

THE NETHERLAND

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Aart Hendriks
Johan Legemaate

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Executive summary

Definitions

- [1]. Dutch law uses various terms to refer to persons with a mental disorder or intellectual disability. The term applied is dependent on the context the person finds him or herself in and the type of law. The term ‘persons with a mental disability’ is increasingly being used as an umbrella term, both by the legislature and the general public.

Anti-discrimination

- [2]. The Netherlands has signed but not yet ratified the UN Convention on the Rights of Persons with Disabilities. The country has not signed the Optional Protocol. The Netherlands has, however, an extensive framework on anti-discrimination legislation. This body of law consists of a general equality and anti-discrimination clause in the Constitution, the 2003 Act on equal treatment on grounds of disability or chronic illness (*Wet gelijke behandeling op grond van handicap of chronische ziekte*) and, since 2006, various anti-discrimination provisions in the Criminal Code (*Wetboek van Strafrecht*). The protection offered by Article 1 of the 1998 Constitution on grounds of mental / intellectual impairment should not be overestimated. The 2003 Act on equal treatment on grounds of disability or chronic illness offers protection against discrimination on any type of disability or chronic illness. Its material scope is, however, confined to employment, occupation, education and housing. Yet, the Equal Treatment Commission gave, in a few cases, its views on the unequal treatment of persons with a mental disorder or intellectual disability. The anti-discrimination provisions of the Criminal Law with respect to mental disorder or intellectual disability have yet not been invoked in criminal law cases.

Specific fundamental rights

- [3]. People with a mental disorder or intellectual disability generally are equally entitled to all other human rights recognised under the Constitution of the human rights treaties the Netherlands is a party to. Legal or factual incompetence can, however, impede the full and equal enjoyment of these rights. This holds true with requests for euthanasia / physician assisted suicide, medical procedures only decriminalised under very strict conditions and when performed by a physician in accordance with the statutory duty of due care. Dutch law seeks to balance the right to engage in sexual relations and the duty to protect vulnerable groups from sexual abuse. People, who lack due to a

mental disorder or intellectual disability the competency to consent to marriage, are prohibited from marrying under Dutch law. Parents with a mental disorder or intellectual disability have a right to procreate, can not be forced to have anti-conception or undergo sterilisation in the interests of others, but have to accept interferences with their private and family life to protect the interests and rights of the (future) child. Since the 2009 elections for the European Parliament, people with a mental disorder or intellectual disability are equally allowed to enjoy the right to vote.

Involuntary placement and involuntary treatment

- [4]. The 1992 Psychiatric Hospitals (Compulsory Admissions) Act regulates the involuntary placement and involuntary treatment of persons with a mental disorder. This Act is not limited to psychiatric hospitals, but also applies to institutions for persons with intellectual disabilities and nursing homes for persons with dementia. This Act does make a distinction between involuntary placement and involuntary treatment. It is assumed that placement will lead to (voluntary) treatment. Involuntary treatment is only justified in exceptional situations defined by law.
- [5]. On the basis of the third evaluation of the 1992 Psychiatric Hospitals (Compulsory Admissions) Dutch government decided to replace this Act by two new pieces of legislation: the Care and Coercion Act (*Wet zorg en dwang*) (dealing with institutions for persons with intellectual disabilities and persons with dementia) and the Act on Compulsory Mental Health Care (*Wet verplichte geestelijke gezondheidszorg*) (dealing with psychiatric hospitals). If both of these Bills are adopted by Parliament this will result in major changes in the Dutch legal framework regarding involuntary placement and involuntary treatment.
- [6]. At present, involuntary placement and involuntary treatment may only be carried out after the fulfilment of strict criteria laid down in the 1992 Psychiatric Hospitals (Compulsory Admissions) and in the absence of less intrusive measures.
- [7]. The Psychiatric Hospitals (Compulsory Admissions) Act contains strict criteria on the assessment of a psychiatric disorder requiring involuntary placement, the maximum duration of involuntary placement and the legal procedures to be followed. In addition, this Act foresees is hospital complaints' committees patients can turn to.

