeding back information and integration with complaints

The relationship between complaints and visits would appear to depend on the type of institution carrying out the visits and its respective role. People undertaking visits may be the same as those who then deal with investigations and complaints in some jurisdictions: *“usually it’s whoever’s picked it up on inspection”*, but in many jurisdictions these roles are kept separate.

It does appear that, in most jurisdictions, the system of complaints is kept relatively distinct from the visit mechanisms. The Ombudsman in New Zealand, as part of the NPM, for example, writes up a report after a visit and this report can include concerns arising from the visit. However, the complaints mandate and NPM visiting mandate is separate. The information from visits will be passed on to the complaints team, but the two are separate. In part this is due to the fact that many complaints mechanisms need to be initiated by the individual rather than the monitoring body.

It also depends on the extent to which the body undertaking the visit is doing that visit in response to a complaint (as would be the approach of an ombudsman, for example), or is carrying out the visit as part of a broader preventive/proactive mandate. The relationship between complaints and visits in the former scenario may be clearer, but challenges then arise as to how to conduct a preventive visit. With respect to the latter type of visit, the challenge is then to identify a procedure whereby concerns picked up during the course of a visit are then fed back into a complaints mechanism.

Confidentiality of complaints

In terms of confidentiality issues relating to the passing on of an individual’s case to a complaints mechanism or to a visiting body, there were a number of approaches adopted. These included those who had initially identified the issue asking the individual expressly if they were happy for the information to be passed along to another agency. However, passing of information between the various statutory bodies was often difficult due to the legislative mandates of the respective bodies.

Convention on the Rights of Persons with Disabilities (CRPD)

As a result of New Zealand’s ratification of the Convention on the Rights of Persons with Disabilities (CRPD) in 2008, the Ombudsman (along with other bodies) took on the role of the independent framework under Article 33(2). Their role is to receive and investigate complaints relating to the implementation of the Convention and they have agreed to focus on, *inter alia*, freedom from torture, cruel, inhuman or degrading treatment. This may prompt a closer relationship between visits and complaints. And there is evidence that the Ombudsman is working closely with other complaints/inspection bodies in New Zealand to identify concerns and channel complaints.

Handling complaints

Complaints tend to be handled in a variety of ways. Often a complaints procedure requires the individual to approach the hospital or

treatment team first, before going on to the hospital administration, health authority and then a body such as an ombudsman. Some ombudsmen have a wider remit that goes beyond mental health. These may be human rights ombudsman or tribunals (as in Ontario, Canada) or Privacy Ombudsman (e.g. Ontario, Canada); Health and Disability Commissions (e.g. New Zealand), Health Care Commissions (Australia) or Mental Health Commissions (Western Australia, Canada, New Zealand); Community or Official Visitors (e.g. Australia); Directors of Mental Health (e.g. Australia); or through District Inspectors (New Zealand) and Chief Psychiatrists (e.g. Australia).

Escalation procedures

If those undertaking the visits pick up on individual cases or concerns, in some jurisdictions there is evidence of an 'escalation procedure', depending on the seriousness of the issue. This can involve, for example, the inspectors ringing the head of the inspection body with concerns post visit, and could follow this up with the ward manager specifically, director of mental health, senior management of the Trust or Chief Executive of the Trust.

After a visit from the Healthcare Inspectorate Wales (HIW), for example, the reviewer will submit a report of their findings to the Chief Executive of the institution, each ward manager and the Mental Health Act Manager. On some occasions (although we were unable to clarify exactly when) the HIW may conduct a visit on the basis of a complaint, received from a variety of different sources. We could not find a formal procedure in place to do so. The visiting scheme is separate from the complaints mechanism, whereby the complainant first raises their complaint with the social services department, which may lead to an investigation and final resolution by an

independent panel. The HIW has said that they 'use the information from all complaints/concerns raised with us to guide our Mental Health Review Service inspection programme'.¹⁰

In some jurisdictions therefore information identified from complaints will form part of a broader picture, which the team can then draw upon when they visit the institution: so self-assessment from the institution itself will be *"triangulated with the information from, for instance, serious adverse incidents that come into us, from complaints, from whistle blowing, from the patient experience reviews and so all of that is looked at in advance and contained in a folder as the central repository to inform the inspectors that's in a folder as the central point of information to inform the inspectors before they go out in inspection, including information in response from the questionnaires from staff or from relatives. When on site, sometimes because of the information, say we obtain from a...serious adverse incident report, sometimes we might drill down further into that incident."*

