International Ombudsman Institute
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GIVING VOICE TO MENTAL HEALTH PATIENTS

SHINING THE LAMP OF SCRUTINY ON THE INVOLUNTARY DETENTION OF PEOPLE WITH MENTAL ILLNESS*

IOI Best Practice Paper – February 2021

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Acknowledgement: Mary Marshall, Counsel to Meadows Law, for suggesting the topic, providing many of the ideas and helpful comments.

Subtitle Remark: *“*Shining the lamp of scrutiny*” is a phrase used in 1969 by Chief Justice J.V.H. Milvain in an Alberta court decision that confirmed the jurisdiction of the Ombudsman’s office for the first time in Canada. Later, the Supreme Court of Canada quoted Justice Milvain when further confirming the role of Ombudsman offices.

Introduction

Responsible democracies endeavour to treat all citizens fairly, regardless of their social or economic positions. Nevertheless, some citizens can be left behind, as two Canadian provincial Ombudsman found in 2019 after conducting independent own motion investigations. They looked at the treatment received by people involuntarily detained in psychiatric facilities or required to take medical treatment after being diagnosed with a mental disorder. The best practices described in this paper are based on Canadian experience, but it is anticipated most apply universally. Many countries share similar processes when admitting and detaining patients in psychiatric facilities. The findings of several papers published in academic journals suggest the unfairness found in Canada exists in other jurisdictions.[1]

This paper has two related purposes. Firstly, it describes how Ombudsman institutions can design investigations that protect the rights and interests of disadvantaged groups, consistent with the 12th International Ombudsman Institute's World Conference theme of "Giving voice to the voiceless." Secondly, this paper furthers the goal identified by the Special Rapporteur in a 2017 United Nations report that calls for an open dialogue aimed at developing guidelines to support all stakeholders in the implementation of rights-based mental health policies.[2]

In the beginning of Ombudsman practice, many offices adopted a purely reactive response to complaints. At the time, this was often sufficient to create meaningful systemic changes. This paper argues that today's Ombudsman need to adopt a proactive approach by seeking opportunities to look at the needs of groups who otherwise might remain voiceless. If an Ombudsman does not accept this responsibility, no one else may address this unfairness. Waiting for the right complaint to be made is not enough because marginalized groups lack the resources and may not come forward on their own. Court action is another potential remedy that has value. Unfortunately, it is a costly, time-consuming, legal process that infrequently addresses these needs.

[1] For references to these papers, see footnotes 16-22.

[2] Dainius Puras, Special Rapporteur, Committee on Economic, Social and Cultural Rights, "Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health," March 28, 2017. A/HRC/35/21. Report to the United Nations General Assembly, June 6-23, 2017. Agenda item 3. Available at: https://undocs.org/A/HRC/35/21.

The coronavirus disease pandemic makes this paper more timely because the fact that detained mental health patients are housed in institutions means that they are at increased risk for COVID-19.[3]

Historical approach

The expansion of Ombudsman services in Canada and internationally in the 1960s and 1970s aimed to protect citizens' rights during an era of rapid expansion of government programs and services.[4] The Alberta Ombudsman, the oldest Parliamentary Ombudsman office in North America, began accepting complaints in 1967.[5] The first Ombudsman, George McClellan, invented his own standard for judging the initial cases he investigated. As he explained it, he viewed complaints "through the eyes of a reasonable man, not necessarily versed in the intricacies of formal law."[6] In other words, the standard of fairness he applied was common sense. His approach worked in an earlier era.

But administrative law and practices have evolved during the past 50 years. Common sense has not been forsaken, but what it consists of remains a matter of interpretation. In today's context, public servants often believe they act in practical ways that respect law and human rights. When an Ombudsman finds reasons to disagree with public servants' perspective, altering their perception requires more than common sense. Arguing the merits or the rights and wrongs of a decision invites resistance. A more convincing approach is to cite accepted administrative principles as the basis for believing a decision-making process requires change.

The beginning of Ombudsman practice seems like a simpler time. McClellan applied common sense based on his personal experience. He waited for complaints to be made. All he had to do was be receptive.

[3] Harris, L. America's Psychiatric Facilities Are 'Incubators' for COVID-19. Mad In America: April 19, 2020. Available at: https://www.madinamerica.com/2020/04/americas-psychiatric-facilities-incubators-covid-19/ and Dickson, EJ. The Coronavirus Crisis in the Psychiatric Ward. Rolling Stone: April 13, 2020. Available at: https://www.rollingstone.com/culture/culture-features/psych-units-coronavirus-covid-19-980461/.

[4] Lindquist, E. "Eras of Reform" table, presented at "Symposium: Future of Parliamentary Ombudsman," Victoria, British Columbia, June 2019.

[5] For an overview of Ombudsman offices in Canada, see Marshall, M.A., Reif L.C. The Ombudsman: Maladministration and Alternative Dispute Resolution, 1995 CanLIIDocs 188. Available at: https://www.albertalawreview.com/index.php/ALR/article/view/1108#:~:text=The%20authors%20seek%20to%20highlight,is%20justified%20in%20a%20dispute.

[6] Alberta Ombudsman annual report for 1968, page 12.

Before accepting the challenge of becoming the first Ombudsman, McClellan served as head of Canada's national police force. One may have expected him to be unsympathetic to the plight of violent offenders. However, that proved not to be the case. Mental health complaints immediately became a priority for McClellan. In September 1967, his inaugural investigation was a complaint from a convicted murderer who, after being locked up for more than 14 years, almost entirely in psychiatric hospitals, was denied access to a review panel to assess his present mental state.[7] Using his common sense approach, McClellan quickly got to the merits of the complaint. He found the person's rights could be restricted depending on which jail he was sentenced to. McClellan wrote:

> I deemed this situation to be discriminatory on the grounds that a person's right to appeal should not be dependent upon which gaol [jail] a court had by its sentence, committed him to as a result of a criminal conviction. In such a circumstance the difference in sentence of only one day could deprive a man years later of his right to appeal against certification as a mental patient.

The government of the day accepted McClellan's argument and the superintendent of the hospital was directed to "certify" the man, allowing him to apply for a review.

In his second annual report, McClellan reported he received numerous complaints from people found not guilty by reason of insanity for violent offences and detained in mental hospitals without the opportunity for review. In one case, a man was found not guilty by reason of insanity of murdering his niece in 1938. He was still incarcerated in a mental health hospital in 1968 even though he was found to be no longer psychotic in April 1946, 21 years earlier.[8] He had been allowed some liberties, such as day releases. McClellan devoted 29 pages of his annual report to this one case. He not only secured the man's release, but he also fought for a permanent pension and other financial assistance, which were reluctantly granted. McClellan felt so passionately about the unfair treatment this man had received, he attended his funeral when the man died of cancer soon after his release.

In 1967, McClellan was able to create change because his new institution attracted the attention of a sympathetic press. The first cases were sensationally unfair based on their merits, demanding the

[7] Alberta Ombudsman annual report for Sept. 1 to Dec. 31, 1967, case 67-130-17.

[8] Alberta Ombudsman annual report for 1968, case 68-110-36.

attention of the public and the government, thereby resolving the case for the individual. The resulting publicity ensured a similar injustice would be corrected for anyone else in the system.

While McClellan's methods may still work in some situations today, traditional media is no longer as pervasive, which makes it a less effective ally. Often in today's world the issues are more subtle, which makes it more difficult to explain in news reports. The old ways need to be supplemented.

Addressing today's needs

In 2019, Ombudsman from two Canadian provinces coincidently published own motion reports about the same disadvantaged group, involuntarily detained mental health patients.[9] Fortunately, Canadian Ombudsman institutions have the ability to conduct own motion investigations, a privilege not universally shared by Ombudsman offices in all countries. Article #16 of the Venice Principles declares that the ability to launch an investigation on the Ombudsman's own initiative is fundamental to the Ombudsman role. Initially, an own motion was conceived as a way to allow an Ombudsman to address a specific instance of injustice, rather than as a tool to identify broad rights-based concerns, such as were suspected at the outset of these investigations. The 2019 reports were written from a modern perspective, focusing on systemic unfairness, rather than the merits of individual cases. While the Venice Principles suggest Ombudsman without own motion powers may be at a disadvantage, systemic change can be achieved from investigations into complaints received. The Alberta experience is that applying the same modern concepts of rights and fairness to complaints received often results in recommendations that are as effective as own motions.

In its published finding, entitled *Committed to Change*, British Columbia reported that approximately 15,000 people are detained for mental health treatment annually. In its report, called *Treating people with mental illness fairly: Report on Mental Health Review Panels*, Alberta did not publish the number of admissions, but Alberta Health Services put the number at 12,265 for 2018/19. Therefore, a total of about

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[9] These two reports include: Chalke, J. *Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act.* British Columbia Office of the Ombudsperson: Victoria. March 2019. Available at: https://bcombudsperson.ca/assets/media/OMB-Committed-to-Change-FINAL-web.pdf; and Alberta Ombudsman. *Treating people with mental illness fairly: Report on Mental Health Review Panels*. Alberta Ombudsman: Alberta, Canada. June 2019. Available at: https://www.ombudsman.ab.ca/wp-content/uploads/2019/06/2019June17-Treating-people-with-mental-illness-fairly.pdf.

