Human Rights and Systemic Wrongs:
National Preventive Mechanisms and the
Monitoring of Care Homes for Older People

Care homes for older people may become places of deprivation of liberty due to their residents' lack of capacity to consent to their stay. The Optional Protocol to the Convention Against Torture requires States Parties to establish National Preventive Mechanisms to undertake visits to all places of deprivation of liberty to prevent torture and other ill treatment. This paper discusses the ways in which National Preventive Mechanisms report on human rights concerns in older people's care homes across 26 Council of Europe states. A framework established by the European Committee for the Prevention of Torture provides a starting point for this analysis. Common themes around restraint, ill treatment, safeguards for involuntary placements and resourcing issues emerge. The paper concludes that whilst National Preventive Mechanisms' narrow visit focus rightfully draws attention to a range of individual human rights breaches occurring in care homes, those abuses often manifest in the broad context of structural deficiencies at state level which NPMs are not equipped to resolve but which form the basis upon which care home residents' human rights ultimately depend.

Key words: care homes, human rights, older people, deprivation of liberty, OPCAT, NPMs

Introduction

Across Europe and further afield, care homes are important sites for the delivery of health and social care to older people. Care homes encompass a wide range of forms and purposes. Noting the definition provided by Huber et al (2009) for the World Health Organisation, our use of the term describes shared living spaces for older people with on-site care for daily living and sometimes on-site nursing care provided by qualified nursing staff. Care home residents in Europe include older people with the highest levels of need and dependency, for example those with multiple co-morbidities including memory problems, such as dementia (Spasova et al 2018), alongside physical frailties and disabilities. In this context, care homes could be seen as benevolent sites of care and necessary safety measures that do not warrant human rights monitoring. However, many care home residents are unable to consent to their placements due to cognitive impairment and mental capacity issues, thus creating potential for care homes to become sites of deprivation of liberty. This, combined with residents' incapacities, creates a heightened risk of ill treatment. Care in these settings, where older people are segregated from the general population may therefore be involuntary with a heightened risk that ill-treatment may occur. In this context, rather than viewing care homes as benevolent care settings with necessary safety measures in place, Steele et al (2020) argue that these institutions require strong human rights monitoring.

Alongside states' domestic legal provisions, a range of extra-jurisdictional human rights standards recognises and attempts to protect against these risks. In the European context, relevant standards include, but are not limited to, the absolute prohibition of torture and inhuman or degrading treatment or punishment, and the qualified rights to liberty and privacy enshrined in Articles 3, 5 and 8 respectively of the European Convention on Human Rights and Fundamental Freedoms (ECHR). European regional standards have their counterparts in international standards including the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT). The implementation and monitoring of these standards have been supported

by the establishment of international, regional and national visiting bodies with a mandate to prevent torture and ill treatment. The United Nations Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) underlines the risks to people deprived of their liberty, noting that 'further measures are necessary to ... strengthen the protection of persons deprived of their liberty' (UN 2003). OPCAT created the Subcommittee on Prevention of Torture (SPT) to oversee the Protocol and carry out preventive visits to States Parties. It also requires States Parties to establish local, independent visiting mechanisms known as National Preventive Mechanisms (NPMs). At a European level, the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, forms the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) which also carries out preventive visits to places of deprivation of liberty in member states of the Council of Europe (CoE). This includes older people's care homes because they constitute places where people might be deprived of the liberty even though they may be less obvious sites for human rights monitoring than prisons or psychiatric institutions (Grenfell, 2019). In this regard, the SPT clarified that OPCAT's definition of a place of deprivation of liberty includes any place that a person cannot leave of their own free will (SPT, 2016) and that effective prevention necessitates attention to a broad variety of issues, including both individual living conditions and systemic issues (SPT, 2010). That is not to say that OPCAT and its inspecting bodies, in their monitoring role, have the capacity to *resolve* systemic issues that are encountered but being alive to them is, we suggest, vitally important for the realisation of care home residents' human rights and the prevention of abuses.

The SPT, the CPT and individual NPMs are required to publish annual reports describing their work and key findings arising from their visits and may publish reports of individual visits. Most also publish thematic reports and other detailed guidance on how human rights standards should be applied and monitored in places of deprivation of liberty. Itis not, however, clear how all NPMs engage with and interpret human rights standards during their visits, what counts as a breach or cause for concern and

whether approaches are consistent from jurisdiction to jurisdiction, particularly in non-custodial settings such as care homes.

This paper provides an overview of care home provision for older people across Europe. It uses the reports of European NPMs and guidance published by the CPT, which has carried out 478 visits since it began work in 1987 (CoE 2021), to review the human rights concerns that arise from deprivation of liberty in such homes. NPM annual reports provide insight into how NPMs monitor care homes and the concerns they identify, supplying data (in this case observations and commentaries about human rights in care home settings), which can be analysed and categorised (Labuschagne 2003). We outline a study of NPM annual reports published between 2007 and 2018 in 26 CoE member states, which sought to understand the ways in which human rights issues in older peoples' care homes have been highlighted and documented in these reports and to identify limitations to this approach. Four major themes emerged from the data as the principal concerns identified by NPMs: Means of restraint, ill treatment, safeguards and limited funding.

These themes illustrate how working with human rights instruments can help spotlight everyday practices and individual experiences of human rights issues for older people in care homes. However, working to these instruments can also obscure more macro and structural problems, such as the correlation of national funding policies or legal provision and protection. Crucially, we argue that the identification and prevention of inadequate care or human rights breaches at individual sites must occur within the identification of structural factors, not least ageism - those practices and beliefs that discriminate against older people (Patmore 2005), and which occur at the individual (micro), institutional (mezzo) and societal (macro) levels (Iversen et al 2009). The identification of practices, behaviours and omissions which breach the human rights of older people in institutions across borders points to more than poor care at individual sites. It indicates a broad-scale and international problem with the ways that older people's lives are valued and their care funded, staffed and run.

Moreover, emphasising the poor care they receive can reinforce ageist discourses by re-producing the vulnerability and victimhood of older people, rather than considering how their care could be better structured (Butler 1989). Ageism becomes a platform on which neglect, including neglect of residents' rights, can flourish and become routine in long term institutional care (Band-Winterstein 2013). As such, it is essential that the structural context underpinning individual experience is articulated and addressed. Here, in addition to identifying the themes and trends from NPM reports, we argue that, whilst human rights tend to be individualistically grounded and justified, they may also play an important role in drawing attention to structural inequalities and troubling manifestations of institutional and societal ageism affecting the human rights of older people in care homes across Europe (Cruft 2005).