Similarly, in the Dutch Healthcare Inspectorate system: *"if the complaint indicates a serious problem in the quality of care we will investigate the complaint but we are not there to give the person that complains satisfaction or assess damage or whatever. Basically we use it as information to assess quality of care in an institute."*

Initiating complaints

Often those undertaking the visits only provide information on the complaints system (e.g. patient advocates or rights advisers) and then leave it to the individual to initiate the complaint. However, those undertaking visits, despite informing patients/individuals that they are not a complaints mechanism, can be put in a situation when they have complaints passed

through them: “we nearly always refer them back” and ask the complainants to write directly to the complaints service. For those who undertake visits as part of an ombudsman function, whereby the visit is in response to a complaint (rather than being a proactive visit of a preventive nature), the relationship between the visit and the complaint is clearer. Here the person undertaking the investigation of a complaint may decide that a visit for that individual is necessary. In addition, if many complaints came in from a particular unit, an ombudsman may use this as evidence of the need to initiate an investigation on their own motion.

However, some bodies which undertake a preventive visit (for example, those designated as a NPM under OPCAT), may refer information they have picked up during their visits to the ombudsman office or those who would investigate individual complaints: For example, the Crimes of Torture Act (COTA) division in New Zealand: “will just pass the information onto the other side of the Ombudsman’s office and let them deal with it... as part of their ordinary complaints service ...we quite often get the Human Rights Commission ring us with issues that have gone to them, we frequently point people in the right direction of the Health and Disability Commissioner. No complaint sort of just falls on the floor.” Some visiting bodies do however keep the individual’s concern in the file on the institution, so that when they visit again at a later stage, this is picked up. And the Chief Inspector of COTA at the Office of the Ombudsman in New Zealand highlighted the significance of the complaints process in terms of alerting the inspection body of particular areas of concern/systemic failures: “if we find that there area a number of complaints coming out of somewhere about the same sort of things which indicates some sort of systemic

breakdown then we’ll go in and look at it from a[n OPCAT] perspective.”

Responsibilities of different bodies in different jurisdictions

Because the complaints mechanisms usually require the individual to initiate them, as one interviewee identified, there is a real concern that there may be issues which fall in the gaps between the responsibilities of different complaints/inspection bodies in a particular jurisdiction. For example, in New Zealand: “Unfortunately with them a lot of the stuff that we find isn’t actually covered by their brief so as we’ve sort of said from day one if the [OPCAT] Inspector’s role hadn’t been developed a lot of the stuff we’ve found would continue to go undetected because in some cases it’s not part of the District Inspector’s brief or in other cases the current auditing mechanisms if you like are not just picking that up.” This raises a number of issues: first, that OPCAT may have provided a bridge to address these gaps and, secondly, the need for clear boundaries and allocation of responsibilities, as well as clear channels of communication/joint working protocols.

As another interviewee from Canada said to us: there is a need for “somehow embedded in the monitoring process a better way of collecting that information from the individuals that are using the services so that’s it’s not incumbent upon the individual to have to come forward but there is some kind of a survey, some kind of information gathering process as part of the monitoring from the actual individuals.”

Evaluation and impact

The importance of evaluating the impact/effectiveness of monitoring was recognised by some interviewees. For example, a respondent in Canada opined: *“That’s the key question isn’t it, the organisation is doing the monitoring but it’s how are they doing the monitoring and it’s not just for monitoring sake. And is really the intention to change practice or is it just to report on the violations if there are any? That’s where it becomes so important that there is that loop in the process, that feedback loop, and there’s a mechanism to actually change that process.”*

We could find few examples of formal evaluation of the effectiveness of mental health monitoring, inspections or complaints. It seemed to be more a perception that they were having an impact or not, due to media attention, the extent to which they perceived the relevant authorities to take their recommendations seriously and the media, political or community response. The evidence on which this is based appeared to be rather anecdotal (although important), rather than a systematic approach based on hard data as observed by the Head of the Council of Official Visitors in Western Australia: *“if we didn’t have a body like this there would be many more breaches of [rights], I’m sure of it, and consumers would feel even more disempowered. Council has also had some big successes in improving the conditions on wards.”*