Competence, capacity and guardianship

- [8]. Dutch law does not provide a definition of competency or capacity. Incompetence has to be decided upon in individual cases. The law recognises that incompetence can be partial and / or temporary.
- [9]. The Civil Code contains various provisions with regard to the management of affairs of persons with a mental disorder or intellectual disability, including three measures of representation that can be imposed by a judge in case the person concerned is unable to manage his or her own affairs (*curatele*, *bewindvoering* and *mentorschap*). There are no minimum or maximum time limits of these measures. The legislation with regard to *curatele*, *bewindvoering* and *mentorschap* does not contain the possibility to appeal a decision of the court to a higher court.

Definitions

- [10]. Dutch law makes use of various terms to refer to persons with a mental disorder and persons with an intellectual disability (henceforth: persons with a mental disorder or intellectual disability). The legal terminology is generally dependent on the context a person with a mental disorder / intellectual disorder finds him / herself in. In the field of (mental) health care, the typology of the 1992 Psychiatric Hospitals (Compulsory Admissions) Act (*Wet bijzondere opnemingen in psychiatrische ziekenhuizen* or *Wet BOPZ*) is leading. This Act distinguishes between ‘individuals suffering from a mental disorder’ (*persoon gestoord in zijn geestvermogens*), persons admitted to a nursing home (*persoon opgenomen in een verpleeghuis*) and persons admitted to a home for the mentally handicapped (*personen opgenomen in een zwakzinnigeninrichting*). Even though the Act does not use those terms, these groups are commonly addressed as psychiatric patients, psychogeriatric patients (notably persons with dementia) and people with intellectual disabilities. In the 1992 Psychiatric Hospitals (Compulsory Admissions) Act ‘mental disorder’ is defined as ‘defective development of pathological impairment of the mental faculties’.
- [11]. In the fields of employment, education and social security, other distinctions are made by the law. For example, the Act on Social Employment (*Wet op de sociale werkvoorziening*) is applicable on individuals with physical, intellectual or mental restrictions (*personen met lichamelijke, verstandelijke of psychische beperkingen*). The Act on employment and income depending on labour capacities (*Wet werk en inkomen naar arbeidsvermogen*) differentiates between individuals who are completely and lastingly unfit to work (*volledig en duurzaam arbeidsongeschikt*) and individuals who are partially labour disabled (*gedeeltelijk arbeidsongeschikt*). In the field of education four types (‘clusters’) of special education are distinguished, including cluster 3 type education aimed at pupils with intellectual and / or physical restrictions (*leerlingen met verstandelijke en / of lichamelijke beperkingen*) and cluster 4 type education targeted at children with educational difficulties (*moeilijk opvoedbare kinderen*) and pupils with longterm mental illnesses (*langdurig psychisch zieke kinderen*). All these laws and related by-laws define mental disorders and intellectual disabilities in terms of functional and social impairments. According to social security laws, like the Act on employment and income depending on labour capacities, disabilities can be measured and expressed in terms of a percentage, with only people who are more than 35 percent ‘unfit to work’ entitled to a social benefit.
- [12]. In the context of civil and penal law, again, various other terms are being used by the law to refer to people who are legally or factually incompetent (*wilsonbekwaam* and *handelingsonbekwaam*), in which case the judge can decide to appoint a guardian / legal representative (e.g. a *bewindvoerder* [aimed

at protecting the property and financial interests of the person concerned], *curator* [aimed at protecting property and financial interests and/or interests regarding care and treatment] or *mentor* [aimed at protecting the interests of the patient regarding care and treatment]). Incompetence is not clearly characterised by law, but the various laws contain above all descriptions. For example, placing a person under custody (*onderbewindstelling*) is defined by Article 1:431 paragraph 1 of the Civil Code as ‘an adult who is temporarily or lastingly unable to adequately manage his assets by himself due to his physical or mental situation’ (*een meerderjarige als gevolg van zijn lichamelijke of geestelijke vermogens tijdelijk of duurzaam niet in staat is ten volle zijn vermogensrechtelijke belangen zelf behoorlijk waar te nemen*). Incompetence is not broken down in percentages but in absolute categories: competent versus incompetent. As a rule a person is considered competent unless proven to be incompetent.