27,000 people are detained each year in the two provinces which have a combined population of about 9.4 million. This substantial number of people can be identified as a marginalized group because one or more physicians have deemed it necessary to admit them involuntarily to protect themselves or others.

British Columbia: Committed to change

Protecting a marginalized population motivated British Columbia Ombudsperson[10] Jay Chalke to investigate.[11] He pointed out that involuntary admission is an extraordinary situation where a patient's fundamental freedom is taken away. At the outset, he was satisfied that health-care professionals are conscientious in their efforts to medically treat people with mental disorders. He accepted that any consequential failure to protect a patient's legal rights would not be a result from a lack of medical commitment by these professionals. Rather, he concluded that the emphasis was on medical treatment and not the importance of patients' legal rights.

Some of British Columbia Ombudsperson's findings were:

1. Form 4 must be filled out by a physician who describes the reasons for admission. If detained for longer than 48 hours admission must to be confirmed on another Form 4 based a second assessment by a second physician . The compliance rate for placing a Form 4 on the patient files was good at 99%. However, the quality of the forms was poor. Numerous forms failed to include reasons that would provide health administrators with cause to detain the patient. An example of an inadequate reason would be a patient being described as having poor judgment or as being agitated. Such reasons do not provide evidence that the person should be deprived of their liberty.

2. Form 6 is required a month after detention and after further examination. Its purpose is to decide if the patient's detention should continue. Numerous examples provided no reasons for believing that discharging the patient put the patient or public at risk.

[10] Many Canadian jurisdictions, including British Columbia, use the term Ombuds or Ombudsperson. Alberta retains the word Ombudsman.

[11] Committed to Change, 2019, p 3.

3. Form 5 is about the psychiatric treatment the patient is to receive. It is completed by either the patient or the director of a facility on the patient's behalf. It should clearly describe a patient's proposed course of treatment and allow them to make an informed decision about whether to seek a second opinion if they disagree. It is important to note that in British Columbia, a capable, involuntary patient has no right to refuse psychiatric care. Form 5 was included in 76% of patient files across British Columbia and as low as 9% in one hospital where the resident psychiatrists concluded it was not needed, even though it is a statutory requirement. The Ombudsperson's investigation found that even where the form existed, nearly all the treatment descriptions were vague and meaningless. Sixteen facilities filled out the section by using a rubber stamp that described generic treatment. Even when the patient signed Form 5, it was unclear what the patient agreed to since the treatment was rarely adequately described. It was also found that in some cases when the director signed for the patient, the director was also the treating physician, which is a conflict of interest.

4. Form 13 informs involuntary patients of their rights under Canadian and provincial law. These rights must be read out loud to the patient and provided in writing using the prescribed form on admission and at other specified times. Form 13 informs patients of their right to contact a lawyer and how to exercise that right. The patient is also told of their right to appeal to the Mental Health Review Board. Although required in all cases, only 49% of patient files contained Form 13. Most of the Form 13s that did exist were not signed at the time of admission as required, but filled in days later.

5. Form 15 allows a patient to nominate a person to receive information about their admissions, discharge and requests for review. Form 16 requires the hospital to confirm the person nominated has been informed of the patient's admission. The purpose of the two forms is to involve someone who can support the patient. If a relative is not nominated by the patient or identified by the director, the director is to inform the Public Guardian and Trustee. Form 15 was present in 43% of patients' files, and Form 16 was present in 32%.

Overall, the British Columbia Ombudsperson found all five required forms were completed only 28% of the time. Presence of the forms is only part of the equation. Their mere existence fails to reflect the fact

that few of the forms were properly completed or not completed within required time limits. Chalke wrote:

> The poor compliance rates appear to reflect a prevailing view that completing the forms is secondary to providing psychiatric treatment…. To the contrary, ensuring that involuntary admissions are legally sound… helps to ensure that those who desperately need treatment receive it in a timely way.[12]

Having identified the problem, Chalke pointed out that there is little oversight to ensure compliance with the legal requirements. One of his recommendations, which was accepted by the government, was that compliance be audited in the future. He also recommended the establishment of an office that would advocate for patients. Overall, Chalke made 24 recommendations for change.

When choosing a path to address systemic unfairness experienced by disadvantaged groups, it is important to select an achievable target. British Columbia opted for a narrow administrative practice—whether necessary paperwork was completed. Seemingly mundane, missing forms on patients' files may have seemed an inconsequential topic in the imagination of the public or government 50 years ago, but Ombudsman institutions increasingly realize administrative processes matter. British Columbia could have opted for a broader topic such as whether people should be detained involuntarily or whether the Mental Health Act appropriately protects people. If the parameters had been set that broadly, their investigation might still be continuing. In the end, they might have achieved less. In complex systems, fundamental change is usually evolutionary. A system can only absorb so much at one time. Achievable recommendations are more likely to be embraced by health-care workers. While restricted to administrative practices, the British Columbia Ombudsperson's findings still drew attention to the rights of mental health patients and to the need to focus on legal as well as medical criteria.

Alberta: Treating people with mental illness fairly

Similar to British Columbia, Alberta proceeded to an own motion investigation without a specific complaint. It had received complaints from individuals in the previous few years about the fairness of the

[12] Committed to change, 2019, p 73.

mental health review panel process. In 2013 and 2014, the Alberta Ombudsman made recommendations for improving the fairness of appeals by patients to mental health review panels. Recommendations arising from those investigations had been accepted by the review panel chairpeople. However, when new complaints were received, subsequent investigations cast doubt on the full implementation of the recommendations.

By opening an own motion investigation with the Minister and Deputy Minister of Health, Alberta Ombudsman Marianne Ryan placed herself in the position where she could make recommendations beyond the review panels. The investigation was addressed to the authorities responsible for appointing the review panel members and for administering the overall health-care system. Ultimately, Ryan made nine recommendations, all of which were accepted in principle by the Minister of Health. An informal progress report from the Ministry has provided assurance that work on implementing the recommendations continues.

Alberta review panels not only consider the admission and detention of patients in psychiatric facilities but also the treatment decisions and the validity of community treatment orders. Physicians may also apply to a review panel for a treatment order if the patient refuses treatment.

The principal findings by the Alberta own motion investigation in relation to the review panels were:

1. Although Alberta law gives patients the right to know the content of the certificates that detained them and their rights to appeal, patients were not fully informed. The Ombudsman pointed out the Alberta Mental Health Patient Advocate had attempted to draw attention to this problem for years. The advocate estimated 45% of its work dealt with this issue. It is the responsibility of hospital administrators, not the advocate, to provide the information. Without knowing the content of the certificate or their right to appeal, patients could not effectively appeal to the review panel.

2. Patients were not given the legally required notice of review panel hearing dates 11% of the time. Patients have the right to waive the time limit for notice of the hearing, but they were often not asked if they wished to waive the time limit. There was no form of documentation recording the patient's wishes.

3. In cases where the review panel did not hold a hearing within the legally required time limit, no reasons were provided.

4. Patients may appeal a review panel decision to a court of law within 14 days. Decisions are issued on the day of the hearing with the requirement that review panels follow with written reasons in a matter of days. The Ombudsman pointed out that if reasons are not issued within a week, it becomes difficult for the patient to form the intent to appeal within 14 days. The Ombudsman investigation found that in 27% of the cases, it could not be determined when the reasons were forwarded to the patient. Further, in 25% of the cases that were dated, reasons were rendered beyond eight days, meaning a patient's ability to appeal was severely impaired.

5. Patients have the right to be represented at review panel hearings by a lawyer. The investigation could not determine how consistently patients were told of this right as it was not documented. One of the three regions in Alberta took a more proactive approach, requiring patients to acknowledge via a handwritten checkbox that they were informed of their right to legal counsel. This practice dramatically increased the percentage of patients who were represented by lawyers. In one region, duty counsel attended all review panel hearings, guaranteeing some level of representation. However, this did not happen in two regions, resulting in much less legal representation.

6. While administrators and the review panel share a responsibility to inform patients they may see their medical records, review panels do not ask patients if they know of this right. The pamphlet given to patients by the health-care facilties did not inform them of this right, although the Mental Health Patient Advocate noted it in one their pamphlets. Particularly in cases with patients representing themselves, it would be difficult to adequately prepare without seeing medical records.

7. When there is a dissenting opinion on a review panel, the reasons for dissent are not included, which is a disadvantage for patients on appeal.

Complimentary investigations

The two provincial Ombudsman investigations are complementary because they look at different aspects of the admissions and detention process. British Columbia looked at actions taken by health-care professionals and administrators in the admitting centres. However, it did not comment on the appeal process available to patients, other than to say that the mental health review panels did not have the jurisdiction to review and criticize the actions of the administrators who admitted the patients. The Alberta Ombudsman's own motion investigation looked only at the review panels.