Providing care to society's most vulnerable entails an obligation to affirm the human rights of residents and, indeed, care home marketing and online material often espouses value-based frameworks and statements of commitments to the rights of residents. The term 'human rights' is rarely used in these materials. It can thus be difficult to ascertain the extent to which care homes work explicitly within human rights frameworks, despite their obligation to do so (Emmer De Albuquerque Green 2017). This paper will first consider care homes as a site for examining human rights, particularly in relation to deprivation of liberty, before considering the role of OPCAT in care homes for older people. Next, the documentary analysis undertaken will be detailed and its findings discussed under the four key themes of restraint, ill treatment, safeguards and limited funding. The paper concludes with a discussion of those themes and the uses and limitations of a human rights framework in care home settings, specifically noting the importance of employing a structural lens and the identification of wider ageism alongside individual human rights breaches or poor care. As many older people in care home settings also have disabilities we briefly consider the intersections of the UN Convention on the Rights of Persons with Disabilities (CRPD) and OPCAT. The backdrop of

COVID-19 and the opportunity to rethink post-pandemic care heightens the concerns we identify and adds urgency to the need to address them.

Care homes: sites for examining human rights

There are at least 4 million beds in care homes across the 30 CoE member states (Eurostat 2020). Sweden and the Netherlands have the highest numbers of such beds per capita (1,400 beds per 100,000 population in both cases), while Greece and Bulgaria have the lowest (39 and 31 beds per 100,000 population respectively). Data covering 2012-2017 demonstrate a rise in the number of care home beds in the 30 CoE member states, with notable increases of more than 100 beds per 100,000 population in Estonia, Lithuania and Luxembourg. Counter to the general trend, the Netherlands, United Kingdom (UK) and Latvia have all experienced decreases in the number of such beds in the same period (Eurostat 2019). Whilst the extent of care home availability, funding arrangements and precise practices of care homes in individual countries may vary, it is clear that care homes are an important form of social care for older people in many European countries (Molinuevo and Anderson 2017).

International comparison is complicated in view of different levels of provision, divergent funding streams and variable funding practices around long-term care. For example, the identification of funding constraints would entail different issues in a country with fewer economic resources than in a country where there are sufficient or plentiful resources but these have not resulted in adequate funding for care home provision. There are also cultural differences in terms of norms for older people's care and associated expectations of the state as a provider in this context. Blackman's (2009) exploration of cultural differences in attitudes to the state's role in providing older people's care across Europe, reveals broadly 'individual-oriented' systems where the state plays an important role in social care for individuals (such as in Denmark or Norway) and 'family-oriented' systems where state provision is sparse and families provide the bulk of social care (such as in Greece, Italy and

Ireland). These orientations are reinforced by different levels of access to older people's care and different economic and welfare state contexts. Notwithstanding economic and cultural differences, demographic and associated financial pressures are shared across many European counties. In 2018, 18% of the European Union's population was aged 65+, with a 2.6% population increase in this age group between 2008 and 2018 (Eurostat 2019). As a result, the proportion of the population requiring long-term care is set to increase, as will the cost of such care. Spasova et al's (2018) study considers data from 30 CoE member states; it reports financial sustainability as a major challenge for most of them over the last 20 years and projects that this will continue to present a challenge for most countries given demographic changes, though it is more pronounced in Nordic and Western European countries.

Within this context, it is important to note that care home provision in Europe is offered on the basis of a mixed economy of welfare across the private, public and voluntary sectors. For example, from 2012 to 2017, private care home ownership doubled in Romania, Slovakia and Slovenia. Whilst these countries have seen significant increases in private provision from a relatively low starting point, publicly owned provision has been decreasing in a range of countries, with significant falls in Croatia, Czechia, France, Germany, Norway and the UK. Private ownership constitutes more than two thirds of provision in Greece, Ireland, the Netherlands, Spain and the UK. The growth of privatisation in the European care home sector is often premised on ideas that the market offers more flexibility and efficiency than public provision but cost cutting, low wages and poor care standards, which may impact on residents' human rights, have occurred in private care homes in several countries (Geraedts et al 2017). Indeed, Steele et al (2020) have identified the extent of privatised care provision for older people is a significant barrier to realising a human rights focus in practice because of the emphasis on extraction of profit above quality of care.

Older care home residents themselves represent a group which requires care and support from others to meet their needs and have their human rights affirmed. Some may experience behavioural disturbances (agitation, disinhibition), poor nutritional status or malnourishment and significant difficulty with mobility or undertaking activities of daily living (Gordon 2014). Dementia is the most common diagnosis experienced by care home residents in many countries. In the UK and Austria, approximately two thirds of care home residents have dementia, though this may underestimate the level of cognitive impairment in care home residents who have not been formally diagnosed: The UK Alzheimer's Society estimates the figure to be closer to 80% (Alzheimer's Society 2013). Statistics regarding the proportion of care home residents with dementia are not always available and there are some outlier countries with lower proportions, such as Portugal, where just 30% of care home residents have a documented dementia diagnosis, but there is evidence to suggest some care home admission policies may exclude those with dementia in that country (Alzheimer Europe 2013).

Overall, it is evident that a large number of care home residents may not have the mental capacity to consent to their care, treatment or residence in the care home itself. Given this profile, older people may be constructed as requiring benevolent care and safety measures due to risks that they may pose to themselves in the community. In this context, human rights issues may be side-lined in the pursuit of safety and risk management (Steele et al, 2020), but important human rights concerns arise when older people are subjected to practices that amount to a deprivation of liberty. Restraint and deprivation of liberty may range from architectural features (locked doors or gates), use of medication to inhibit certain behavioural issues or use of equipment (various forms of telecare surveillance, CCTV) (Commission for Social Care Inspection 2007: 8-9). The use of 'grey' forms of restraint has also been identified, where staff practices intended to protect residents (such as diverting attention, telling 'white lies' or using persuasion) may transgress their human rights (Oye and Jacobsen 2020).

Care homes are therefore sites of deprivation of liberty, which render lawful (for example through substituted decision making) practices that would otherwise unlawfully breach human rights. Indeed, the frequent involuntary nature of care in such institutions means that there is a heightened risk of ill-treatment because of blurred lines between lawful and unlawful forms of treatment (Lea et al, 2018). Concerns have been repeatedly raised about poor care, abuse and ill treatment occurring in care homes for older people. The prevalence rates vary according to international studies but in several European studies care home staff acknowledge that they have observed or taken part in an abusive incident (Yon et al 2019). For example, in an Irish study, staff acknowledged observing neglect (58%), psychological abuse (27%) or physical abuse (12%) at least once in the last year. There were also self-reported admissions of having been involved in neglect (27%), psychological abuse (8%) and physical abuse (3%). Other forms of abuse such as sexual and financial abuse also featured in this study, but were rare (Drennan et al 2012: 68-69). In a German study, a number of nurses in care home settings acknowledged using physical force or deceit to 'benevolently coerce' residents in their 'best interests' and the study revealed correlations between types of abuse and staff shortages or burn-out (Goergen 2004). Grenfell (2019) also points to the difference between using restraint as a routine management tool and as a last resort – the latter may be sanctioned but may leak into a more routine use of this practice. These factors may create an ambiguity in the distinction between poor care and abuse in care homes, with one UK study demonstrating professionals overlooking or reinterpreting abusive practices as 'poor care' when working in poorly resourced environments and where there were doubts about what better options existed (Ash 2013). Indeed, even the concept of abuse in care homes can be deconstructed. For instance, one study discusses three types of abuse in care homes - abuse due to insufficient resources, abuse justified as a best interests intervention and abusive outcomes as a result of institutional practices (Cooper et al 2008). In this context, staffing and funding levels are important factors to consider as potentially correlated with human rights concerns.