For example, one interviewee observed that their impact is probably assessed *“through the recommendations we make and the dissemination of inspection findings, we can and do influence policy.”*; and another

commented that *“...the Inspector’s report actually it does have an impact, they get picked up by the media when they’re published. In that sense it does have an impact and depending on how it’s used politically, then it sometimes forces the government’s hand to either provide services or not to close services they planned to close and that sort of thing.”*

Another respondent remarked: *“I think [our visits] have a very good impact actually. If approved centres weren’t being inspected I think there would be a likelihood I suppose with any type of scenario where people are the victims of power imbalance, I think there would be a much higher likelihood of abuse of various descriptions.”* And one respondent pointed to some evidence on the ground of a perceived impact: *“I think where we have witnessed restrictive practice, inappropriate restraint and made recommendations regarding staff training, we have noted improvements to care have been made, and care taken on the wards.... I do think an impact can be made by regulation and review and by our method of level of scrutiny and monitoring of mental health and learning disability wards.”*

Some interviewees felt that the degree of respect for the organisation played a crucial factor in legitimising their monitoring work. In the words of the Chief Psychiatrist from Victoria, Australia: *“people have personal respect for us and that means never playing sides, it means being honest, and it means not being swept away by the politics of things.”*

Evaluation methods

Interviewees generally recognised the challenges of evaluating the impact of inspections: *“there are a lot of mechanisms at work that influence quality and it's very difficult to separate the activities of our institution from other influences”,* and the fact that *“[I]ike in mental health in general the outcomes are very slippery.”*

We did find, however, some examples of different types of evaluation. These included some forms of **self-evaluation** through, e.g. the distribution of **anonymous questionnaires** to patients and staff following an inspection: *“they report on it anonymously as to whether they were treated with respect, were they happy with the way they were inspected and so on... so that's one sort of measure.”* The Community Visitors Scheme in South Australia has recently introduced a system to collect follow-up information from patients to find out how useful the visit/meeting was for them. This approach focuses very much on the inspection process, rather than the actual outcomes/impact of the inspection.

Linked to this is seeking **“feedback from service users** and with a lot of initiatives with voluntary organisations, we are doing some joint work with a number of different mental health and learning disability organisations, including the advocacy organisations, so you get some internal feedback from folk you're doing joint work with.” The Chief Psychiatrist in Victoria has highlighted the value of service user feedback in his Annual Report: *“In some instances, however, the office receives direct feedback from a consumer or carer that the complaint has been resolved.”*

Implementing and following up recommendations

One interviewee from the New Zealand COTA NPM monitoring body felt that one useful measure of ‘impact’ was the extent to which recommendations were implemented: *“we're still in the process of developing the best way of measuring prevention and the current focus is on the uptake of recommendations.”* And the Australian Chief Psychiatrist from Victoria responded: *“I don't know how to answer that other than the tracking over time. The annual report tries to track over time the things like ECT and seclusion. I don't think we have another way of saying are you making a difference?”*

In some instances there was no real procedure for follow-up on recommendations. However some jurisdictions did attempt to track the extent to which recommendations they made had been followed: *“the only way we can measure our effectiveness as a preventive mechanism is by now looking at the uptake of those recommendations.”* In some jurisdictions, such as New Zealand, tracking occurred via follow-up visits: *“Every year we pull out the recommendations and look at the ones where something had to be done. ... And I'll be going to a site specifically to see whether they fixed something that they said they would.”*

One Community Visitors' scheme in South Australia has a database of reports/ information on units to identify and track issues: *“when the reports come in our policy officer extracts issues of concern and that goes into a database so that we can identify the number of times that issues such as restraint, seclusion, assault etc has come up within the unit so that we can comment on it in our annual report, that it actually highlights where the complaints come from.”* The reports also seek to highlight

best practice *“where units are doing things really well.”* And another Western Australia visitor scheme representative remarked: *“we continually follow up on issues and also meet with the management of all the facilities on a regular basis. Matters and issues that we haven’t been able to resolve at a lower level and serious systemic issues are raised at those meetings. Ultimately [the Head of the Council of Visitors] will raise issues at a higher level with the Minister for Mental Health and other relevant parties as well. Our Annual Report which must be presented to Parliament is a crucial advocacy tool.”*