Neither provincial Ombudsman examined the underlying legislation that authorizes involuntary treatment or with the formal policies to comply with the legislation. Rather, they looked at breakdowns in the application of the rules. In the British Columbia example, unfairness stemmed from existing legal protections being ignored. This was shown by health authorities' failure to administer required forms. A common element of modern investigations illustrated by both Canadian cases is that unfairness may be committed by conscientious health-care workers. While unfairness has to be identified, both provinces presented their findings in a tempered way, aimed at achieving the best resolution. Sensational stories bring good results in some circumstances, but how findings are presented should match the context.

Both cases illustrate the power of own motion investigation aimed at protecting vulnerable, disadvantaged people who are the least likely to bring forward a complaint that will address their needs. Relying on a single individual complaint may not address underlying problems. While Canadian Ombudsman institutions are granted the authority to conduct own motion investigations, having the authority is only good if it is exercised. In this regard, Alberta may not represent the best example. In hindsight, Alberta might have served patients better if it had investigated earlier. Hints had been received from advocacy organizations that problems existed, but no complaints came in the door until 2013. The Ombudsman investigated then, but as noted elsewhere the results failed to fully address the systemic unfairness.

Role of the court

As previously mentioned, an Ombudsman should seek opportunities to give voice to disadvantaged groups because no one else may be able to address the unfairness. Advocacy groups and other regulatory groups play important roles, but rarely, if ever, do they have the Ombudsman's investigative powers. Court scrutiny occurs, but access to courts is limited due to cost. Also, court decisions may not be delivered in a timely fashion. Coincidently, one month after the Alberta Ombudsman findings were released, in July 2019, an Alberta court independently confirmed many of the problems identified.[13] Four years earlier, in May 2015, Justice K.M. Eidsvik initially cancelled the admission certificate of an individual, whom she referred to as JH. At that time, she overturned a review panel decision that was held six months after JH was admitted in September of 2014. Fortunately, JH could access legal aid. In 2019, Justice Eidsvik considered whether JH's rights under the *Canadian Charter of Rights and Freedoms* had been breached. In an extraordinarily comprehensive decision, she concluded they had in the following ways:

- His admission certificates were incomplete and did not adequately provide the legal authority to detain him;
- He was not provided written reasons for his detention;
- He was not advised of his right to free legal advice;
- He was treated with medication not medically required without his consent; and
- The review panel process was not fair, as JH did not know the case against him because he was not provided information.

Many of Justice Eidsvik's rulings were congruent with the Ombudsman's findings. Adequate reasons are frequently not provided to patients on admission to hospitals. They are not informed of their rights to legal counsel and not provided information needed on which to base an appeal. She stated patients have the legal right to a fair judicial process and concluded the process JH was subjected to was unfair.

Justice Eidsvik went further than the Ombudsman when she ordered the province's legislation be updated to make it compatible with the *Canadian Charter of Rights and Freedoms*. She said the criteria for holding an individual in the current Alberta *Mental Health Act* is overly broad and does not focus on the key criteria required to remove an individual's liberty. Even though the Alberta government acknowledged it needed

[13] *JH v Alberta Health Services*, 2019 ABQB 540. Available at:
https://www.canlii.org/en/ab/abqb/doc/2017/2017abqb477/2017abqb477.html

to revise the *Mental Health Act* to meet the Ombudsman's recommendations and the JH decision, it nevertheless took the JH decision to the Alberta Court of Appeal. On September 11, 2020 the Court of Appeal upheld the lower court's decision.[14]

In the case of JH, he was held in part because authorities wanted to provide medical treatment they deemed advisable and because they wanted to find alternative housing for him that was not immediately available. These criteria did not meet the test needed to detain someone against their will.

In this case, the recommendations of the Ombudsman and court are complementary. Health administrators in Alberta were already working on meeting the Ombudsman's recommendations at the time of the court decision. The court decision reinforced many of the findings and went further by ordering legislative change. While the Ombudsman potentially could call for legislative change, the choice was made to address the underlying culture of the review panel process in a broad way and with the goal of motivating the administration to reform.

Court intervention in this area is rare. The British Columbia investigation refers to the most significant court case in that jurisdiction, the McCorkell decision rendered by a British Columbia court in the 1990s.[15] The fact that the most relevant court case in that jurisdiction was more than 20 years old shows how rarely people with mental disorders collect the resources or inclination to go to court, reinforcing the importance of the Ombudsman's role. If an Ombudsman does not provide oversight, it may never be done. The McCorkell case commented on the constitutionality of the province's legislation, but it was a moot decision, meaning it was rendered long after the patient involved had been released. It also illustrates that while courts may issue an order requiring practices compatible with the Canadian *Charter of Rights and Freedoms*, someone should monitor compliance, a task for which an Ombudsman may be better adapted.

The court option can present other barriers. New Zealand Chief Ombudsman Peter Boshier reports that he wrote to New Zealand's Minister of Justice in 2019 expressing concerns that courts fail to reasonably

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[14] JH v Alberta (Minister of Justice and Solicitor General), 2020 ABCA 317. Available at: https://albertacourts.ca/docs/default-source/qb/jh-v-alberta-(minister-of-justice-and-solicitor-general)-2020-abca-317---reasons-for-judgment.pdf?sfvrsn=2dd29280_2

[15] *McCorkell v. Director of Riverview Hospital*, 1993 Canlii 1200 (BCSC). Available at: https://www.bcss.org/wp-content/uploads/2018/12/McCorkell-Decision-Full-Text-6.17.1993.pdf.

accommodate disabled people (including those with psychosocial disabilities), and judges are offered no training on how to make courts accessible.

Criteria for detention

The British Columbia Ombudsman found evidence of a lack of a cultural understanding in the health care system. It was not understood that patients' legal rights are just as important as ensuring they receive psychiatric treatment. Justice Eidsvik examined the merits of only one case and found that the decision-makers did not focus on legal liberty issues as required, but on broad medical and housing considerations instead. These findings are consistent with some international academic articles.[16] These articles suggest that the health context dominates rather than the required legal tests necessary to detain someone, such as whether a patient is at risk or might place other people at risk.[17]

Many countries share remarkably similar admission and review processes, including Australia, the United Kingdom, Ireland, Canada and New Zealand. Countries such as Japan, Thailand and South Africa have review panels, but exactly how similar their processes are is outside the scope of this article. Many other countries have a review process, often by a judge and sometimes by a committee. While some of the observations below likely apply to all of those processes, the academic studies were based on the review panel process. Common findings were:

- Panels have a psychiatrist as one member and their opinion predominates. They often provide a medical opinion to the rest of the panel members without having examined the patient, which is procedurally unfair. If they provide evidence, it should be offered in an open hearing subject to cross examination.[18]

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[16] An article identifying some of the relevant literature is: Thom, K., Nakarada-Kordic, I. Mental Health Review Tribunals in Action: A Systematic Review of the Empirical Literature. *Psychiatry, Psychology and Law*, 2014, 21(1):112-126. The point is made specifically on page 116.

[17] Carney, T., Beaupert, F. Mental health review tribunal: rights drowning in un-'Chartered' health waters? *Australian Journal of Human Rights,* 2008, 13(2):181-208. p. 182-3 and Mental Health Review Tribunal Decision-making: A Therapeutic Jurisprudence Lens. *Psychiatry, Psychology and Law*, 2011, 10(1):44-62. p. 45, 53, 59-60

[18] Four articles reached that conclusion. Mental Health Review Tribunals in Action, p. 117, 122; Shah, A. Is the Mental Health Review Tribunal Inherently Unfair to Patients? *Psychiatry, Psychology and Law*, 2010, 17(1):25-31; Mental health tribunals: rights drowning in un-'Chartered' health waters2008, p. 183; and Mental Health Review Tribunal Decision-making 2003, p. 58.

- Conversely, lay members on the panel have little say.[19]
- Legal representation gives a patient a better chance of release.[20]
- Phrases such as "lack insight," "best interest of patient," and "noncompliance" are common in admission documents and review panel decisions, but they provide little or no medical or legal evidence to suggest detention is required.[21]
- Medical criteria often takes precedence over legal protection of rights.[22]

The academic studies are not based on analyses of individual cases, but mostly on the observations of the decision-makers. It raises the question about whether decision-makers would be as open in their opinions during an Ombudman's investigation into an individual complaint if they know their own decision might be criticized. The conclusions of the academic studies suggest lines-of-inquiry should an Ombudsman investigate an individual case. An investigator could examine whether the decision-maker explained where the authority to detain a person came from and how the legal criteria were applied in the case. Lack of discussion of the legal criteria might suggest the decision relied mostly on the opinion of professional caregivers on what constitutes the best interests of the patient without weighing the requisite legal criteria for involuntarily detaining a person. As well, imprecise language such as "lacks insight" suggests a legal basis for detaining the patient has not been defined.