All of the issues highlighted in this section demonstrate that care homes are an important site for examining older people's human rights. Significantly, care homes provide a setting where older people are congregated and where their ability to consent to care may mean their human rights can be compromised. This is particularly important in the context of increasing privatisation of older people's care across Europe. Amongst the human rights concerns mentioned thus far, deprivation of liberty is of particular relevance to OPCAT and we consider this at further length next.

Deprivation of liberty

For the purposes of OPCAT, 'deprivation of liberty' means 'any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will' (OPCAT: Article 4(2)). Institutions with the ability to deprive someone of their liberty include, as might be anticipated, prisons, police stations, remand and detention centres, but also hospitals, psychiatric facilities and care homes, whether state or privately run (UN 2018).

Given the large proportion of care home residents who have some form of cognitive impairment, it is likely that many lack the capacity to make everyday decisions about their care, treatment and residence. As such, a deprivation of liberty occurs because the person may not be able to consent to being cared for in a care home, giving rise to human rights concerns if no legal procedure exists to authorise this. Human rights concerns may also arise, however, where those legal procedures that do exist to authorise the deprivation of citizens' liberty inadequately protect the rights of those subjected to them. Moreover, the Special Rapporteur on the Rights of Persons with Disabilities notes that, sometimes, states are even unaware that a deprivation of liberty has occurred due to a 'mistaken belief' that its practices are 'benevolent and well-intentioned and do not constitute deprivations of liberty' (Special Rapporteur 2019).

As might be expected, domestic laws concerning deprivation of liberty vary between European states. They often comprise a mixture of hard and soft law and are based on disparate legal traditions and approaches (Boente 2017). Whilst this patchwork quilt of provisions is all but inevitable, becoming a party to an international treaty means that a state at least evidences an intention to respect, protect and fulfil the human rights contained in that instrument. Often, international agreements will not become part of a state's domestic law without further legislative action on the part of the state concerned but, once incorporated into domestic legal systems, and irrespective of their internal legal differences, those states thereby undertake to ensure the compatibility of domestic measures with their external international obligations. Where possible, an international human rights law approach to the care sector provides both a framework for problematising the treatment of those within the care system and a 'basis for transformation' in the development of care premised upon values of 'equality, inclusion and justice' inherent in human rights standards (Steele et al 2019: 2). Furthermore, in view of the Special Rapporteur's observations noted above, monitoring on the basis of international human rights standards provides a valuable means of questioning accepted practice, a crucial undertaking in light of the identification of a 'wide gap' between law and practice (Carver and Handley 2020: 394).

As noted, OPCAT uses a broad definition of the institutions that fall within the remit of the SPT and NPMs. However the issue of deprivation of liberty is approached, it is clear that, across Europe, care homes will, from time to time, necessarily have to take this action in respect of their residents and so be subject to OPCAT. This paper now turns to discuss what this means.

OPCAT and preventing human rights breaches in care homes

UNCAT entered into force in 1987 and is an international human rights treaty which aims to prevent torture and other acts of cruel, inhuman, or degrading treatment or punishment around the world. It distinguishes between 'torture', as defined in Article 1, and 'cruel, inhuman or degrading treatment

or punishment' (hereinafter 'ill treatment') which is covered by Article 16. Article 13 places obligations on States Parties to UNCAT to prevent, criminalise and investigate both torture and ill treatment.

Torture and ill treatment are not 'disembodied evil[s] that can be… eradicated by a preponderance of statements' (Ledwidge 2006: 71-72). UNCAT articulates the international community's de jure prohibition on torture and ill treatment. However, the United Nations subsequently created the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) to aid the de facto prevention of torture and ill-treatment. OPCAT, which entered into force in 2006 , is designed to strengthen the protection of people deprived of their liberty in proactive fashion. Central to OPCAT is the idea that a system of regular, independent visits to places of deprivation of liberty (OPCAT: Article 1) can serve as an important safeguard against abuses, and prevent torture and ill treatment in places that, by their very nature, may avoid the public gaze.

Described as a 'ground-breaking instrument' (Evans and Haenni-Dale 2004), OPCAT envisages a mutuality of intent and effort at the international and national levels in undertaking the practical task of preventing torture and ill treatment. As noted above, a two-tier monitoring system is established via Articles 2 and 3. The international visiting body is the SPT which has a preventive mandate focused on an 'innovative, sustained and proactive approach to the prevention of torture and ill treatment' (UN 2018). OPCAT affords the SPT unrestricted (albeit not unannounced) access to places of detention (OPCAT: Article 14) in States Parties to OPCAT and the right to examine the treatment of people held in those places (OPCAT: Article 11). States Parties must do everything in their power to facilitate access (OPCAT: Article 14(1)) and may not object to the SPT undertaking a visit unless on 'urgent and compelling grounds of national defence, public safety, natural disaster or serious disorder' (OPCAT: Article 14(2)). In addition, OPCAT requires each State Party to appoint, resource and guarantee the expertise and independence of national visiting arrangements by creating an NPM

(OPCAT: Articles 17 and 18). The SPT is required to 'advise and assist' States Parties with the establishment of their NPMs and to 'advise and assist' NPMs themselves (OPCAT: Article 11). An NPM has four main functions: Visiting places of detention, advising States Parties and those involved in depriving citizens of their liberty, educating those involved in depriving citizens of their liberty and the wider community, and co-operating with States Parties and other stakeholders, such as the SPT (UN 2018). Labelled 'the most significant single measure which States can take to prevent torture and ill treatment occurring over time' (UN 2018: 1), the key element of an NPM's mandate is to undertake monitoring at the national level in order effectively to prevent torture and ill treatment and ensure States Parties' realisation of their obligations under international law.

To guarantee the successful fulfilment of their mandate, NPMs receive substantial powers, rights and privileges (OPCAT: Articles 19 and 20). They can access any institution where people are deprived of their liberty and interview anybody within that institution with full privacy and confidentiality. This naturally includes people deprived of their liberty, but also extends to staff or anyone else on the premises, as well as whistle-blowers, who are protected from reprisals or sanctions (OPCAT: Articles 19 and 20). NPMs can access documentation relating to persons deprived of their liberties (in this case, residents), which include but are not limited to, medical files. While NPMs cannot require change, they may make recommendations to the State Party based on their findings (OPCAT: Article 19). This latter power includes that to 'Submit proposals and observations concerning existing or draft legislation' (OPCAT: Article 19 (c)). Such recommendations aim to improve detention conditions and the protection of people deprived of their liberty. Article 22 OPCAT obliges the State Party to enter into dialogue with the NPM on possible implementation measures and, by way of Article 23, States Parties to OPCAT undertake to publish and disseminate the annual reports of their NPMs. In this way, it is hoped that a practical and constructive dialogue will be established between States Parties and NPMs, driven partly by reports being publicly available.