- [13]. These terms are all being used to refer to a (sub)category of people with a mental disorder or intellectual disability, or to people with a mental disorder or intellectual disability in a particular area of social life. Although these terms are closely related, they do not necessarily overlap. For example, an individual suffering from a mental disorder (‘a psychiatric patient’) does not necessarily qualify for involuntary placement, but may have a mentor or other judge appointed legal representative.
- [14]. Under the influence of the international disability rights movement (A.C. Hendriks, ‘From social (in)security to equal employment opportunities. A report from the Netherlands’, in: M. Jones & L.A. Basser Marks (red.), *Disability, divers-ability & legal change*, Den Haag / Boston / Londen: Martinus Nijhoff Publishers 1999, p. 153-170), followed by the inclusion of Article 13 in the EC Treaty and subsequent adoption of EC Directive 2000/78 and the UN Convention on the Rights of Persons with Disabilities, there is a tendency in the Netherlands to use the term *personen met een verstandelijke handicap* (‘persons with a mental disability’) as an umbrella term to refer to all types of mental and intellectual impairments. This is clearly reflected in the Act on equal treatment on grounds of disability or chronic illness (*Wet gelijke behandeling op grond van handicap of chronische ziekte*), an Act that fails to define the terms ‘disability’ and ‘chronic illness’. It is only in the Parliamentary Records, that as such are not binding but merely a source of inspirations for judges when interpreting the law, that these terms are described: ‘Disabilities and chronic illnesses can be physical, intellectual and mental in nature. A disability is moreover irreversible. A chronic illness is not always irreversible, but always long-lasting.’ (Parliamentary Documents (*Kamerstukken II*) 2001/02, 28 169, no. 3, p. 24).
- [15]. Whereas there are some judgments on the definitions and, above all, application of the terms ‘disorders’ and ‘disability’ – e.g. on whether ‘alcoholism is a mental illness – case-law as such has no significance when it comes to defining these terms and exploring their meaning.

- [16]. It can thus be concluded that there is not a single legal term to refer to persons with a mental disorder or intellectual disability. The law uses various terms, dependent on the context a person finds him or herself and dependent on the type of law. The term 'persons with a mental disability' is increasingly being used as an umbrella term, both by the legislature and the general public. These developments have not been influenced by case-law.

1. Anti-discrimination

- [17]. For a long time, Dutch legislators and the public at large considered persons with a mental disorder or intellectual disability as being unable to participate as equals in society and lacking the mental / intellectual capacities necessary to generate an income for themselves by performing paid work. The Netherlands was proud of its generous social security system, bestowing individuals with a mental disorder or intellectual disability with a right to wage-replacement and a minimum income. A large number of sheltered workplaces had been created for persons with a mental disorder or intellectual disability who often resided in a publicly financed care institution.
- [18]. At the same time, the Dutch attach great importance to such values as respect for diversity and non-discrimination. In fact, the very first Article of the 1983 Constitution (*Grondwet*) of the Netherlands concerns the right to equality and the prohibition of discrimination on various grounds. Even though it is often maintained that there is no hierarchy between the fundamental rights enshrined in the Constitution, it is no coincidence that the right to equality and the prohibition of discrimination ranks first in this document.
- [19]. It was not until the late 1990's that Dutch politicians and policy makers started to acknowledge that people with (mental) disabilities also faced discrimination in the Netherlands. In fact, prior to the adoption of the General Act on Equal Treatment (*Algemene wet gelijke behandeling*) in 1994, an almost unanimous Parliament did not see a need to add the criterion 'handicap' to the enumerated list of protected non-discrimination grounds. This criterion was considered less suspect and difficult to define. Prohibiting discrimination on grounds of disability was moreover thought to jeopardise all the disability-specific facilities in place. Non-disabled persons could, it was maintained, then also claim privileged parking places, social benefits and special accommodation.
- [20]. By the end of the 1990's, the political and societal climate had completely changed. An overwhelming majority in Parliament favoured the introduction of non-discrimination legislation to protect people with disabilities from unjustified forms of disadvantageous treatment. Various studies had demonstrated that people with physical and mental disabilities were indeed prone to and subjected to discrimination in the Netherlands, while lacking adequate legal protection (M.A. Gras, *Een schijn van kans. Twee empirische studies naar discriminatie op grond van handicap en etnische afkomst*, Deventer: Gouda Quint 1996 & A.C. Hendriks, *Gelijke toekomst tot de arbeid voor gehandicapten*, Deventer: Kluwer 2000). It was not until 1 December 2003, one day before the expiration of the implementation period of Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation, that the before mentioned Act on