Unintentional results

In an effort to address the power imbalance, the British Columbia Ombudsperson recommended legislation to fund a body assigned to the task of providing independent rights advice and advocacy to involuntarily admitted patients in all designated facilities. Alberta supports the concept because an advocate plays an effective role in Alberta. In the early 1990s, Aleck Trawick, Alberta's fourth Ombudsman, recommended the establishment of a Mental Health Patient Advocate, which occurred. The advocate has become an important part of the Alberta Mental Health process and recently was granted

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[19] Mental Health Review Tribunals in Action, p. 119.

[20] Mental Health Review Tribunals in Action, p. 121.

[21] Mental Health Review Tribunal Decision-making, p. 45

[22] Mental Health Review Tribunal Inherently Unfair, p. 30; Mental Health Review Tribunals in Action, p. 116; Mental Health Review Tribunals: rights drowning, p. 182; Mental Health Review Tribunal Decision-making, p. 53, 58.

additional responsibilities to ensure patient's rights on intake are protected, congruent with the findings of the Alberta own motion report and the JH case. One note of caution is offered. When the Alberta legislators passed the enabling legislation for an advocate's, they assumed Ombudsman oversight was an unnecessary duplication of service.

The inability of the Alberta Ombudsman to oversee the advocate weakens the capacity of the advocate to protect patients. Firstly, if the Ombudsman had the jurisdiction to investigate the advocate, the Ombudsman would be in a position to support the advocate's findings and recommendations, thereby strengthening the advocate's effectiveness. In the past, advocates have complained their recommendations were ignored. Secondly, removing the Ombudsman's jurisdiction means the Alberta Ombudsman cannot conduct an investigation into the admission process similar to the one that took place in British Columbia. Further, the advocate may not conduct the investigation because s/he lacks the resources and the investigative power of the Ombudsman. The Alberta Ombudsman's jurisdiction is restricted to the mental health review panel. When the Ombudsman investigated the mental health review panels, investigators found that information the panels collected about the admission process suggests many of the shortcomings identified in British Columbia at the admissions level exist in Alberta. However, the Alberta Ombudsman cannot directly investigate.

If there is a lesson from the Alberta experience, it is that all recommendations come with risk. Normally this risk is mitigated because when a recommendation goes astray, another complaint in the future will permit the issue to be revisited. In this case, the mistake was limiting the Ombudsman's jurisdiction. Restrictions to jurisdiction are changes an Ombudsman office may wish to resist most strongly, particularly when a vulnerable population is left with fewer oversight mechanisms.

Lessons learned

The United Nations Special Report,[23] the international academic studies and the own motion investigations from two Canadian Ombudsman offices all suggest mental health patients are a vulnerable population whose treatment might improve with increased oversight. Ombudsman offices need to seek opportunities to do this work. However, the reality is the Alberta Ombudsman did little in the area for about 20 years. Everyday contact was turned over to the Mental Health Patient Advocate, and no complaints were made to the Alberta Ombudsman to trigger an examination of the review panels.

When addressing disadvantaged groups, Ombudsman may have to adapt to take a more systemic approach. Fifty years ago, McClellan accepted complaints from individuals and looked at the merits of each case. In his June 28, 1968, recommendation letter to the Deputy Attorney General, McClellan simply addressed the circumstances of the case that came to him. He made no systemic recommendation then or in the 29-pages he devoted to the case in his annual report. Twenty-nine pages was almost twice the length of *Treating people with mental illness fairly*, the Alberta own motion report discussed in this best practices paper. In today's world, it is inconceivable that an Ombudsman would devote so much space without systemic recommendations. Awareness of this role may not have occurred to McClellan even though he obviously recognized he was reporting on an important case with implications beyond the individual.

In 1968 the Ombudsman concept was new to Canada, and the media found the Ombudsman a fresh and exciting source of news. Consequently, systemic change did occur because the case generated media attention driving improvements in the overall administration of mental health facilities. Today, conventional media is not as influential and lacks the resources to conduct thoughtful follow-up pieces. Investigating complaints from individuals and using the media remain in the Ombudsman's repertoire, but they need to be supplemented.

Fortunately, new tools assist the Ombudsman in recognizing unfairness and in motivating authorities to accept change. Fairness principles tested in court, expanded on by practioners and applied by an

[23] Another United Nations report relevant to involuntarily detention is the Optional Protocol to the Convention Against Torture. Available at: https://www.ohchr.org/en/hrbodies/opcat/pages/opcatindex.aspx

Ombudsman today, create a standard for identifying and arguing why an administrative practice is unfair. The new tools can be persuasive.

For the most part, health-care professionals are compassionate and dedicated. By citing fairness principles, the debate rises above simple disagreement by explaining to decision-makers the reasons why their "tried, tested and true" practices no longer meet present standards. Caring individuals who received an explanation based on well explained principles are more likely to accept and implement change. Even if they remain skeptical, principled explanation will likely convince their superiors or the politicians setting overall strategy, which will again motivate change. Ombudsman offices are in a stronger position to deliver this than they were 50 years ago. A much more developed understanding of fairness principles has evolved. During and after investigations, these new ideas provide a measuring stick that allows fairness to be explained, which may be more satisfying to public servants than the older method of applying common sense and telling them they were wrong. Although not the only measuring stick, Alberta applies and publishes a standard it calls *Administrative Fairness Guidelines*.[24] The Canadian Ombudsman community publishes an aid to creating fair polices called *Fairness by Design*.[25]

When looking for ways to protect vulnerable people, it makes sense to limit an investigation to a significant piece of the puzzle. It is not necessary and not advisable to attempt to fix everything at once. Investigations must be defined and achievable. Limited investigations produce understandable recommendations that can be adopted by administrators and can lead to a shift in the culture of the organization. British Columbia demonstrated this approach. It was concerned legal rights were not being protected. But its investigation focused on a seemingly simple matter, whether forms were filled out properly. They built a convincing case that showed the British Columbia health-care system did not sufficiently respect the legal rights of detained people. By emphasizing the importance of legally required forms, many more patients should now experience due process. The academic studies suggest due process protects people, especially those in a disadvantaged population, from unreasonable detention.

To protect vulnerable people, it may be necessary to revisit some lessons. In the Alberta example, previous investigations resulted in recommended improvements aimed at protecting involuntary patients. The recommendations were accepted, but poorly implemented. A public, own motion investigation elevated

[24] Alberta Ombudsman. *Administrative Fairness Guidelines*. Available at: https://www.ombudsman.ab.ca/determining-fairness/administrative-fairness-guidelines/

[25] *Fairness by Design*. Available at: https://bcombudsperson.ca/assets/media/Fairness-by-Design_web_1.pdf

the issues to a higher level. The result will be policy change imposed by the highest levels of the health administration.

Lesson summary

1. **Individual complaints are important but insufficient.** Receiving complaints remains an important source of information about the treatment of disadvantaged groups. However, individuals from these groups often complain less, and individual complaints may not identify the underlying causes.

2. **Be proactive.** Ombudsman who possess the power to conduct own motion investigations have an advantage. Important issues can be suggested in a variety of ways. A common source is informal contacts with complainants who never actually take the step of submitting a formal complaint in writing. Other sources may be advocates and often conversations with the administrators themselves.

3. **Aim for achievable issues.** The scope of an investigation should be small enough to win and big enough to matter. A narrower focus allows for recommendations that can be readily accepted and implemented by the authorities.

4. **Plan the investigation**. Planning is particularly important when the investigation requires auditing a large number of records, not just looking at an individual case. Carefully designed information requests at the outset save time and provide confidence all relevant documents are received.

5. **Explain findings.** To encourage acceptance by all parties, explain the Ombudsman's recommendations based on principles that will convince conscientious administrators that the recommended reform is something everyone can agree to. Describing a clear factual basis for findings makes it difficult for recommendations to be rejected.

6. **Consider the context.** Consultation with the authority before releasing recommendations may not be mandatory, but it is a good practice. The goal is to improve government. Recommendations

should be offered in the manner that invites the most positive reception. Experience shows releasing a draft report often achieves change quicker because administrators want to demonstrate at the time the report is released that they are addressing the issues. They may even identify gaps the investigation has not identified.

7. **Follow-up recommendations.** Particularly with public investigations, authorities find it expedient to accept recommendations in principle. They are likely sincere in their acceptance, but Ombudsman should set expectations on implementation. This could include timelines, and a requirement that the authority should confirm that the recommendations have been complied with and that the desired outcome has been achieved. The Ombudsman should tell the authority at the outset it will publish follow-up reports.

8. **Identify flags.** If looking at cases involving individuals, rather than overall administrative processes, the academic studies suggest likely shortcomings include a failure to identify and apply legal criteria and a lack of precise language, which suggests attention has not been given to the required medical and legal criteria.

9. **Anticipate unintended consequences.** While likely an unavoidable risk, even good recommendations can lead to unforeseen results.