Article 11(b) OPCAT provides for the SPT to maintain contact with, advise and assist NPMs in their establishment, training and in carrying out their role, handing the SPT 'oversight [whilst] exercising something of a paternalistic interest' in the activities of the NPMs (Evans and Haenni-Dale 2004: 52). This is perhaps unsurprising given the discretion afforded to States Parties in appointing their NPMs and in light of Steinerte's (2014) observation that the quality of the NPMs is paramount to OPCAT's success. Although OPCAT Article 17 requires a State Party to 'maintain, designate or establish' its NPM, there is no prescription with regard to the form it must take. States Parties are free to use an existing institution, or combination of institutions, or to create a new one. For Steinerte, the key is that an NPM is crafted in accordance with the local political, social and legal conditions in which it operates. There is, she maintains, no ideal-type NPM (Steinerte 2014).

Although there may be no ideal-type NPM, there are clear guidelines relating to outputs from the 'system of regular visits' that each NPM must undertake (OPCAT: Article 1). Each visit should produce a visit report which identifies any concerns and proposes 'practical and verifiable corrective measures' (UN 2018: 27). Reports should be prepared as soon as possible after the visit, 'enable the institutions visited to make the connection between the visit and the report' and allow any reader to 'form a realistic picture of the situation' (UN 2018: 26). In terms of their coverage, as well as describing the place visited, the regime, policies, practices and regulations under which it operates, and detailing space, facilities and living conditions, visit reports must include observations and accounts of torture and ill treatment. Examples of good practice should also be noted.

The SPT advises NPMs to publish their visit reports (UN 2018: 27) but this is not a requirement of OPCAT. In addition to producing visit reports, however, each NPM must also produce an annual report which the State Party is obliged to publish (OPCAT: Article 23). This should include details of its most important findings, current challenges to the protection of the rights of persons deprived of their liberty and to the effective execution of its mandate (UN 2018:31). Most NPMs in the CoE

produce their annual reports in whole or part in English and it is these annual reports that provide the basis for this study.

Methodology

In order to examine states' approaches to monitoring the human rights of older people in care homes, a documentary analysis of available CoE member states' NPM reports was undertaken. As an approach to reviewing or evaluating documents, documentary analysis 'requires that data contained in these texts be examined and interpreted in order to elicit meaning, gain understanding, and develop empirical knowledge' (Bowen 2009: 27). Documents are created independently of the research process and require interpretation when used in a research context (Tight 2019). Utilising the free availability of NPM reports, here documentary analysis was selected in order to gain a sense of how older people's rights are upheld in care homes. Although documents only capture selective data and cannot be interrogated beyond the data they contain, this approach allowed the formation of an overview of the ways in which the rights of older people in care homes were reported on through the NPM mechanism in multiple CoE member states. This section will discuss the method and analytical strategy adopted in conducting the project.

An important element of the analysis was to categorise issues reported by NPMs, allowing insight into which issues were reported more or less frequently, and to what extent these findings reflected the jurisdiction, type or designation date of the NPM concerned. Four stages of analysis were completed. The following sections outline the chronology of that analysis.

Stage One: Identifying NPM annual reports for analysis

We selected NPMs in the CoE for study.[1] While noting the differences in provision and cultural preferences in care for older people described above, all member states of the CoE must be parties to the ECHR and so are subject to the same human rights standards, albeit states are afforded a margin of appreciation in the implementation of those, and other human rights standards, to which they commit. All NPMs in the CoE are also subject to visits and reports by the CPT. Where states had designated an NPM, the first stage included an examination of those NPMs' annual reports to ascertain whether visits to care homes were conducted and reported on, and whether such reports were available in English. Some NPMs did not monitor care homes or did not provide their annual reports in English and, thus, were excluded from the subsequent analysis, leaving 26 NPMs for our study.[2] The annual reports of these 26 NPMs were assessed for relevance. This means that for some NPMs, all annual reports were relevant, because they reported on care homes each year. Other NPMs reported on different institutions each year, with the result that some of their annual reports were excluded from the analysis. All of the reports included in the study relate specifically to care facilities for the elderly. In a small number of cases these might be part of a larger institution such as a hospital and some facilities may accommodate both residents who are deprived of their liberty and those who are not. NPM reports do not always make these distinctions clear. Table 1, below, provides an overview of the 26 NPMs included in our analysis with details of NPM type, designation date and the years for which relevant annual reports were published.

Table 1. Overview of the NPMs included in the analysis

[1] The following countries designated an NPM: Albania, Armenia, Austria, Azerbaijan, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Italy, Liechtenstein, Lithuania, Luxembourg, Malta, Moldova, Montenegro, Netherlands, North Macedonia, Norway, Poland, Portugal, Romania, Serbia, Slovenia, Spain, Sweden, Switzerland, Turkey, Ukraine and United Kingdom.

[2] The following NPMs were included in the analysis: Albania, Armenia, Austria, Azerbaijan, Bulgaria, Croatia, Czechia, Denmark, Finland, Georgia, Germany, Hungary, Italy, Liechtenstein, Lithuania, Netherlands, North Macedonia, Norway, Poland, Romania, Serbia, Slovenia, Spain, Switzerland, Ukraine and United Kingdom.

Stage Two: Categorising concerns using the CPT checklist

The second stage of our analysis focused on concerns reported relating to care homes for older people. Currently, there are no formal, international standards for assessing care homes in the same way as exist for prisons (UN 2016), for instance, which hampers inter-state comparison. To achieve consistency of analysis and aid understanding of the common themes and challenges reported by the NPMs included in our study, we opted to categorise the data emerging from the analysis. The CPT developed a checklist as an aid to its own visiting teams and, as the CPT and NPMs undertake visits with the same purpose of preventing torture and ill treatment, that checklist provided a useful starting point to group the findings in NPM annual reports. The checklist includes nine broad categories of concern to be addressed during the CPT's own visits to care home settings: General information; Ill treatment; Living conditions; Health care; Means of restraint; Safeguards (Involuntary placement); Safeguards (Involuntary treatment); Safeguards (Deprivation of legal capacity); and Other issues (Pirjola and Raškauskas 2015: 23). We anticipated correctly that these concerns would be reflected in NPM reports, which could thus be categorised in the same way.

The concerns reported by the NPMs in our study were initially sorted into the nine categories identified by the CPT. Where the report's text or commentary enabled us to do so, we used the NPM's own description of a concern in the process of making categorisations from the data. One concern expressed by an NPM could frequently be related to several categories. For example, an NPM might criticise irregular mealtimes as a form of ill treatment, resulting in the concern being placed in both the 'Ill treatment' and 'Living conditions' categories. We were not seeking to produce mutually exclusive categories in this first stage of analysis but wanted to account for NPMs' observations of potential human rights breaches as fully as possible.