equal treatment on grounds of disability or chronic illness (*Wet gelijke behandeling op grond van handicap of chronische ziekte*) came into force.

1.1. Incorporation of United Nations standards

- [21]. On 30 March 2007, the Netherlands was amongst the first countries to sign the UN Convention on the Rights of Persons with Disabilities. Different from 87 other countries, the Dutch government did not ratify the Optional Protocol.
- [22]. Dutch government has expressed the intention, and communicated to Parliament, the intention to ratify this Convention. A Ratification Bill, that needs to be adopted by both Houses of Parliament is currently under preparation. It is not known yet when a draft version of the Bill will be sent to the Council of State for consultation, after which a final version of the Bill can be submitted to Parliament.
- [23]. In the absence of ratification, the provisions of the UN Convention on the Rights of Persons with Disabilities have no legal significance in the Netherlands. Unlike the European Court of Human Rights in the case of *Glor v. Switzerland* (30 April 2009, application number 13444/04), Dutch courts have refrained from referring to this document.

1.2. The anti-discrimination national framework

- [24]. The Netherlands has a solid anti-discrimination framework, consisting of general and – ground and / or context – specific anti-discrimination laws and provisions. Most relevant for the present report are the anti-discrimination clause in the 1983 Constitution (*Grondwet*), the Act on equal treatment on grounds of disability or chronic illness (*Wet gelijke behandeling op grond van handicap of chronische ziekte*) and the anti-discrimination provisions in the Criminal Code (*Wetboek van Strafrecht*).
- [25]. According to Article 1 of the Dutch Constitution ‘All persons in the Netherlands shall be treated equally in equal circumstances. Discrimination on the grounds of religion, belief, political opinion, race, or sex or on any other grounds whatsoever shall not be permitted.’ This provision seeks to express, through the first sentence, the principle of equal treatment in general terms and, through the second sentence, the prohibition of discrimination with respect to specific grounds. It was the original intention to have an exhaustive number of protected grounds. The proposed closed system was broken up by way of a

parliamentary amendment by adding the words ‘or any other grounds whatsoever’. It was the intention of the legislature that this open-ended clause would leave space for new legal developments.

- [26]. For – at least – three reasons Article 1 of the Constitution offers little protection against discrimination on grounds of mental disorder or intellectual disability. First, despite its open-ended character Dutch courts and policy makers make a distinction between listed and non-listed grounds. Differentiation on a listed ground is generally considered more suspicious than on a non-listed ground. Dutch courts interpret international anti-discrimination provisions, notably Article 14 of the European Convention on Human Rights and Article 26 of the International Covenant on Civil and Political Rights similarly. According to a recent decision of the *Hoge Raad* (the High Council of the Netherlands, the supreme court in decisions in the field of civil, criminal and fiscal law) anti-discrimination provisions primarily seeks to prohibit distinctions on the basis of *aangeboren* (inborn) criteria (Hoge Raad 25 September 2009, *LJN* BH2580; can be retrieved – but only in Dutch – via www.rechtspraak.nl). The case concerned the difference Dutch social security law makes between former partners with children and former partners without children. Under reference to the judgements of the European Court of Human Rights in the cases of *Stec* and *Carson et al.*, the Hoge Raad considered that if a distinction does not concern an inborn feature, such as sex, race or ethnicity, the decision of the legislature should be respected unless the distinction is deprived of a reasonable ground.
- [27]. In 2006, a governmental committee rejected the idea to change this provision and add the ground disability (together with some other grounds) (*Commissie rechtsgevolgen non-discriminatiegronden*, Den Haag: ministerie van Binnenlandse Zaken en Koninkrijksrelaties 2006). Disability – including mental disorders and intellectual disabilities – is thus not explicitly being referred at by the anti-discrimination clause in the Dutch Constitution. Second, this provision first of all applies to the so-called vertical relations (State-individual). This Article also has *Drittwirkung* or normative meaning for the horizontal relations (private parties amongst themselves), but its precise meaning is dependent on contextual factors. In an effort to clarify the significance of this provision for the horizontal relations laws were enacted regulating the relations between private parties in specific areas. Disability was not included in the 1994 General Act on equal treatment (*Algemene wet gelijke behandeling*). Instead, in 2003 a special act was adopted prohibiting discrimination with respect to disability in employment and occupation, the before mentioned Act on equal treatment on grounds of disability or chronic illness (*Wet gelijke behandeling op grond van handicap of chronische ziekte*). Third, Article 120 of the Constitution prohibits the constitutional review of statutory acts by judges. This further restricts the protection Article 1 can offer to discrimination on grounds of disability or a mental disorder or intellectual disability. These limitations may also explain the absence of case-law under Article 1 of the Constitution with respect to discrimination on grounds of mental disorder or intellectual disability.