10. **Listen to affected groups.** Consider if those impacted will benefit from and support the Ombudsman recommendations.

The conclusions reached by Canadian Ombudsman with respect to the mental health admission process supports the theme of the 12th International Ombudsman World Conference, "Giving voice to the voiceless." Mental health distress affects people globally and across all walks of life. Despite its prevalence, people living with mental health issues continue to battle stigma associated with their conditions. Vulnerable populations, including people living with mental health needs, experience a range of disadvantages, negatively impacting their personal and professional circumstances. People in the midst of difficult circumstances often need the Ombudsman's service most, and the resulting investigations generate the greatest benefit to the system because they shine the lamp of scrutiny into areas that otherwise might remain unnoticed.

Annex: This paper is based on Canadian experiences. However, since the IOI anticipates that many countries share similar experiences in this field, we also want to shine light on practices and experiences from other Ombudsman offices. The following sidebar stories (listed in alphabetic order by country) include feedback and observations received from IOI member institutions around the world.

OBSERVATIONS FROM HUNGARY

Hungary has also ratified the UN CRPD. However, the Hungarian legislation in force, just like the relevant Canadian regulations, still allows for detention based on disability if it is accompanied by dangerous or immediately dangerous behaviour. The **Commissioner for Fundamental Rights** of Hungary is thus inspecting the proceedings relating to the involuntary placement and treatment of this vulnerable group.

A brief comparison of legislation allows us to discover numerous similarities between the Hungarian and Canadian problems, despite the fact that – due to the differences on the level of regulations – the regimes related to mandatory psychiatric treatment are somewhat different.

The first and most significant difference is that within the Hungarian legal regulation, the possibility of involuntary placement and that of involuntary treatment are not clearly distinguished. Nevertheless, involuntary treatment must be approved too, i.e. ordered by the court, involving an independent expert, in the framework of accelerated non-contentious proceedings. During these proceedings, representation must be provided for the persons concerned. This is usually met through an appointed guardian *ad litem*.

Keeping an appropriate documentary discipline as prescribed by law is also rather problematic in Hungary. Usually, the patients' records do not adequately and specifically support the genuine necessity of ordering involuntary treatment, or the assessment of necessity–proportionality. The Hungarian practice also sees many cases where the medical documentation contains vague wording which is by no means appropriate for demonstrating the necessity and indispensability of involuntary treatment (e.g. "agitated", "lack of cooperation/lack of awareness of illness", "not controllable"). There is also a strong medical perspective on behalf of doctors: compared to medical considerations, the enforcement of patients' rights and fair procedures are considered to be of secondary importance. There are many instances where persons struggling with lifestyle difficulties (e.g. alcohol or drug problems) end up in psychiatric wards instead of proper forms of care (e.g. nursing homes or addiction treatment facilities). This practice would not be possible if proceedings were carried out in accordance with legal regulations.

In Hungary, it is compulsory to provide proper representation for the persons concerned throughout the proceedings. Representation may be assured by a relative, an authorized representative, a patients' rights representative (whose role is similar to the function of the "Mental Health Patient Advocate" in Alberta), or in lack of the above, a guardian *ad litem* (i.e. a lawyer paid by the state). However, in reality, patients do not have this information, so in nearly all cases, guardians *ad litem* are appointed for them by the court. Our experience shows, however, that the latter perform their job with little motivation, questionable conscientiousness, and poor efficiency.

In conclusion, please find below some of the main findings from inquiries conducted by our expert in connection with the enforcement of fundamental rights of psychiatric patients and persons living with psychosocial disabilities:

- Our expert agrees that the personal experience of those concerned is especially important. She therefore always considers the individual complaints of those concerned as the starting point of her inquiries. Naturally, there are many cases in which a genuine, systemic problem is exposed through an *ex officio* inquiry. It is essential to complete individual complaints with *ex officio* inquiries if they reveal comprehensive systemic problems. This is where Ombudsman can be proactive.

- Staff in charge of this specific area continuously monitor emerging problems to see which inquiries could result in *ex officio* investigations. These inquiries are also conducted in consideration of the follow-up of the implementation of earlier recommendations. Our experience shows that, even if recommendations are received with the best of intentions, it is necessary to request periodic feedback regarding their implementation.

- In our expert's reports, she puts a particularly strong emphasis on ensuring that her conclusions are well-founded and thoroughly elaborate, as this can significantly enhance the acceptance rate of the recommendations offered. Similarly to the observations of this paper, she believes that it is important to put forward constructive proposals, instead of merely enumerating faults and instances of non-compliance.

- In connection with the role of the court, our expert has two observations to share:
  - The activity of the European Court of Human Rights is an essential basis for our work. A case with Hungarian relevance (case of Plesó v. Hungary (application no. 41242/08)) is of fundamental importance, as the court handed down its decision, making numerous conclusions, which impacted on our entire system of institutions.

- We also want to mention the report of an ex officio inquiry in 2018, which analysed the regulation of court proceedings related to involuntary psychiatric treatment and our expert's recommendations. As a result of this report, the Curia carried out an analysis of the jurisprudence of court proceedings related to involuntary psychiatric treatments. A summary report will be soon available on the Curia's website. According to our knowledge, the report will contain numerous conclusions confirming all-time Ombudsman's practice and supplementing the Ombudsman's recommendations.

OBSERVATIONS FROM INDONESIA

Regulation in Indonesia require the Government to protect the rights of people with mental illnesses. Government and society are obliged to conduct treatment and care in the facilities of health services for people with mental illnesses, who are displaced, threaten the safety of themselves and/or others, and/or disrupt public order and/or public safety. The Government is also obliged to conduct rehabilitation efforts for people with mental illnesses who are incapable and have no family or guardian.

In the implementation, the Government of Indonesia was assisted and partnered with elements of society, both through Social Welfare Institutions (LKS) and individually. The existence of a large number of LKS became an asset and opportunity for the Government to fix various social problems, one of which was to further empower people with mental illnesses. On the other hand, the existence of LKS also can become a problem, if the quality of social welfare implementation tends to decrease.

In accordance with its duties to oversee the implementation of public services, during 2018 to 2019, the **Ombudsman of the Republic of Indonesia** supervised and monitored the implementation of services for people with mental illnesses by the LKS. The aim is to ensure that the LKS carries out its duties and functions in assisting the government in the framework of alleviation of social problems for people with mental illnesses, and to know the role Central and Local Governments play in paying attention to the LKS for people with mental illnesses.

The following LKS became the Ombudsman's monitoring focal points: the Communication Forum for Children with Disabilities (FKKADK) in Bintan District; Atma Husada Mahakam Hospital in East Kalimantan; Joint Adulam Ministry Samarinda Foundation (JAMS) in East Kalimantan; Galuh Foundation in Bekasi; Fajar Berseri Foundation in Bekasi Regency; and Phala Martha Mental Disability Social Rehabilitation Center in Sukabumi.

All six LKS collaborated with the local social services' focus on handling rehabilitation and empowerment of people with mental disabilities or people with mental illnesses, such as carrying out medical rehabilitation by partnering with the government's hospital, providing physical, psychosocial, religious, skills training, re-socialization, or social advocacy. Some of LKS even have been supported with living quarters and isolation rooms that have been adjusted to the needs of people with mental illnesses. However, in the result-based monitoring, the Ombudsman still found that some LKS face certain problems and obstacles in carrying out their roles and functions, such as: a lack of budget, human resources, and integrated service standards, as well as the number of targeted citizens indicated to exceed capacity.

Based on the monitoring results, the Ombudsman provided the following special notes/suggestions in an effort to improve the problem of social welfare services for people with mental illnesses:

- The government is expected to immediately issue regulations related to persons with disabilities, not to only accommodate the Ministry of Social Affairs and Ministry of Health, but other Ministries as well. The issue of people with disabilities is not only the responsibility of the two ministries. Furthermore, government also needs to harmonize existing regulations in Indonesia, to accommodate the Law on Persons with Disabilities;
- Coordination between Ministries is also needed in order to implement programs for and fulfil the rights of persons with disabilities;
- Social Welfare Institutions in particular and Indonesia in general, still lack professional human resources in the field of social welfare. It is expected that in the future, professional social workers, who have qualified competencies, obtained both from education, training, and/or experience in social work practices, will carry out service tasks and handle social problems;
- In the future, all LKS have to be legal entities (i.e. be established by an authentic deed), even though – pursuant to Minister of Social Affairs Regulations No.7 of 2017 – LKS that provide social rehabilitation services for persons with disabilities may, but do not have to be legal entities;
- For the Minister of Social Affairs, to sanction LKS who deliver rehabilitation that is not in accordance with existing standards.
- The Ministry of Social Affairs does not have data on the total number of LKS throughout Indonesia, because permits are issued by the local government; in this case the provincial social service. Central and local governments need to cooperate in the field of data collection to verify the number of LKS in the country;
- The Ministry of Social Affairs does not have valid data related to people with mental disabilities throughout Indonesia. In fact, the government has the authority to collect, verify and validate the data of persons with disabilities throughout Indonesia. The government is expected to create a nationally integrated system in order to help realizing the program on target;

- The central government has difficulty in intervening in the implementation of social rehabilitation services in the region due to decentralization and de-concentration of authority, as mandated in the implementation of regional autonomy;
- The local governments do not allocate adequate funds for social rehabilitation programs and services;
- The local governments often replace employees in the field of social rehabilitation, which burdens the central government, who has to strengthen human resources capacity to different people every year;
- In conducting social rehabilitation services, the LKS has not heeded the existing service standards. One way to control and monitor is to accredit all LKS. Such accreditation process can be done by third parties. Later, the results of this accreditation are required to extend the operational license of the LKS;
- Improve recovery rooms / quiet rooms / isolation rooms for patients in a way that they do not look like medical rooms or prison cells. By this, the person concerned is expected to become more comfortable and calm, and can thus recover faster.