Stage Three: Developing the list of concern categories

The second stage of the analysis resulted in a comprehensive grid which set out the number of concerns identified in each category in each NPM report. The analysis revealed some difficulties in using the CPT checklist, however. The category 'Other issues' contained a wide range of concerns but the checklist did not permit sufficient granularity of detail to enable further analysis. In this category, many specific concerns raised by NPMs were, therefore, obscured by the 'Other issues' label. In addition, in other categories such as 'Living conditions', certain trends in NPM reporting became apparent but here too, the generic CPT categories did not enable detailed analysis. As a result, an additional list of categories was developed and added to the initial CPT checklist. This additional list is inductive and based on the analysis of NPM reports. The categories it contains include only those concerns that NPMs address regularly in their annual reports. The additional list replaced the 'Other issues' category and includes the following categories which, on analysis, were clearly identifiable within it:

Legislation, policy and standards; Finance, resources and budget; Staffing, Management, Leadership, Documentation, Profession-Specific and Training Issues; Rights, Values and Ethic of Care; Inappropriate Placement; Repairs, Facilities, Equipment and Adaptations; Nutrition, Hydration, Diet, Catering and Meals; Night Time Care; Social: Family, Friends and Social Contact, Leisure, Social Integration & Activities; Toileting and Continence; Palliative Care, Deaths in Care; Hygiene, Personal Care, Bathing, Laundry Issues; Psychological Care; and Overcrowding, Privacy, Personal Space or multiple occupancy.

Figure 1, below, shows how often each category was reported when all relevant annual reports were combined.

Stage Four: Identifying and analysing major themes

Using this second list of categories, the fourth stage of the analysis was undertaken, comprising a qualitative analysis that identified and developed the major themes arising from the concerns raised across all categories.

We acknowledge some limitations to this research design. By including only NPM annual reports, only part of the picture for each country is painted. Some NPMs supply great detail in these reports and provide a wealth of information each year; others simply offer summaries and remain generic. Other types of reports may, of course, offer additional information relevant to this analysis, but those were beyond the scope of this research. Another limitation relates to the inductive coding method we employed. In order to organise and make sense of the qualitative, textual data, rendering it quantifiable, relevant reports were coded line by line based on the CPT's list, with the additional issues being recoded once the 'Other issues' category had been expanded into its new, constituent categories. Each NPM report was coded by two members of the research team, ensuring checking and error avoidance. Errors and discrepancies were discussed and resolved between coders before a final coding was allocated. Nevertheless, the possibility remains that experts from other disciplines might code some issues differently and achieve differing outcomes as a result. Occasionally, when analysing an NPM report, it was unclear if the setting being described was a care home or a medical or psychiatric setting for older people. As a result, some data may capture NPM visits to other types of setting, albeit for a similar group of people. Finally, because the analysis focuses exclusively on NPM annual reports, the results reflect the reporting of NPMs themselves: Reports were taken at face-value and not triangulated with other data.

A quantitative analysis is insufficient on its own to identify the concerns that are most significant. Two important findings from the analysis regarding the nature of the reports themselves need to be considered. First, clear differences emerge between NPMs in the level of detail in their reports, the length of their reports and how often they report on certain categories. Second, there are significant

differences in the apparent priorities of NPMs themselves. These differences were not visible through a straightforward quantitative measurement of how often certain categories were mentioned by individual NPMs because some reports provided a large amount of detail and in some cases there was a degree of repetition, both of which tended to obscure trends in the data. Conversely, some countries provided more focussed reports so the absence of certain categories did not signify a lack of evidence of this in the care homes visited by that NPM but may simply have indicated that that data was neither sought nor recorded. Although a simple quantitative approach would not permit coherent analysis, the categories employed revealed some interesting qualitative propensities in NPMs' priorities and in the ways in which they conceive of human rights issues. For example, the reports from the UK provide little detail on the day-to-day experience of living in an older people's care home, but the emphasis on process and procedure is apparent. By contrast, the reports of Ukraine and North Macedonia adopt a focussed perspective on the fabric of the care home setting, living conditions, including bricks and mortar, and the quality of care available within systems with less funding than many of their counterparts. In these instances, however, there was less emphasis on legal procedure. Meanwhile, the Austrian and Slovenian NPMs provide multiple lengthy reports with plentiful but occasionally repetitive detail across the categories. Even the most detailed NPM annual reports represent only high-level summaries and, as such, our study did not expect to find a definitive indicator of the extent of human rights issues in care home settings across reporting countries.

The four key themes emerging from our analysis are: Use of restraint, ill treatment, safeguards in the context of involuntary placement, and limited funding. These themes reflect the analysis of category mentions while taking into account NPMs' different reporting styles. There is inevitably an element of subjectivity in this choice but while other investigators might have identified different key themes from the same process, the discussion below demonstrates the importance that NPMs themselves attach to them, the extent to which the concerns they relate to overlap and their central importance

to a discussion of the human rights of care home residents. These in turn suggest attention needs to be paid to the further issue of the ways in which rights are understood and discussed in NPM annual reports. In December 2020, after our analysis was completed, the CPT published a factsheet on social care homes of all types (CPT 2020). The findings of our investigation discussed below, arrived at by a different methodology from that used by the CPT, nevertheless presage the concerns indicated by the CPT in its factsheet. Our findings are discussed in detail below.

Findings

Before proceeding, it must be pointed out that any finding of poor care or a human rights breach should not be read as indicating that poor care is endemic to a particular country and, indeed, it is positive to see countries' transparency around issues where improvement is needed. A corresponding point is that a number of countries do not raise significant issues in their reports but this should not be read as indicating that human rights breaches do not occur in care homes in these countries.

Means of Restraint

The use of restraint measures was commented on in the reports of all but two countries. The majority of reports described forms of restraint observed in NPM visits such as physical and chemical restraint. They included architectural or equipment-based features that facilitated restraint such as locked doors, surveillance systems and the use of equipment like bed rails. Physical restraints were mentioned in a number of NPM reports, such as binding the hands of a resident (Austria, Serbia) or tying residents to beds (Lithuania, Norway), chairs (Austria) or even railings in corridors (Bulgaria). Additionally, nets and 'cage' type apparatuses around beds (Austria, Hungary) or in rooms (Ukraine) or corridors (Slovenia) were indicated. Locked doors were widely reported but less common features included darkened corridors (Austria), wire fencing (Serbia), bars on windows (Ukraine) and surveillance systems (Serbia, Spain). Concerns about the poor documentation of restraint, including

start and finish times, arose frequently (Bulgaria, Serbia, Slovenia, Austria). There were also references to poor recording of the use of force in two reports: One evidenced some administrative confusion about what constituted restraint resulting in imprecise numbers (Norway) and another comprised neglectful record-keeping (Bulgaria). Medical restraint through sedation was commonly referenced, as were excessive use of sedation (Austria, UK), poorly supervised sedation practices (Czechia, Finland, North Macedonia) and unexplained use of sedation (Austria). Other issues that might be considered a restraint include early bedtimes (Austria) or the use of wristbands (Germany).