- [28]. Instead, in 2003 a special act was adopted prohibiting discrimination with respect to disability and chronic illness. The Act on equal treatment on grounds of disability or chronic illness (*Wet gelijke behandeling op grond van handicap of chronische ziekte*) was modelled after the 2004 General Act on equal treatment (*Algemene wet gelijke behandeling*), but its material scope is much more narrow. While the General Act applies to employment and occupation, education and access to and the provision of goods and services, the Disability Act merely applies to employment, occupation and public transport (provisions with respect to the later field of social life have not yet entered into force). The scope of the Disability Act is, however, in conformity with and does not exceed the scope of Directive 2000/78/EC that demanded Member States to adopt their laws, regulations and administrative provisions necessary to comply with its provisions. While this directive refers – besides other grounds – only to ‘disability’, in the Equal Treatment Act in the Netherlands refers to disability and chronic illness. Dutch government has always stated that the Disability Act is incremental by nature and expressed its intention to merge the Disability Act with the General Act. The latter has not been elaborated yet. Since December 2003 the scope of the Disability Act has, however, been broadened by adding the grounds ‘housing’ (2009) and ‘primary and secondary education’ (2009).
- [29]. Under this Act ‘discrimination is defined as direct discrimination, indirect discrimination, an instruction to discriminate, harassment and a failure to provide a reasonable accommodation (in Dutch: *doeltreffende aanpassing* or effective accommodation). The Disability Act is the first and so far the only piece of legislation acknowledging that a failure to provide an effective accommodation without reasonable grounds constitutes a form of discrimination.
- [30]. Under the Act on equal treatment on grounds of disability or chronic illness (*Wet gelijke behandeling op grond van handicap of chronische ziekte*) individuals who deem that they have been discriminated against can file a complaint with a court and / or petition the Dutch Equal Treatment Commission. By the October 2009, there were less than ten judgments by courts on the Disability Act. Whereas the Commission has applied the concept of reasonable accommodation in various cases, courts so far never referred to this obligation.
- [31]. All cases on disability discrimination decided by lower courts, concerned persons with physical impairments. The Equal Treatment Commission annually decided upon 15-30 disability rights cases (2006: 23; 2007: 27; 2008: 17; October 2009: 9). Some of the cases concerned alleged discrimination on grounds of mental disorder or intellectual disability, notably with respect to access to education and assistance offered to pupils / students with extra needs. In a very few cases, almost all submitted by parents of a child with a mental disorder or intellectual disability, the Commission found a violation of the Disability Act. The Commission also dealt with a few complaints by people

with a mental disorder or intellectual disability and employment. The complaints concerned alleged harassment and alleged unequal pay. In none of these cases did the Commission find a violation of the Disability Act.