OBSERVATIONS FROM ISRAEL

The Office of the **State Comptroller & Ombudsman** of Israel believes that own motion investigations are an excellent way of identifying those areas of public administration that are characterized by the systematic violation of rights of populations that have difficulty in protecting themselves. Ombudsman institutions that do not have a mandate for own motion investigations should adopt creative measures in order to be proactive in their investigations and reach out to disadvantaged groups, thereby constituting a central and influential factor in the protection of their rights.

The investigation of a complaint often discloses a general defect in the modus operandi of the public body. Ombudsman institutions should be alert to the fact that the accumulation of complaints on a particular matter are likely to indicate a defective administrative method or a systematic infringement of the law, and should investigate the complaints in a broad manner, by identifying the systematic defect and pointing out the need to rectify it.

In the State of Israel, there exists a special model, which answers the need for both the investigation of individual complaints and the systematic examination of public administration. This model combines the functions of Ombudsman and State Comptroller in one institution. The State Comptroller and Ombudsman is thereby able to check the propriety of the actions of the public authorities both as Ombudsman, through the eyes of the individual complaining about an act that has harmed him/her, and as State Comptroller, via a systematic examination of the general defects disclosed by the complaints.

Furthermore, the information gathered by the state audit divisions on matters relating to the complaints assists in the investigations conducted by the Ombudsman, enhancing the efficacy and quality of the investigation procedure. Conversely, information accumulated from the complaints received by the Office of the Ombudsman, serve the state audit divisions when conducting audit in public bodies.

For example, complaints about the system of hospitalization in government mental hospitals and the rehabilitation of people with mental disorders in the community provided the foundation for audit reports on these topics. State audit has also been conducted on aspects of the reform on the transfer of insurance liability in mental health and aspects of the implementation of the National Program for Suicide Prevention - actions of the government ministries.

Indeed, as pointed out in this paper, there is an inherent difficulty in receiving complaints from disadvantaged groups, such as mental health patients, who face hurdles in exercising their rights. In order to overcome this difficulty, the Ombudsman institutions must take creative and proactive measures to produce ambassadors in the community who can mediate between the Ombudsman and the disadvantaged groups. To this end, the Ombudsman must conduct information-sharing activities in welfare bureaus, social organizations and volunteer organizations who have contact with these groups.

In addition, it is necessary to consider how the Ombudsman can facilitate the filing of complaints by these groups. For example, the Israeli Ombudsman institution has established reception bureaus in the social and geographic periphery, enabling the verbal filing of complaints by persons who are unable to submit complaints in writing.

In addition to the above, we wish to mention two basic points that in our opinion should also be addressed when considering “Giving a voice to mental health patients”:

a) While examining how public administration copes with disadvantaged groups, such as the mentally ill, Ombudsman institutions must also take into consideration specific sub-groups, such as minors or the elderly, and examine whether these sub-groups require special attention from the Ombudsman institutions as well.

b) Apart from conducting own motion investigations, which relate to the actions of public administration in its handling of mental health patients, Ombudsman institutions must take into account the need to pay special attention to the methodology of the investigation of complaints of the mentally ill.

The investigation of complaints of this group raise difficult issues that require consideration and policy formulation, such as how to cope with claims of medical confidentiality raised by the medical team treating the patient, whether it is necessary to map out the judicial issues relating to legal capacity frequently arising from the complaints, and what is the standing of the guardians of wards who file complaints by themselves - should the guardians be informed about the filing of the complaint or the findings of the investigation?

An example of the last dilemma can be illustrated by the case of a complainant under involuntary hospitalization who asked our office for assistance in getting him discharged from the mental hospital in which he was hospitalized and insisted that we do not inform his guardian of his having filed the complaint. Furthermore, those handling the complaints and receiving the public should be instructed how to communicate with the mentally ill in the most respectful fashion for optimizing the investigation of the complaint.

These issues, and many others arising from the investigation of complaints, require broad examination by the Ombudsman institutions and the formation of a uniform and coherent policy.

OBSERVATIONS FROM LITHUANIA

On the mandate of the Institution

The Constitution of the Republic of Lithuania establishes the duty of the **Seimas (Parliamentary) Ombudsmen** to investigate citizens' complaints about the abuse of office by the bureaucracy of State and municipal officials (except judges). In addition to handling complaints, the Seimas Ombudsmen were also empowered to perform the national prevention of torture (NPM) and assigned the function of the National Human Rights Institution (NHRI). While exercising the complaints handling mandate, the Seimas Ombudsmen also have a light to conduct investigations on their own initiative. Moreover, as an NHRI, the office can also launch inquiries into fundamental human rights issues.

In carrying out the NPM mandate, the Seimas Ombudsmen use broad power. They have the right to choose which places of deprivation of liberty to visit, which persons to question and interview and to question any other persons, who could provide the necessary information. In performing this function, they make continuous visits to different sites carry out inspections to determine if there are any forms of torture or other forms of cruel, inhuman or degrading treatment.

On the involuntary detention of people with mental illness in Lithuania

The Law on Mental Health Care provides that involuntary hospitalisation of a person with mental illness may last no more than three business days. If involuntary hospitalisation lasts more than three business days, the mental health care institution has to apply to the Court for the extension of the involuntary hospitalisation no later than 48 hours after the hospitalisation started. Such requests must be examined by the Court within five business days from the filing date. Only two psychiatrists and one administrative employee authorised by the head of the mental health care institution can decide to apply for an extension of the term of involuntary hospitalisation.

Moreover, a patient with a mental or behavioural disorder is also entitled to an additional assessment of their mental health condition by three psychiatrists outside the mental health facility where the patient is involuntarily hospitalised. However, the costs of this procedure should be covered by the patient himself.

There are specific criteria, of which at least one should exist for a person to be involuntarily hospitalised. There should be a real risk that a person's actions or omissions could cause significant damage to their or others health, life or property.

It should be noted that both the Seimas Ombudsmen and the Committee Against Torture have repeatedly emphasised the need to ensure the patients' right to be heard by a judge when dealing with the matter of their involuntary hospitalisation. This right is enshrined, and opportunities provided in Article 13(4) of the Law on Mental Health Care establish a person's right to attend a court hearing themselves or, if this is not possible due to their health condition, to be heard by a judge in a mental health care facility or participate in an online interview. However, the Court's decision to issue the permit for the extension of involuntary hospitalisation and/or treatment is not a subject to appeal.

Practices in the field of involuntary detention of people with mental illness

Unfortunately, the practice described in this paper, i.e. an emphasis rather on medical treatment and less on the importance of the patients' legal rights, is also true to the context of Lithuania. As mentioned above, our office has a somewhat broad competence.

We are mainly engaged in the issues related to the involuntary detention of people with mental illness by:

- **Issuing positions on draft laws and proposing amendments to the existing laws**

  This practice was quite successful in 2018 when the new Law on Mental Health Care was being created. Our office provided several opinions to Government bodies and Parliament and initiated discussions with different stakeholders and the ministries in question. Although not all proposed changes were achieved, most of the draft law aspects that were not compatible with international human rights standards were removed from the final version.

- **Monitoring place of detention**

  Monitoring mental health care institution we have found that in some facilities the provisions of the internal rules defining procedures for involuntary hospitalisation do not comply with existing legal regulation. Patients, who did not want to continue their treatment, were not allowed to leave, although their hospitalisation was treated as voluntary. There was no written consent to change their treatment. Most patients were unaware of the duration of treatment, medication and side effects, or alternative therapies.

- **Investigations into fundamental human rights problems**

  These in-depth investigations fall under the NHRI mandate. Although there were no direct investigations into the matter of involuntary detention of people with mental illness, we have at least one investigation per year related to the rights and liberties of people with disabilities, including persons with mental illnesses. In 2019 we assessed whether the provisions of the Law Amending the Civil Code of the Republic, which provide that Court decisions on declaring persons to be legally incapacitated taken before 1 January 2016 must be revised (due to the changes of the legal incapacitation concept) within two years after the date of entry into force, were implemented correctly. The investigation found that only less than half of the Court rulings passed before 1 January 2016, according to which persons were declared to be legally incapacitated, were revised within the time limit provided for by law. In view of the fact, that under the new regulation the institute of complete legal incapacity has been amended to allow a person to be declared legally incapacitated only in certain areas, in the event of a change in the legal status (capacity) of persons, not only ineffectively protects the rights and freedoms of these persons; it also led to excessive restrictions thereof.