The rationale for restraint was rarely discussed, but some reports mentioned justifications such as management of aggressive behaviour (Netherlands, Bulgaria) or to enable staff to carry out personal care tasks (Denmark). In one country, residents informed the NPM that they believed restraint was being used as a punishment for their behaviour (Spain). The prevention of an older person falling is discussed as a rationale for restraint (Austria, Croatia), and is regarded as disproportionate. Indeed, the proportionality of restraint arises in a number of reports. The use of physical restraint is criticised when more benign alternatives, such as psychosocial methods, would work well (Austria, Netherlands). Excessively long periods of restraint are discussed in several country reports (Serbia, Czechia). Staff knowledge of procedures around restraint was critiqued (Norway, Spain) and improper restraint was discussed in the reports for a number of countries (Lithuania, Serbia, Slovenia and the UK).

The legal context for restraint is discussed briefly in some reports, for example the review of deprivation of liberty policy (Germany). However, several country reports note the absence of a legal framework for restraint in care homes (Serbia, Croatia). In one country there was some legal reform noted but no comprehensive regulations in place for guaranteeing the rights of residents in care homes (Spain). Additionally, the absence of monitoring mechanisms was documented (Georgia).

Notably, the restraint theme that emerged from the data was closely linked, in NPMs' observations, with the second key theme of ill treatment.

Ill treatment

Ill treatment arose as a major theme in most NPM reports, although three countries did not reference any instance of this in their reports (Italy, Liechtenstein, Romania) and five others made no reference to ill treatment outside of improper, disproportionate or unsafe restraint (Finland, Netherlands, North Macedonia, Romania, UK). This reflects the finding that there was significant overlap between ill treatment and the means of restraint, discussed above.

A significant finding is that the NPM country reports frequently commented on ill treatment, but rarely in relation to abusive acts of commission. Only one report specified the categories of abuse that had been encountered, including physical abuse and financial abuse (Austria). Otherwise, it was more common to find non-specific wording, such as 'ill treatment', 'extreme maltreatment' or 'improper treatment' without any indication of what this comprised. On the other hand, some examples were provided which correspond clearly with ill treatment, even if this is not directly specified. Reports identify emotional or psychological abuse, for example 'bullying' by staff members (Azerbaijan), physical abuse, such as being slapped or struck by a staff member (Hungary, Slovenia) or forms of financial abuse, such as feeling pressure to pay to insure one's care (Ukraine) or being over-charged fees (Czechia). Specific instances of neglect also featured, such as being left for long periods in urine- or faeces-soaked clothes and bedding (Germany). Whilst abusive incidents between residents were highlighted on three occasions (Poland, Hungary, Azerbaijan), these bore a different significance to abusive practices perpetrated by staff members or caused by omission. The emphasis on 'treatment' also places the lens of action on staff members rather than the impact that the action might have from the perspective of the older person.

As discussed above, there are significant overlaps with the category of restraint, particularly as regards disproportionate, excessive or unsafe restraint practices. However, there are also overlaps with categories of 'living conditions' and 'health care', particularly in relation to medication issues. Living conditions that overlap with ill treatment include residents being subjected to insanitary or unsafe environments or organisational practices leading to degrading treatment. Some country reports provided specific examples of insanitary living environments, with strong smells of urine and faeces (Austria), dead insects (Azerbaijan), inadequate toileting facilities (Croatia), dirty or stained bedding (Georgia), running out of basic sanitary products such as toilet paper (Hungary) or a lack of running water (Serbia, Ukraine). In addition, there were accounts of facilities in serious disrepair with potential risk to the safety of residents (Croatia, Serbia, Ukraine). Ill treatment also overlapped significantly with health care issues, particularly in relation to medication. A number of countries discussed medication dispensing which was insufficient (Austria, Czechia, Norway, Ukraine), incorrect (Austria, Lithuania, Norway), excessive (Austria, Lithuania, UK), poorly documented (Bulgaria) or careless (Czechia). A lack of access to specialist care or medications was also identified (Lithuania, Ukraine). Malnutrition was raised regularly (Austria, Czechia, Germany) and this was occasionally related to insufficient availability of food (Czechia), inadequate portions (Germany) or a lack of attention to specialist dietary requirements (Croatia, Georgia). Poor food or kitchen hygiene or facilities were also highlighted (Lithuania, Romania).

Ill treatment overlapped with the category of staffing, particularly staff shortages posing dangers regarding omissions of care (Austria, Croatia, Czechia, Germany, Ukraine). In Ukraine, the death of a resident was directly attributed to the absence of staff. The quality of staff was raised in some reports, for example the provision of care that was deemed to be amateur (Czechia) or care by staff members who had limited ability to speak the native language (Germany). Poor documentation (Austria, Bulgaria, Germany) and one mention of falsified documentation (Czechia) led to inadequate pain control and other omissions for residents. A lack of staff could lead to long periods where call

bells were not attended to (Austria) and insufficient nursing care (Czechia), as well as low morale, burn-out and high levels of sickness in the staff teams (Germany, Hungary). In turn, the limited availability of clinical or professional supervision for care home staff was linked to a lack of empathy, respect or bullying behaviours in care homes (Austria, Hungary, Serbia).

Safeguards for involuntary placements and treatment

The risk of ill treatment in whatever form underlines the need for safeguards for involuntary placement and treatment. The CPT checklist pays special attention to the review of safeguards in the context of involuntary placement or treatment and for those residents who may lack decision-making capacity regarding their placements. Indeed, three of the nine CPT categories relate to information-gathering regarding such safeguards. It was surprising, therefore, that these three categories, even when subsumed together, were the least frequently discussed categories in NPM country reports. Such safeguards provide important checks and balances for affirming the human rights of the most vulnerable residents in care homes and, as discussed, a significant proportion of residents in care homes suffer cognitive impairment, meaning that they might lack such capacity. Where these categories are used, a variety of disparate concerns are raised and, unsurprisingly, there are clear inter-country differences in the legal frameworks providing these safeguards.

Guardianship laws, which are mentioned in 11 countries, are country-specific and there is much diversity in terms of functions, responsibilities and who is likely to be appointed as a guardian. In one country (Bulgaria), a large proportion of care home residents has a guardian appointed but, in the majority of cases, this guardian is the manager of the care home. Some concern was also raised in this country about the unfeasibly large number of people under the guardianship of one manager, who the NPM felt were too many to be the responsibility of one person. In other countries, the majority of guardians were relatives or next of kin, rather than care home managers (Romania). Guardians are frequently involved in admissions to care homes and must provide their written

permission where the resident lacks capacity to do so (Serbia, North Macedonia) but, in some countries where this practice occurs, the NPM reported that involuntary admissions to locked care facilities cannot be consented to by a guardian (Slovenia, Croatia). Guardians were sometimes not consulted or involved adequately (Croatia, Germany) and residents complained that they had no right to replace their guardian if they were not able to be involved due to geographical distance for example (Spain). Guardianship provides an important safeguard in the context of involuntary placement or treatment or for those who lack capacity to consent to their placement. However, a grey area may exist for those who do not lack capacity, so do not have a guardian appointed, but whose circumstances mean that they find it difficult fully to understand a decision, leaving them without representation or support (Poland). From another perspective, guardianship may be seen as an enabler to the deprivation of older people in segregated premises (Steele et al, 2020) and we return to the importance of a structural lens later in the article.