One of the Ombudsmen we spoke to from Canada also attempts to track and follow-up recommendations: *“we monitor throughout to ensure that the recommendations that have been accepted are actually implemented and I can tell you (because I did check this) that we’ve only had three recommendations that have been denied.”* This follow-up process can take a variety of forms: *“Some things can be immediate, some things we can monitor them for six months but our staff are required to continuously follow up on those. Those files would be flagged... As a manager I also go through those just in case somebody forgets to go through and I’ll be sending reminders.”*

As the Dutch Healthcare Inspectorate respondent indicated: *“We might do a check by visiting the institution, either announced or unannounced, it depends or we might ask for an audit report. There are different instruments to monitor the implementation.”* In contrast, one of the Chief Psychiatrist Reports in Australia has noted that its *“current database has limited capacity to document or track the outcome of complaints.”*¹²

The extent to which recommendations of visiting bodies can be followed up depends on the type of recommendation being made. If the recommendation related to a particular individual, for example, it may be easier to follow up. For other recommendations, those for example which may require a change in the legislation or policy, follow up is more challenging and may take longer: *“some things can be immediate, some things we can monitor them for six months.”*

One of the challenges raised in following up on recommendations was that the authorities were not necessarily obliged to implement them, as a respondent from the Nova Scotia Ombudsman observed: *“these are recommendations so we can’t force them so we rely on our power of persuasiveness.”*

Tracking complaints

There are many examples where there is no tracking of complaints, with few statistics being gathered on the proportion of complaints overall that relate to mental health. For example, there would appear to be no outcomes-based data to show any causative link between quality indicators and the new complaints mechanisms in New Zealand.¹³ In another jurisdiction, those undertaking the visits acknowledged that it has limited capacity to track or document the outcome of complaints. This may be partly explained by the fact that if the monitoring body is a generic one, they may not tend to be focused on mental health issues specifically (e.g. as with the Health Care Commissions in Australia).

Accreditation

An accreditation process could provide some form of evaluation, but it is voluntary and is not always reported to governments and the information is not necessarily public. And some concerns have been expressed that it is a 'blunt tool'. The RQIA in Northern Ireland has recently applied for external quality accreditation with the EFQM (an independent body that helps organisations to drive improvement through the EFQM Excellence Model, which is a comprehensive management framework). This provides some external scrutiny of their function and there is also, in some cases, some external overview by sponsoring departments.

Rights-based evaluation

We heard comments that some considered there is a need for the evaluation to be

external, rather than self-evaluation, and for this to be based on human rights principles. The CRPD has prompted a number of changes with respect to monitoring in some jurisdictions. For example, in Canada it has increased awareness of the need to promote the rights of patients as well as focusing attention on the need for a monitoring role and a more strategic approach to mental health. In New Zealand, the Ombudsman has recently taken on the role of an independent mechanism with responsibility for protecting and monitoring implementation of the CRPD, in addition to the OPCAT NPM function.¹⁴ The role is shared with two other organisations, and a joint monitoring framework has been developed. This process has served to provide further focus on the rights of disabled people in detention.

Recommendations

Based on the documents we have analysed and the interviews we have conducted, we would propose the following recommendations. The recommendations are subject to two caveats: first, our research was completed within an extremely short time scale and, secondly, the focus of our study was on other jurisdictions, rather than the CQC's own approach. The limited scope and restrictive time frame for the study should therefore be borne in mind in your consideration of the recommendations below. In response to feedback from the CQC, we have included a table at the end of this document which summarises the key functions of the respective bodies identified within each jurisdiction, as they relate to mental health and/or OPCAT monitoring, complaints and healthcare regulation. As we highlighted to you previously, there are some gaps in the table as we weren't able to locate all the relevant information in every jurisdiction in the study.

OPCAT monitoring

Ratification of OPCAT raises a number of obligations, which have a bearing on monitoring within the context of mental health:

- It is crucial to retain the focus on a preventive visiting function – this is particularly imperative in light of OPCAT obligations.
- There is a need to retain independence of the inspection role, in particular, independence of those individuals undertaking the visits, even if this raises difficulties in light of external/political factors and resource constraints.
- We recommend retaining expertise of inspectors or visitors to carry out monitoring visits, to include knowledge of mental health, social work, psychiatry or psychology. It would also be highly desirable to ensure advocacy/service user/carer involvement.
- Training of those undertaking the visits need not be generic, but should involve reference to mental health and human rights issues. Regular and on-going support should be provided to those undertaking the visits.
- There is a need to ensure sufficient frequency of visits and focus on qualitative and quantitative monitoring. On the basis of the research we have conducted, annual visits are perceived to be the minimum required. As the Association for the Prevention of Torture (APT) note an 'effective programme of preventive visits combines periodic in-depth visits and shorter, ad-hoc visits', and what is 'regular' requires repetition and depends on a variety of factors. There should be a consideration of different types of visits, including routine annual inspections, as well as those based on themes, follow-up visits and those responding to particular incidents, concerns or complaints.
- There is therefore a need to maintain a combination of announced and unannounced visits.
- It is advisable to use visit protocols, proformas or standard templates to guide the inspection process and ensure consistency and uniformity of approach. The requirements of OPCAT would seem to promote greater standardization and consistency of approach in this regard.

Mental health monitoring

- Monitoring objectives/ strategy relating to the mental health legislation seemed rather vague and somewhat aspirational in the jurisdictions that we looked at for our study. For example, one body's strategy is to provide 'optimal safeguards for all users of mental health and learning disability services'; another aims to 'ensure that those detained under the Mental Health Act have a voice and are supported and empowered as far as possible to make decisions'; and other examples of objectives include 'promoting welfare and safeguarding [patient] rights' or 'to protect the interests of all people who use mental health services'. In order to promote good practice, we would suggest a need for organizations to align their mental health monitoring objectives relating to the detention of patients more specifically with the NPM obligations under OPCAT and focus on ensuring: frequency, independence, expertise and the preventive nature of visits, as well as reflecting other human rights obligations, for example under the ECHR and CRPD.
- It is crucial to maintain regular private meetings with individual patients to capture their experiences of detention and their views on the conditions, quality and standards of care. It is also helpful to capture patient voices in advance of formal visits to help focus on areas of concern during the visit e.g. via patient experience reviews and informal discussions with patients or questionnaires to patients in advance of the visit. This approach was perceived to be particularly beneficial in highlighting issues of concern to the Inspectors in some jurisdictions in the study and would help to bolster the duty in s.120 of the Mental Health Act 1983 to visit and interview relevant patients.
- Additionally, it has been found to be helpful for independent visitors or inspectors to liaise with community visitors or advocates (at individual institutions as well as more generally with advocate groups/services) as a means of acquiring useful intelligence about the conditions or standards of detention and experiences of detained patients. Advocates or community visitors tend to have frequent and direct contact with patients, often on a weekly/monthly basis. Detained patients would seem to value the opportunity to speak to an independent visitor on a regular basis. Liaising with community visitors or advocates offers a valuable opportunity to gather insights and useful information about the day-to-day experiences of detained patients. However, there is a need to treat the information received in this way with caution and seek supporting evidence, as it is not always reliable. Nor should it replace professional expertise, but could augment a more formalized and less frequent visiting regime.
- It is important to involve carers/relatives in the inspection process and capture their views in addition to those of others, particularly for vulnerable detained patients who may lack capacity or those who may be subject to the DoLS provisions. Relatives/family members who are visiting on a daily or weekly basis can also be a useful source of information to monitors/inspectors about daily life at the unit and the conditions/standards of care.
- Maintaining a good relationship with relevant NGOs can also provide a useful source of information to independent monitors.
- It is important to ensure that human rights principles/considerations are

informing and influencing the day-to-day work of **all** inspections/visits. Also, where there are different bodies or individuals with responsibility for carrying out the visits, handling complaints and devising a strategic approach, it can be confusing and frustrating for patients/service users. It would offer greater clarity to adopt a combined approach, however the challenge is to ensure that a distinct approach/focus on mental health monitoring is maintained within that.

- Some organisations are prepared to offer informal advice, support, guidance or examples of good practice to providers to assist with service improvement and compliance. This is particularly helpful to providers/institutions as it provides valuable benchmarks to assist with implementing service standards and legislation.
- The monitoring role should be seen as encompassing not only visiting but also informal information gathering or intelligence, receipt of and responding to complaints, and a strategic approach. There is a need here to ensure that there are regular meetings between relevant departments; joint-working protocols or memorandums of understanding; frequent and clear communication with all stakeholders and appropriate staff training/awareness.

Complaints mechanisms

- It is crucial that monitoring encompasses a proactive as well as a reactive approach: complaint mechanisms tend to be reactive and patient/service user led – and there needs to be a coherent way to link the visiting function with the complaints mechanism.