- **Investigation of complaints**

  As part of the classical Ombudsman mandate, the investigation of complaints is generally a reactive procedure initiated by the applicant's complaint and usually focuses on the problems and safeguards the applicant's rights. However, due to our mandate's broad scope, the information provided by a specific applicant might later be used to initiate an own motion investigation by the Seimas Ombudsmen. Moreover, even if a specific issue raised in the complaint does not fall within the Ombudsman's competences, we can still use our mediation powers and contact institutions on behalf of the applicant to help resolve the issue in question.

OBSERVATIONS FROM MEXICO

The Office of the **Ombudsperson of Mexico City** (Comisión de Derechos Humanos de la Ciudad de México, CDHCM), has been careful to accomplish the obligation established in Article 4.3 of the UN Convention on the Rights of Persons with Disabilities, in order to consult with the people with disabilities about an administrative or legislative procedure that may affect them. Public audiences have been organized to guarantee that their voice is being respected in terms of the most attainable standards in human rights. For the Ombudsperson Office, this is the most important goal when developing policy for people with disabilities.

(see: https://cdhcm.org.mx/wp-content/uploads/2020/03/Version_Lenguaje_sencillo_Informe.pdf)

In addition to the right to be consulted, it is important to respect the right to equal recognition before the law (Article 12) as well as the right of living independently and being included in the community (Article 19). The Committee has been clear to establish that institutionalization is against those rights so the main goal is to achive effective and appropriate measures to facilitate their full enjoyment.

(see: https://cdhcm.org.mx/2020/12/recomendacion-general-02-2020/)

In terms of respecting both articles (12 and 19) the Office of the Ombudsperson has established that institutionalization has to be stopped definitively. In order to achive that goal, states must offer options to the people and families for independent living and a clear procedure to guarantee conscent of every decision that affects their lives. Involuntarily detention cannot be accepted, under any circumstance.

The Office of the Ombudsperson insists on following the UNs Convention on this matter, a well as the Interamerican Human Rights Court jurisprudence to ensure the best protection against all forms of discrimination against people with all disabilities, in particular, mental health related disabilities.

OBSERVATIONS FROM NEW ZEALAND

Peter Boshier, Chief **Ombudsman of New Zealand**, made a number of observations that may assist any Ombudsman office when investigating mental health needs. In the New Zealand context:

- The Ombudsman is careful to involve people with lived experiences when considering unfairness, pursuant to Article 4.3 of the UN Convention on the Rights of Persons with Disabilities, which states that disabled people should be actively consulted with when making decisions about their needs/welfare. It is important to hear the voices of those concerned in the investigation process, to seek their input in the information gathering stage, and to provide them with an opportunity to comment on the draft opinion/report.

- There has been a clear emphasis on moving away from a medical based model of disability towards a social based model of disability, as well as increasing momentum in the disability community to follow a huma rights based model.

  Medical based model

  A medical based model views disability as a problem of the person, directly caused by disease, trauma, or other health condition, which therefore requires sustained medical care provided in the form of individual treatment by professionals. Within its framework, professionals follow a process of identifying the impairment and its limitations (using the medical based model), and taking the necessary action to improve the position of the disabled person. The management of the disability is aimed at a “cure”, or the individual’s adjustment and behavioural change that would lead to an effective cure.

Social based model

The social based model sees disability as a socially created phenomenon. In this model, disability is not an attribute of an individual, but rather a complex collection of conditions, many of which are created by the social environment. The management of the problem requires social action and is the collective responsibility of society at large to make the environmental modifications necessary for the full participation of disabled people in all areas of social life.

Human rights based model

The human rights based model is an extension of the social based model of disability. It acknowledges and embraces impairment in the lives of disabled people and recognizes it as a natural part of human diverstiy. This framework places a strong focus on active participation of disabled people noting that disabled people are experts in their own lives and should be stakeholders in all matters that concern them.

- In the cases where an involuntarily detained person does not participate in a decision concerning their care, New Zeland makes a difference between substituted decision-making and supported decision-making. Chief Ombudsman Boshier refers to the April 2014 UN Disability Committee's "General Comment No.1" on Article 12 of the Disability Convention (equal recognition before the law). It noted that the full implementation of equal recognition before the law will need a paradigm shift. This will require supported, rather than substituted, decision-making, in circumstances where a person is deemed unable to make independent decisions without assistance. The UN Disability Committee advised that none of the countries that have reported to it have grasped the full extent of this requirement.

New Zealand has gained considerable expertise in this area through a number of recent investigations related to involuntary detention in prisons and mental health facilities. Details are available on the Website of the Ombudsman New Zeland.

OBSERVATIONS FROM PAKISTAN

The mental health care issue requires greater attention and awareness in Pakistan as it is still considered a stigma when compared to Canadian culture.

In Pakistan patients with Psychiatric disorders mostly seek traditional methods of treatment. There are few mental health care facilities in Pakistan and mental health care for prisoners is not much different than for the general population.

However, **Sindh Province of Pakistan** has taken a lead and passed the Sindh Mental Health Act, 2013 and its rules namely Sindh Mental Health Rules, 2014 along with establishment of the Sindh Mental Health Authority in 2017. However, the implementation needs improvement. This is mainly due to lack of enough knowledge to deal with mental patients and lack of financial and human resources.

This paper highlights very important and sensitive issues faced by the mental health patients and necessitate the pro-active role of Ombudsman as custodian of public interest through their own initiative to provide relief. The paper gives an insight to all stakeholders to deal with mental patients especially those in isolation due to Covid-19, it will help in meeting SDG10 and SDG16 by ensuring equal opportunities, ending discrimination and providing access to justice for all.

Provincial Ombudsman (Mohtasib) Sindh

OBSERVATIONS FROM ROMANIA

According to Romanian legislation, mental health is one of the fundamental components of individual health, being a major objective of public health policy. The Government of Romania, through its specialized bodies is obliged to take measures to prompt and protect the mental health of the population, for the prevention and treatment of mental disorders. In this sense, the Ministry of Health is the competent authority to organize and control this activity.

A good practice example from the **People's Advocate Romanian** in this field is the *Special Report on the Observance of Human Rights in Psychiatric Hospitals in Romania*, prepared in 2019. For this report the People's Advocate started a wide

range of investigations in 17 hospital medical units and in a neuropsychiatric recovery and rehabilitation centre. The purpose was to assess the situation regarding the observance of fundamental human rights in psychiatric hospitals and psychiatric hospitals for safety measures in Bucharest and throughout the country. The process involved 11 of the territorial offices and three of the specialized departments of the People's Advocate namely: the department for family rights, youth, pensioners and people with disabilities, the department for human rights, equal opportunities for women and men, religion cults and national minorities, and the department for the prevention of torture and other cruel, inhuman or degrading in places of detention.

As a working tool for the investigation teams we develop a set of 17 objectives, which included indicators of possible human rights violations in psychiatric hospitals, such as the procedural rules and protocols in force, living conditions provided to patients (incl. intra- and inter-hospital transfer), the category of persons with disabilities admitted to hospitals, admission procedure applicable to patients with mental illnesses, respect for patients' rights and informing patients about these rights (consent), prevention and intervention in cases of self-harm or aggression towards others, supervision, procedures regarding the restraint of patients, human resources and budget allocation. At the end of the investigations, these objectives proved to be useful in systematizing a wide range of Information and helped us draw conclusions for the report.

We were interested in the dysfunctions that have been reported by hospitals to the authorities, which have the duty to remedy them, as well as the reaction of the authorities concerned. Following the conclusions of these investigations the People's Advocate made a number of recommendations; some of which aimed at taking administrative measures, others on completing the legislative framework or setting a priority of public mental health policies

Regarding the legislative and public policy changes, the People's Advocate recommended:

- the adoption of a coherent national plan on the implementation of a strategy in the field of mental health, taking into account the World Health Organization’s document on "*European Mental Health Action Plan 2013-2020*";
- amending the Law on Mental Health and the Protection of Persons with Mental Disorders, to include a separate chapter dedicated to provisions on the psychiatric system for safety measures;
- developing standards for accreditation and licensing of psychiatric medical care units, in accordance with their mixed profile (currently, they are accredited as social services);
- amending staff regulations in psychiatric hospitals, with a view to increase staff in numbers;

- completing legislation in the field of mental health with provisions regarding the deinstitutionalization of patients, who no longer require hospitalization, and the establishment of multidisciplinary measures (medical and social;
- supplementing the legislative framework with provisions on vocational training specific to the field of psychiatry, so that staff interacting with the mentally ill can benefit from training on optimal management of risk situations with respect for human rights.