- [32]. Since January 2006 the Penal Code contains various provisions on discrimination on grounds of ‘physical, mental or intellectual disabilities’ (*lichamelijke, psychische of verstandelijke handicap*). These provisions (Articles 137c, 137d, 137e, 137f, 137g and 429quater) prohibit various types of discrimination, including hate speech. So far no case law exists on any of these provisions with respect to the grounds mental or intellectual disabilities. There are also very few decisions with respect to the other protected grounds. The scarcity of jurisprudence is thought to be related to the difficulty to prove discrimination, notably discriminatory intent.
- [33]. Under the influence of EU law Dutch law and practice are rather ambivalent about positive action measures (‘preferential treatment arrangements’), including such measures for persons with a mental disorder or intellectual disability. Politicians and society at large dispute the added value of such measures. The Constitution does not refer to this and courts are rarely asked to assess the legitimacy of such measures (so far only with respect to women and members of ethnic minorities). The before mentioned Act on equal treatment on grounds of disability or chronic illness (*Wet gelijke behandeling op grond van handicap of chronische ziekte*) allows for positive action measures for people with a disability or chronic illness by way of a temporary measure to reduce the disadvantaged position of people with a disability or chronic illness. It is, as yet, unclear how this provision (Article 3 para. 1 under c) is to be applied – e.g. for all people with a disability or chronic illness or also for subgroups. There is one opinion of the Equal Treatment Commission on positive action measures for – amongst others – people with a disability or chronic illness. The Commission concluded here that such programmes can be justified provided that they do not confine themselves to employees affected by a labour disability seeking to return to the labour market (Opinion 2006-61, can be retrieved – but only in Dutch – via www.cgb.nl).

2. Specific Fundamental Rights

2.1. The Right to life

- [34]. The right to life is neither referred to in the Dutch Constitution, nor in Dutch case-law. This right is, however firmly protected by law in the Netherlands and reflected in various legal provisions and judgments. This right is enshrined in Article 2 of the European Convention on Human Rights and Article 6 of the International Covenant on Civil and Political Rights, both treaties ratified by the Netherlands, as well as various provisions in the Criminal Code. The latter provisions prohibit murder, manslaughter, assistance with suicide etc. These provisions equally apply to and protect persons with a mental disorder or intellectual disability.
- [35]. In the Netherlands, individuals have the right to reject medical treatment or any other interference with their integrity (cf. Article 11 of the Constitution and the Patients Rights Act, *Wet op de geneeskundige behandelingsovereenkomst*). Under very strict conditions, a physician performing euthanasia upon the request of an individual or assisting him or her upon his or her request with suicide and fulfilling the statutory duty of due care will be exempted from criminal prosecution under the 2001 Termination of Life on Request and Assisted Suicide (Review Procedures) Act (*Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding*), that came into force on 1 April 2002. Although it is often assumed that people in the Netherlands enjoy the right to life *and* the right to die, the latter right has no basis in the (case) law and individuals have not entitlement towards others to assist them in ending their life.
- [36]. The rejection of medical treatment or a request for euthanasia or physician assisted suicide presuppose that the individual is competent and able to voluntarily express his or her will. This is not necessarily the case with individuals with a mental disorder or intellectual disability. In case of factual or legal incompetence, requests for euthanasia / physician assisted suicide do not meet the criteria of the 2001 Termination of Life on Request and Assisted Suicide (Review Procedures) Act. A legal representative can not ask for euthanasia on behalf of someone else. The law does foresee in the possibility of drawing up a euthanasia directive at a time that the patient is (still) fully competent, but physicians are bound to critically examine the voluntary nature of this directive and to assess whether all criteria are met. The question whether people with symptoms of dementia or another neurodegenerative disorder are entitled to euthanasia / physician assisted suicide is a topical issue of debate.
- [37]. Children born with a mental disorder or intellectual disability are equally entitled to the right to life / necessary health care. Physicians may only consider

withholding or refraining treatment in case of no chances of survival, an extremely poor prognosis for the future or – though still debated – a prognosis of severe suffering. A mental disorder or intellectual disability does not fall in any of these three categories.