Concern over safeguards relating to consent also arose regularly. Placements made without consent were found by the NPM in some countries. Occasionally individual consent was replaced by the consent of the older person's family but without a legal framework for the oversight of this process (Croatia, North Macedonia). The inability to provide consent was occasionally noted to have been ignored through, for example, the signing of contracts with people who would not have understood what the contract was (Czechia, Slovenia) or conflating a lack of capacity with a rationale to place without consent (Croatia, Serbia). Occasionally, consent was not well documented (Lithuania). However, several NPMs pointed to grey areas around consent, for example people who had capacity to consent but were not helped to understand the decision (Poland, Czechia) or care homes remaining unclear about the extent to which the person who was asked to consent could make decisions due, for instance, to fluctuating capacity or frequent changes of decision (Norway, Slovenia). Staff knowledge about mental capacity and the safeguards that exist in law in this area

were raised as deficiencies in provision and protection which led to human rights abuses and which required better training and staff support (Austria, Azerbaijan, Croatia, Ukraine).

As discussed, legal frameworks vary enormously throughout the CoE region but these were discussed regularly in NPM country reports. New laws had been passed concerning guardianship, mental capacity, involuntary treatment or placement or deprivation of liberty in a number of countries (Bulgaria, Czechia, UK) yet the lack of comprehensive legal frameworks was raised in a range of countries, including some of those with new laws in place (Bulgaria, Czechia, Georgia, Serbia, Slovenia, Spain). In one country (Serbia), the opinion of medical doctors was being used to substitute for a comprehensive legal framework. Confusing or contradictory laws were also observed. For example, two countries noted that the laws for coercive measures in care homes were the same as those covering psychiatric hospitals and required a psychiatrist to monitor the arrangements. With no access to psychiatric support in care homes, coercive measures in these settings did not comply with the extant legal framework (Croatia, Slovenia). Some countries had quite clear remits for courts, such as requirements to consult the court about medical restraint (Austria). Other countries had clear mechanisms for reviewing decisions out of court where, for example, a social board or external expert would make decisions about involuntary placement (Denmark, Netherlands).

Other safeguards included a national guarantor for safeguarding the rights of older care home residents (Italy), measures allowing for poorly performing institutions to be shut down (Bulgaria) or early warning systems to identify structural or performance issues (Austria). However, in other situations it was a lack of safeguards that led to NPM commentary, such as the absence of community resources being a sole reason for a number of placements (Serbia) or, worryingly, the absence of pathologist examination or documentation for deaths in care where the resident who died was buried on the grounds of the care home (Bulgaria). Documentation provides a transparent means of

safeguarding the rights of residents who do not or cannot consent to their placement, but poor documentation practices mean that this is sometimes ineffective (Austria, Bulgaria, Serbia).

Funding and Financial Issues

Funding is not a human rights issue per se. Funding and Financial Issues are not included in the CPT checklist used to analyse findings in the second stage of our analysis but we did include them in the third stage. It was noteworthy that only eight NPMs raised funding or financial issues in the context of human rights reporting despite the fact that a lack of resources appeared to lie behind many of the other concerns raised, for instance lack of staff, or staff training, poor physical conditions. Our analysis suggested that funding was central to the delivery of care home residents' rights but an exclusive focus on specific and individualised human rights risked ignoring the structural issues upon which the achievement of rights, more broadly construed, relied.

Where funding issues were raised explicitly they included a lack of funding for staff, particularly on night-shifts (Austria, Bulgaria) or specialist staff such as nurses and medical staff (Bulgaria, Serbia, Ukraine). One NPM reported steps being taken to increase funding for specialist social work and physiotherapy staff (North Macedonia) but low salaries for doctors or social workers providing services to care homes meant that it was difficult to attract specialists (Bulgaria, Croatia, Ukraine). Psychological care was deemed expensive and low priority in the context of other pressing needs in some countries (Austria, Georgia).

Budgets for care home services were raised regularly within countries which highlighted funding issues. The management of budgets at municipal level in one country led to difficulties balancing budgets for a wide range of public services and the needs of care home residents or training staff on important issues such as dementia or working with mental health needs (Bulgaria). Material resources were under-funded in other countries, with NPMs noting a lack of funding for repairs and

renovations (Bulgaria, Slovenia, Ukraine) and basic medical, hygiene or sanitary products (Lithuania, Ukraine).

Legal reforms of care home funding had been made in one country (Czechia) but the transitional arrangements for this reform had given rise to uncertainty. Many older people were not aware of, or in receipt of, new payments and there was variance in institutions' understanding of what amounted to 'basic' funded care and what was 'excess' and, thus, required self-funding by older people. Attention to macro funding mechanisms provides a political claim to affirm the human rights of older people in care homes, yet calls for legal reform of funding arrangements were only made by NPMs in three countries (Czechia, Serbia, Ukraine).

Making human rights real in care homes for older people

This paper has analysed how NPMs - bodies established to prevent human rights abuses in places deprivation of liberty - have described their concerns regarding the rights of residents in care homes for older people in CoE member states. It has drawn attention to the different national contexts in which these rights must be observed. The reports analysed reveal significant concerns and, perhaps surprisingly, those concerns are observed consistently across the full range of states from which the NPMs report. We suggest that a focus on specific, individualised human rights, as exemplified in the CPT checklist and mandated by the functions accorded to NPMs, needs to be underpinned by states' willingness to address systemic and structural issues of culture, ageism, discrimination and resources which affect a wider range of care home residents' rights. These are not, of course, issues that can be resolved by the NPMs themselves, but they can be highlighted through the process of NPM visits and monitoring, as we have observed from the NPM reports.

Many reports referenced rights in the broader sense of a human rights culture and analysis was undertaken of all entries that made a specific mention of rights, ethics or values. The analysis showed

that a rights culture corresponding with ethical principles was most frequently raised, for example rights to freedom (Austria, Germany, Netherlands), dignity (Austria, Azerbaijan, Croatia, Finland, Italy, Serbia), confidentiality (Austria, Georgia), privacy (Austria, Croatia, Finland, Lithuania, Norway, Romania, Serbia) and consent (North Macedonia, Serbia). These rights cultures often corresponded with a duty owed by the care home staff or management and were reflected at the micro or individual level. Elsewhere, rights were raised in the context of an ethic of care, such as treating people with care, compassion and respect (Austria, Serbia) and working in a person-centred way (North Macedonia).