- Where there is separation of complaints investigation and monitoring, there are concerns that some issues may fall within the gaps. Consequently, it is vital to ensure that there are clear boundaries and allocation of responsibilities, as well as clear channels of communication/ joint working protocols between those undertaking the complaints and visiting functions respectively. In that sense, it would seem sensible to integrate the complaints process within the monitoring framework to enable effective follow up, information gathering and targeted monitoring. There is evidence that where there is some linkage, the information about complaints which may reveal systemic or significant issues can be used to inform the broader picture, which the visiting/inspection team can then draw upon when they visit the relevant institution/s.
- It would be useful to identify how concerns picked up during visits can be fed into a complaints process, which does not necessarily rely on the individual concerned initiating it.

Evaluation and follow-up

Although there are significant challenges to evaluation and impact of the visiting and monitoring functions generally, the following tentative recommendations can be made:

- There are a number of forms of evaluation that have been and could be used. However, on their own they may not provide a comprehensive form of evaluation, as they tend to evaluate different issues and each has its own limitations. Therefore, a combination of evaluation methods would seem to be appropriate.

- Some jurisdictions used anonymous questionnaires as a form of evaluation and these provided some useful input from staff and patients/service users about the impact of the inspection process.
- Evaluating the extent to which findings are picked up by the media may also be another form of evaluation.
- Accreditation by external bodies, such as the European Foundation for Quality Management (EFQM) Excellence Model may be useful, but should not be considered as comprehensive.
- There should ideally be some form of external evaluation and, particularly, an evaluation based on human rights principles.
- It is also helpful to build in some form of follow-up to verify compliance of recommendations by the institution and adequate recording of that information. It may be useful to separate out those recommendations which are easier to implement (e.g. if it related to a particular individual/ local concern/issue) and those that may be more strategic or systemic (such as requiring a change in legislation or policy). Different timelines and ways of tracking progress could be devised for each recommendation. This information could be made public, where possible, and can be highlighted in the annual report of the organisation.
- A number of methods can be used to follow-up recommendations, including following-up specific issues on further visits; keeping a database of reports or concerns; asking for audit reports; and keeping statistics on complaints and the extent to which recommendations have been implemented.
- Several bodies in the study recognized the value of utilizing informal mechanisms of enforcement – often perceived to be far preferable to (and perhaps more effective than) formal sanctions. It is important to develop and nurture informal personal relationships between those doing the visits and those on the ground – both staff and patients/service users. This will help to promote consistency of visiting as well as in-depth knowledge and awareness of the issues at particular institutions.
- It is crucial to build strong relationships, credibility and respect from staff and service users to achieve the monitoring mandate. This is enhanced by regular visiting and continuity of personnel, as well as the expertise/experience of the inspectors. Those carrying out the inspections are more likely to command respect and trust, which in turn may assist with co-operation and compliance, where they have appropriate knowledge and take time to develop relationships with staff and patients/service users. However, it is also important for inspectors/monitoring bodies to be aware of the risks of ‘regulatory capture’ in this regard.

Table 1: Overview of monitoring/complaints/regulatory bodies and key functions

	Statutory Mental Health Act Monitoring	OPCAT Designated NPM	Complaints	Integrated healthcare regulator	Separate healthcare regulator	Provision of informal advice/guidance
Scotland	✓ (MWC)	✓ (MWC)	✓ (MWC)		✓ (HIS)	✓
Wales	✓ (HIW)	✓ (HIW)	✓ (HIW)	✓ (HIW)		✓
Northern Ireland	✓ (RQIA)	✓ (RQIA)	✓ (RQIA)	✓ (RQIA)		✓
Republic of Ireland	✓ (MHC: Inspectorate of Mental Health Services)		✓ (MHC)	✓ (MHC: mental health)	✓ (HIQA)	✓
New Zealand	✓ (DI)	✓ HRC & Ombudsman	✓ (H & DC)		✓	✓
Canada			✓ Provincial Ombudsmen		? (voluntary accreditation)	
Australia			✓ (CP)		✓ (Healthcare Commissions/CP)	✓ (+ visitors)
Holland		✓ (HI)	✓ (HI)	✓ (HI)		✓
Denmark		✓ Generic ombudsman	✓ (Patient Complaints Board)		✓ (National Board of Health)	✓
Sweden		✓ Generic ombudsman	✓ Generic ombudsman		✓ (Board of Health and Welfare)	✓