Other recommendations addressed by the People's Advocate to the Ministry of Health aim at taking administrative measures such as:

- measures to remedy the deficiencies regarding restraints by standardizing the restraint registers, mentioning the less restrictive techniques to be initially applied, and the other mandatory registrations according to the legal regulations in force;
- continuous training of psychiatric hospital staff, who apply restraint procedures, to respect human dignity and the rights of restrained patients;
- checking the means of restraint used by hospitals;
- professional training (incl. the observance of human rights) for staff of the national mental health network;
- an adequate plan of measures to fill vacancies in psychiatric hospitals, so that the medical and auxiliary staff in hospitals is appropriate to the number of patients;
- multidisciplinary personalized intervention programs (occupational therapists, psychologists, social workers etc.) to psychosocially rehabilitate patients with mental illnesses;
- anti-stigma and anti-social exclusion campaigns for patients with mental illnesses, to respect their light to dignity;
- identify adequate ways to reintegrate mentally ill patients that constitute social cases in cooperation with public administration authorities and other actors involved;
- diversify the ways of financial support for the mental health system, e.g. through national programs or programs to attract dedicated funds.

What the People's Advocate set out to do through this Special Report, was to identify and predict solutions to systemic problems in the field of mental health, problems that have led or may lead to the violation of the fundamental rights of patients with mental health problems, but also of the staff, who take care of them.

The report emphasizes the necessity to follow international standards on procedures for hospitalizations and involuntary treatment and to ensure that these procedures do not – in any way – violate human rights. At the same time, it underlines the importance of making joint efforts to eliminate involuntary hospitalizations and treatments of people with mental disabilities.

The People's Advocate believes that many of the national mental health systems should be reformed to align with international standards that practices using coercion of patients need to be replaced by consent-based approaches.

OBSERVATIONS FROM SERBIA

Since the establishment of the Institution in 2007, the **Protector of Citizens of the Republic of Serbia**, has been dealing with the protection of the rights of persons with mental disabilities through specialist areas: the rights of persons deprived of their liberty and the rights of persons with disabilities. Significant aspects of the work of the Protector of Citizens in this area is preventive work as National Preventive Mechanism (NPM).

The main characteristics of the social position of persons with disabilities are their low visibility and participation in society. In addition to investigating rare individual complaints, the Protector of Citizens initiated own initiative proceedings, which found that regulations in this area needed improvement.

In 2011, the Protector of Citizens pointed out shortcomings in the legal framework, i.e. the absence of a systemic law to regulate the health and legal protection of persons with mental illnesses, as well as their detention in psychiatric hospitals. In his opinion to the Ministry of Health, the Protector of Citizens explained that the long-term detention of persons with mental illnesses in psychiatric hospitals where psychosocial rehabilitation is not available is essentially preventing their inclusion in society and therefore may lead to inhuman and degrading treatment. It stressed the importance of making a clear distinction between consent to a medical treatment and consent to placement in an institution. Due to our efforts, the Law on the Protection of Persons with Mental Illnesses was adopted in 2013, thus improving the legal framework for the protection of the rights of persons with mental illnesses, including hospitalization in psychiatric facilities. The procedure of hospitalization without consent is now regulated in such way, that it will only apply to persons with mental illnesses, who seriously and directly endanger their own life or the lives, health or safety of other persons.

The need for inpatient treatment shall be assessed by a physician at the nearest health centre or emergency medical service. If such assessment identifies that inpatient treatment is necessary, the person concerned will be referred to a psychiatric institution, where they will be examined by a psychiatrist, who determines whether the above mentioned reasons, prescribed by the law (that the person due to their mental illness may seriously and directly endanger their own life or lives, health or safety of the others), exist for inpatient treatment. In case psychiatrists determine that there are reasons to hospitalize the patient without consent, they are obliged to make a "decision on detention" immediately and without the patient's consent. A final decision on whether to keep patients in hospital for further treatment or to release them from hospital is to be made by the psychiatric council of the institution. A psychiatric institution, which hospitalizes persons with mental illnesses without their consent, is obliged to deliver a notice of detention for these patients to the competent court within 24 hours of the psychiatric council's review, including medical documentation and explanation about the above mentioned reasons prescribed by the law for the hospitalization without consent.

The NPM inspected records and found that the competent courts made decisions on the hospitalization of persons with mental illnesses without their consent within the prescribed deadline (i.e. 3 days). The NPM further observed that the hearings were held in the hospitals, where the persons were accommodated, that the patients were heard, that they were served with the detention decision in a timely manner and that they had an opportunity to exercise their right to appeal. The concerned persons and their legal representatives may file an appeal against this decision within three days from the day of receipt. The court shall without delay submit the appeal to the court of second instance, which shall decide within three days from the day of receipt.

As a rule, other physicians than the ones normally taking care of the concerned patients, are hired as expert witnesses in the procedures of involuntary hospitalization. However, in 2015, some psychiatric hospitals determined to hire physicians, who are employed at the same hospital where the patient is detained, as expert witnesses in the procedure of compulsory (involuntary) hospitalization.

In one visit, the NPM detected that all patients in a psychiatric clinic had given written consent for their hospitalization. According to the clinic, patients agreed to voluntary admission, after physicians explained the health benefits of the treatment. The physicians confirmed that the patients' wish to be discharged from the clinic would be considered by the institution's psychiatric council. If the council considers the patients to be a danger for themselves or others, a procedure of compulsory hospitalization would be initiated. However, during the visit, one patient approached the NPM, stating that she wanted to go home.

Physicians explained that they already informed to the patient, that her constant desire to go home was a consequence of her illness. In addition, the clinic said that the patient was a danger to herself. However, since she did not “rush to the door”, the clinic had not yet initiated a procedure for involuntary hospitalization. Bearing in mind that the patient was detained at the clinic, even though she expressed her willingness to revoke her consent, the NPM recommended that patients, who had given their consent and who later express their will to revoke it, should no longer be detained on the basis of this consent. If the above mentioned reasons, prescribed by the law (that the person due to their mental illness may seriously and directly endanger their own life or lives, health or safety of the others), exist for a further placement of these patients, a procedure for hospitalization without consent must be initiated before the court in accordance with the regulations.

The Law on the Protection of Persons with Mental Illnesses – contrary to the valid standards – has introduced provisions envisaging isolation measures for patients. Bearing in mind reports of International Treaty Bodies, which state that the isolation of persons with severe or acute mental illnesses constitutes cruel, inhuman or degrading treatment, and taking into account that isolation measures are not practice in psychiatric institutions in the Republic of Serbia, the Protector of Citizens proposed deleting provisions relating to the isolation measures for persons with mental disabilities.

In connection with the application of measure of physical restraint, the Protector of Citizens recommended that the restraints must be comprehensively documented by recording information such as: reasons for applying the measure, description of the measures applied before resorting to physical restraint, exact date and time, name of the responsible psychiatrist, documentation of possible injuries to the patient as well as other patients and/or staff, or whether and when a legal representative or family member was notified. This has led to a reduction in the frequency and duration of physical restraints to patients, and to better supervision by medical staff and physicians.

According to the psychiatric facilities visited by the NPM, patients are informed upon admission about all diagnostic procedures that will be carried out, and they usually give their written consent for these measures. However, when measures are changed during the treatment, patients are not required to re-new their written consent for these new measures. The NPM therefore recommended to inform patients about new medical procedures and to obtain their written consent for these new measures as well. During its visits, the NPM also observed that the forms used for admission often included accommodation and treatment, i.e. a general consent to all future medical measures. The NPM underlined that consent to hospitalization and consent to treatment are two separate issues and that admission forms need to be harmonized to take this into account.

Negative effects of deprivation of legal capacity (capacity to act) have been observed, when legal guardians give consent on behalf of the patients concerned (substitute decision-making). A systematic approach and interdepartmental cooperation are essential. The overall aim must be to find a systemic solution in the field of protection and promotion of mental health, deinstitutionalization and the development of community services. Furthermore amendments to family law regarding guardianship are essential to empower people with mental disabilities.

The Protector of Citizens stressed the necessity to amend regulations in order to create an efficient and sustainable system of "deinstitutionalization", which in addition to health, largely includes the social aspect, i.e. creating appropriate conditions for care and support of people with mental illnesses and their families. Unfortunately, activities aimed at establishing non-institutional care and support, such as on day hospitals, dispensary treatment and establishing community mental healthcare centres, have not been implemented enough. Instead, large psychiatric hospitals still house a significant number of patients, who do not need further hospital treatment, but remain there simply because not enough after-care facilities are available to provide them with adequate care outside the hospital setting.

During 2019, the Protector of Citizens proposed organizing thematic meetings and training together with the Ministry of Health to inform health care workers about the NPM mandate and previous findings and recommendations for the treatment of persons with mental illnesses, as well as the importance of their relevant implementation. We expect these activities will be implemented in the future.