2.2. The right to freedom from torture or cruel, inhuman or degrading treatment or punishment

- [38]. The right to freedom of torture, as laid down in Article 3 of the European Convention on Human Rights and Article 7 of the International Covenant on Civil and Political Rights, ranks as one of the most fundamental rights in the Netherlands. There are no indications of State induced or State condoned abuse of persons with a mental disorder or intellectual disability. The law requires care providers to treat everyone with due respect, while care institutions should comply with strict quality standards. The Health Inspectorate (*Inspectie voor de Gezondheidszorg*) has a broad mandate to measure compliance with these standards. Sample text. Sample text. Sample text. Sample text.
- [39]. The Dutch Criminal Code foresees in higher penalties in case of (sexual) abuse of persons with a mental disorder or intellectual disability (Article 243 and 247 *Wetboek van Strafrecht*). From the case law it can be learnt that these provisions do not generally apply to instances of sexual abuse with persons with a mental disorder or intellectual disability, but only to situations of persons with a disorder inhibiting them to consent to or resist sexual intercourse (e.g. *Rechtbank Den Haag* 9 February 2007, *LJN AZ8336* and *Rechtbank Zwolle* 27 March 2008, *LJN BC8233*, can be retrieved – but only in Dutch – via www.rechtspraak.nl). The District Court (*Rechtbank*) in Zwolle recently decided that this strict criterion also applies to cases of mental retardation. The fact that the case concerned a 16 years old girls staying in an institution for children with mental health problems and a bus driver of 58 years old was not a factor taken into account by the court (*Rechtbank Zwolle* 29 September 2009, *LJN BJ8981*, can be retrieved – but only in Dutch – via www.rechtspraak.nl).
- [40]. The latest report of the European Committee for the Prevention on Torture (CPT) on the situation in the Netherlands does not contain comments on or recommendations with respect to mental health institutions (CPT/Inf (2008)2). For older reports of the CPT, see under V Involuntary placement and involuntary treatment.

2.3. The right to freedom from exploitation

- [41]. Dutch law seeks to strike a fair balance between autonomy and protection. In order to protect people from exploitation, the law contains provisions on minimum salary; maximum working hours etc. and prohibits the performance of certain harmful acts or to otherwise violate one's dignity (e.g. voluntarily consent with female genital mutilation). People performing sheltered employment under the Act on Social Employment (*Wet op de sociale werkvoorziening*) are entitled to a labour contract and decent pay. All these acts have also been drawn up to protect people with a mental disorder or intellectual disability.
- [42]. Special reference should be made here to legislation protecting (potential) organ donors and research subjects with a mental disorder or intellectual disability. These laws, the Organ Donation Act (*Wet op de orgaandonaties*) and the Medical Research with Human Subjects Act (*Wet medisch wetenschappelijk onderzoek met mensen*) contain special provision protecting people with a mental disorder or intellectual disability or otherwise vulnerable from exploitation.
- [43]. In a few instances, individuals receiving a social – notably income-replacement – benefit have appealed to Dutch courts, alleging that the duties imposed on them to find and accept work constitute a form of forced labour. This is also relevant for people with a mental disorder or intellectual disability, now that many of them have no work or are required to perform adapted work. The appeals lodged so far were not successful for the applicants (cf. Centrale Raad van Beroep 5 October 2009, *LJN BJ8854*; can be retrieved – but only in Dutch – via www.rechtspraak.nl).

2.4. The right to liberty and security

- [44]. The right to liberty and security is firmly protected by Article 15 of the Dutch Constitution, Article 5 of the European Convention on Human Rights and Article 9 of the International Covenant of Civil and Political Rights. According to these provisions, deprivation of liberty shall not take place save in exceptional situations foreseen by law and in accordance with a procedure prescribed by law. These provisions equally protect the liberty and security of persons with a mental disorder or intellectual disability. They do not only provide theoretical, but also practical protection. Dutch courts closely follow and apply the standards developed by the Strasbourg Human Rights Court with respect to Article 5, although national courts are not always certain about the precise meaning and implications of certain ECtHR decisions in this area, such as the case of *Varbanov* (Appl.no. 31365/96). In this and other judgments the Court spoke about 'medical experts', according to Dutch case-law: 'psychiatrists'. The question is, however, whether only a psychiatrist qualifies

as a ‘medical expert’ and, if so, whether it a psychiatrist can delegate his or her responsibilities to a physician in training for a psychiatrist.