Human rights were raised occasionally, referring back to the ECHR (Bulgaria, Ukraine), the European Social Charter (Azerbaijan) or the Convention on the Rights of Persons with Disabilities (Serbia). Frameworks and policies for making complaints or giving feedback provided some insight into the enfranchisement rights of older people (Austria, Czechia, Georgia, Serbia, Slovenia). In respect of social rights such as the right to a healthy diet or good oral health care (Germany) it was a little vague as to whether they constituted a claim on the state or on the institution, or referred more to a commitment and value-base on the part of the NPM. Rarely, there were glimpses of the status of older people in society although reference to specific age-based discrimination was not found in the reports. One report described older people being scolded and described as 'naughty' for 'billing and cooing' to each other, masturbation or sexual attraction within the care home (Hungary). Here, the attitude of staff was the subject of the commentary rather than the ageism and infantilisation inherent in the example. Values of social inclusion and participation were more encouraging (Austria, Czechia, Romania, Serbia), with one positive example offering a glimpse of inter-generational solidarity through a community in-reach programme involving younger people and older care home residents befriending each other (Azerbaijan). This example is a rare instance where social rights impact on more macro issues in society rather than remaining at an individual level of analysis. It is of course important to note that care home workforces are often highly gendered, with high

proportions of migrant workers and frequently include high turnover and vacancy rates (Allan and Vadean, 2017). The point here is not to reinforce discriminatory attitudes towards this workforce. Rather, we point to structural influences on ageism in institutions that may be places of deprivation of liberty.

Human rights monitoring provides insight into practices of restraint, incidences of ill treatment and the ways that safeguards are afforded in cases of involuntary placement or the placement of those lacking capacity to consent. However, these good intentions to affirm older people's rights at policy level are not automatically translated into meaningful change in everyday life for care home residents (Steele et al, 2020). For example, guardianship may be seen as a safeguard for older people in these settings, but it can also be framed as an enabling mechanism for deprivation and restriction (Grenfell, 2019). Our research has shown that a nuanced analysis of the issues emerging from care home monitoring is needed to understand current challenges. Only if the causes for those challenges are identified, can abuse in care homes be prevented and appropriate care provided. There appears to be a correlation between ill treatment and other CPT themes, particularly the means of restraint, living conditions, health care and staffing issues. Yet, safeguards are not given sufficient attention despite their emphasis in the CPT checklist. It is a significant finding that the CPT checklist and subsequent factsheet only partially match the issues discussed by NPMs in their annual reports. We conclude that a more detailed framework that placed individual rights in a wider cultural, financial, legal and political framework would be helpful for NPMs to structure their findings and uncover systemic problems. Social care monitoring is one of the biggest areas of concern for NPMs because no clear guidance exists determining standards to be expected when visiting care homes, and national regulations may not provide instructions for appropriate levels of care. Such guidance would need political and sector-wide support in order to translate it into practice and apply it into the lived reality of care home residents as the identification of micro practices; for example guidance on restraint and ill treatment in individual care homes lacks rigour when set alongside substantial

shortfalls that can be attributed to funding and financial issues such as poor staffing and poor living environments, which are rarely discussed. The relationship to structural inequalities such as societal ageism is not mentioned in any NPM report. The identification of societal ageism is, however, crucial in order to unveil the widespread and international trends found in our analysis. The framework is here incidentally employed to highlight these macro issues.

Structural accounts, including the identification of ageism, are essential in the overall mission to improve the rights of older people who need care and support in residential settings. In the absence of this, the focus of accountability for shortcomings may fall on individuals providing care in care home settings, while the wider issue of inadequate macro structures is neglected. Additionally, deprivations of liberty may be accepted as benign safety measures that do not warrant monitoring if older people's rights are not foregrounded. Human rights standards provide a useful lens for understanding the care of the most vulnerable older people but risk proving purely descriptive or normative without analysis or explicit reference to more structural problems, including funding shortfalls. Indeed, an intense focus on human rights alone may obscure attention to structural issues in an unhelpful way that re-produces continuing human rights issues for older people in care homes and thereby poses a significant problem for guaranteeing their rights and combatting the experience of ageism. Furthermore, the emphasis on human rights breaches in individual care settings may reinforce the vulnerability of older people and underline concepts of dependence and the need for protection within existing care infrastructure, rather than seeking the perspectives of older people themselves and their vision for better care and better lives as in the sole example of individual practices being linked to social rights in the illustration from Azerbaijan above.

As well as paying attention to the structural context of the care home sector, NPMs might achieve greater impact through recognising OPCAT's intersections with other human rights instruments and emulating practice as it occurs under those instruments. Many older people also have disabilities so

considering the Convention on the Rights of Persons with Disabilities (CRPD) can help to realise older people's rights in a broader structural sense. Implementation and monitoring under the CRPD is resembles that which occurs under other core human rights instruments, including OPCAT, but is more purposive and progressive in its approach (Stein and Lord 2010). Under the CRPD disability is defined as the inability to participate fully in society based on the interaction between individual impairment and external barriers (CRPD, 2006). The Committee on the Rights of Persons with Disabilities seeks to bar detention based purely on grounds of impairment as this is discriminatory (CRPD Article 12) and underscores the need to obtain consent to treatment (CRPD Article 14), as well as the need to ban restraint methods contradicting the prohibition of torture (CRPD Articles 14 and 15). It might therefore prove beneficial for NPMs to recognise and monitor the rights of older people in line with CRPD jurisprudence. Understanding disability as a social construct and occurrences such as loss of autonomy not as a natural process, but as an active decision that needs to be thoroughly justified and monitored, helps prevent abuse against older people (UN General Assembly, 2019). Some may continue to question the extent to which OPCAT advances the rights of older people, or whether preventive monitoring may instead legitimise detaining people based purely on their disability. By actively advancing the rights of older people in line with CRPD commentary NPMs can contribute towards ending the widespread detention of persons based on their disability as a constituent element of their monitoring function and role in preventing abuses of human rights.

As indicated, we recognise that the COVID-19 epidemic has had devastating consequences for the residents of older people's care homes throughout Europe (WHO 2020), illustrating with dreadful clarity the vulnerability of these residents and systemic failures to protect them. It has further heightened the need to assure and affirm the rights of older people in care homes internationally. COVID-19 and its catastrophic impact on the residents of care homes far and wide provides fresh urgency to ensuring that the rights of older residents are upheld and that attention is given to macro-level issues of adequate funding and structural inequalities. Whilst the data analysed in this study

pre-dates COVID-19, an early European study from May 2020 demonstrates the high exposure of older care home residents to the disease (and heightened risk of death as a result) and the inconsistent means of monitoring infection control in these settings across Europe (European Centre for Disease and Prevention Control 2020). Aside from the heightened risk of physical illness and death, older care home residents are also more likely to have become more isolated during the pandemic as family and friends are unable to visit, thereby increasing older people's vulnerability to poor care, abuse, neglect and, as a result, breaches of their human rights (Gardner et al 2020). The COVID-19 pandemic illustrates the need to protect the most basic rights of care home residents and how those rights depend on the systemic issues we have discussed. The scale of the pandemic is unusual - the issues it reveals are not. Only with sufficient awareness of the relationship between individual rights and their interaction with wider systemic issues will it be possible to develop a robust universal framework of appropriate care for older people in care homes.

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