Abbreviations:

CP: Chief Psychiatrist

DI: District Inspectors

HI: Healthcare Inspectorate

HIS: Healthcare Improvement Scotland

HIQA: Health Information and Quality Authority

HIW: Healthcare Inspectorate for Wales

HRC: Human Rights Commission

H&DC: Health and Disability Commissioner

MHC: Mental Health Commission

MWC: Mental Welfare Commission

RQIA: Regulation and Quality Improvement Authority

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3. Department of Health Victoria, *Chief Psychiatrists Annual Report 2010-11* (June 2012) at p. 7.
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13. R. Paterson, *The Patient's Complaints System in New Zealand* (2002) 21(3) *Health Affairs* 370-379.
14. *New Zealand Ombudsman Report for 2011-12* pp. 57-58.

Appendix: Further points on OPCAT

As noted above, OPCAT has provided some jurisdictions with a more structured approach to visits as well as a broader human rights framework in which to conduct its monitoring work more generally. This is also underscored by developments under the Convention on the Rights of Persons with Disabilities (CRPD) and whether the institution is also designated as the independent framework under that Convention.

The CRPD has prompted a number of changes with respect to monitoring in some jurisdictions. As noted above, the CRPD can provide a useful tool in which to frame issues from a human rights perspective. In addition, with respect to the practicalities of monitoring, designation as an Article 33(2) body requires it to monitor implementation of the Convention. Article 16(3) of the Convention provides: 'In order to prevent the occurrence of all forms of exploitation, violence and abuse, States Parties shall ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities.' The combination of these two provisions has led some to argue that Article 33(2) framework bodies should be monitoring places of detention in respect of disability and mental health issues. This raises a number of issues, (particularly for our context) the potential duplication of roles with those designated under OPCAT, given that there are very few bodies which are designated under both OPCAT and the CRPD. Although these matters do not yet appear to have been given detailed consideration in the UK, they do warrant further thought on how to manage co-ordination between the relevant institutions.

OPCAT specifically requires the following which may be of particular relevance to undertaking visits to mental health institutions or other places where individuals may be deprived of their liberty where mental health issues arise:

Article 18(2) provides: 'the States Parties shall take the necessary measures to ensure that the experts of the national preventive mechanism have the required capabilities and professional knowledge. They shall strive for a gender balance and the adequate representation of ethnic and minority groups in the country'.

Article 19

The national preventive mechanisms shall be granted at a minimum the power:

- (a) To regularly examine the treatment of the persons deprived of their liberty in places of detention as defined in article 4, with a view to strengthening, if necessary, their protection against torture and other cruel, inhuman or degrading treatment or punishment;
- (b) To make recommendations to the relevant authorities with the aim of improving the treatment and the conditions of the persons deprived of their liberty and to prevent torture and other cruel, inhuman or degrading treatment or punishment, taking into consideration the relevant norms of the United Nations;
- (c) To submit proposals and observations concerning existing or draft legislation.

Article 20

In order to enable the national preventive mechanisms to fulfil their mandate, the States Parties to the present Protocol undertake to grant them:

- (a) Access to all information concerning the number of persons deprived of their liberty in places of detention as defined in article 4, as well as the number of places and their location;
- (b) Access to all information referring to the treatment of those persons as well as their conditions of detention;
- (c) Access to all places of detention and their installations and facilities;
- (d) The opportunity to have private interviews with the persons deprived of their liberty without witnesses, either personally or with a translator if deemed necessary, as well as with any other person who the national preventive mechanism believes may supply relevant information;
- (e) The liberty to choose the places they want to visit and the persons they want to interview;
- (f) The right to have contacts with the Subcommittee on Prevention, to send it information and to meet with it.

Article 21

1. No authority or official shall order, apply, permit or tolerate any sanction against any person or organization for having communicated to the national preventive mechanism any information, whether true or false, and no such person or organization shall be otherwise prejudiced in any way.
2. Confidential information collected by the national preventive mechanism shall be privileged. No personal data shall be published without the express consent of the person concerned.

Article 22

The competent authorities of the State Party concerned shall examine the recommendations of the national preventive mechanism and enter into a dialogue with it on possible implementation measures.

Article 23

The States Parties to the present Protocol undertake to publish and disseminate the annual reports of the national preventive mechanisms.

These provisions have been further elaborated by the UN Subcommittee on Prevention of Torture, established under OPCAT, through its *Guidelines for National Preventive Mechanisms*.^{*} Relevant provisions are as follows:

11. The necessary resources should be provided to permit the effective operation of the NPM in accordance with the requirements of the Optional Protocol
12. The NPM should enjoy complete financial and operational autonomy when carrying out its functions under the Optional Protocol.
13. The State authorities and the NPM should enter into a follow-up process with the NPM with a view to the implementation of any recommendations which the NPM may make.
14. Those who engage or with whom the NPM engages in the fulfilment of its functions under the Optional Protocol should not be subject to any form of sanction, reprisal or other disability as result of having done so

^{*} CAT/OP/12/5, 9 December 2010, available on <http://www2.ohchr.org/english/bodies/cat/opcat/mechanisms.htm>.

15. The effective operation of the NPM is a continuing obligation. The effectiveness of the NPM should be subject to regular appraisal by both the State and the NPM itself, taking into account the views of the SPT, with a view to its being reinforced and strengthened as and when necessary.
20. Recalling the requirements of Articles 18 (1) and (2) of the Optional Protocol, the NPM should ensure that its staff have between them the diversity of background, capabilities and professional knowledge necessary to enable it to properly fulfil its NPM mandate. This should include, *inter alia*, relevant legal and health-care expertise.
25. The State should ensure that the NPM is able to carry out visits in the manner and with the frequency that the NPM itself decides. This includes the ability to conduct private interviews with those deprived of liberty and the right to carry out unannounced visits at all times to all places of deprivation of liberty, in accordance with the provisions of the Optional Protocol.
26. The State should ensure that both the members of the NPM and its staff enjoy such privileges and immunities as are necessary for the independent exercise of their functions.
27. The State should not order, apply, permit or tolerate any sanction, reprisal or other disability to be suffered by any person or organisation for having communicated with the NPM or for having provided the NPM with any information, irrespective of its accuracy, and no such person or organisation should be prejudiced in any way.
28. The State should inform the NPM of any draft legislation that may be under consideration which is relevant to its mandate and allow the NPM to make

proposals or observations on any existing or draft policy or legislation. The State should take into consideration any proposals or observations on such legislation received from the NPM.

29. The State should publish and widely disseminate the Annual Reports of the NPM. It should also ensure that it is presented to, and discussed in, by the national legislative assembly, or Parliament. The Annual Reports of the NPM should also be transmitted to the SPT which will arrange for their publication on its website.

Points for NPMs

30. The NPM should carry out all aspects of its mandate in a manner which avoids actual or perceived conflicts of interest.
31. The NPM, its members and its staff should be required to regularly review their working methods and undertake training in order to enhance their ability to exercise their responsibilities under the Optional Protocol.
32. Where the body designated as the NPM performs other functions in addition to those under the Optional Protocol, its NPM functions should be located within a separate unit or department, with its own staff and budget.
33. The NPM should establish a work plan/ programme which, over time, encompasses visits to all, or any, suspected, places of deprivation of liberty, as set out in Articles 4 and 29 of the Optional Protocol, which are within the jurisdiction of the State. For these purposes, the jurisdiction of the State extends to all those places over which it exercises effective control.
34. The NPM should plan its work and its use of resources in such a way as to

ensure that places of deprivation of liberty are visited in a manner and with sufficient frequency to make an effective contribution to the prevention of torture and other cruel, inhuman or degrading treatment or punishment.

35. The NPM should make proposals and observations to the relevant State authorities regarding existing and draft policy or legislation which it considers to be relevant to its mandate.
36. The NPM should produce Reports following their visits as well as produce an Annual Report and any other forms of Report which it deems necessary. When appropriate, Reports should contain recommendations addressed to the relevant authorities. The Recommendations of the NPM should take account of the relevant norms of the United Nations in the field of the prevention of torture and other ill-treatment, including the comments and recommendations of the SPT.
37. The NPM should ensure that any confidential information acquired in the course of its work is fully protected.
38. The NPM should ensure that it has the capacity to and does engage in a meaningful process of dialogue with the State concerning the implementation of its recommendations. It should also actively seek to follow-up on the implementation of any recommendations which the SPT has made in relation to the country in question, liaising with the SPT when doing so.