- [45]. The 1992 Psychiatric Hospitals (Compulsory Admissions) Act (*Wet bijzondere opnemingen in psychiatrische ziekenhuizen*) forms the legal basis for the deprivation of liberty of persons with a mental disorder or intellectual disability who pose a danger to themselves or others stemming from a mental illness (see below, under V Involuntary placement and involuntary treatment). Measures depriving a person of his or her liberty need, under this law, to be decided upon by a judge. The length of a measure is maximally one year, after which renewal is necessary.
- [46]. Persons with a mental disorder or intellectual disability are, in case of a criminal offence, in principle subjected to the mainstream criminal law procedures. The law foresees in a special TBS-regime in case of criminal offences committed by persons with a mental illness or disorder influencing behaviour, as a result of which they can not be held (fully) accountable for their behaviour. TBS stands for ‘placement under a hospital order’ (*ter beschikking stelling*), a treatment measure imposed by a court. There are two types of TBS: a hospital order with compulsory treatment (custodial measure) and a conditional hospital order. The Netherlands has a total of eight custodial clinics and four Forensic Psychiatric Clinics (FPKs). The advantage of the TBS system is that persons with a mental disorder or intellectual disability are not treated like ‘ordinary’ criminals and that attention is being paid to their special needs. The disadvantage of this system allegedly is, that TBS measures can, different from a criminal sanctions, regularly be renewed.

2.5. The right to fair trial

- [47]. Under Dutch law, a mental disorder or intellectual disability does not affect one’s right to a fair trial, protected by Article 6 of the European Convention of Human Rights and Article 14 of the International Covenant of Civil and Political Rights. In cases of legal or factual incompetence, a legal representative acts on behalf of the person concerned. The nominated representative are (in this order): a court appointed representative, a person nominated by the patient him or herself, the patient’s spouse or partner, a parent, child, brother or sister of the patient. Generally, the court will not only ask the representative’s opinion but also the opinion of the person concerned.
- [48]. According to Article 18 of the Constitution, everyone in the Netherlands can be assisted by lawyer or other legal specialist during court procedures. For those lacking the funds to pay for legal assistance themselves, there is a system of legal aid, organised and being paid for by the Ministry of Justice. The particularities of this system are laid down in the Law on Legal Aid (*Wet op de rechtsbijstand*). People with a mental disorder or intellectual disability are also

entitled to legal aid under this act. In fact, there is a special regulation drawn up by the Council for the Judiciary (*Raad voor de rechtspraak*)¹ on legal aid for psychiatric patients (*Regeling rechtsbijstand psychiatrische patiënten*). This regulation seeks to ensure that psychiatric patients facing deprivation of liberty will receive the assistance of an experienced legal aid provider with knowledge about the particularities of psychiatry and the mental health legislation. There are, as far as we are aware of, no regulations or other guarantees specifically geared to the needs of people with a mental disorder or intellectual disability to ensure their right to a fair trial. There is neither any case law articulating or otherwise exploring the right to a fair trial of people with a mental disorder or intellectual disability.

- [49]. Mental and intellectual disorders severely affecting the credibility of statements made by the persons concerned will generally not be considered as valid by a court. As a corollary, persons with a mental disorder or intellectual disability allegedly having been subjected to (sexual) abuse encounter serious problems proving the guilt of their perpetrators, who are also entitled to a fair trial.

2.6. The right to privacy, including the access to one's own confidential medical records

- [50]. The right to privacy is protected by Article 10 of the Dutch Constitution, as well as Article 8 of the European Convention of Human Rights and Article 17 of the International Covenant on Civil, Political and Cultural Rights. This right protects 'anyone', including persons with a mental disorder or intellectual disability. It is not an absolute right. Interferences with this right are deemed justified in case of voluntary consent, when foreseen by law or in case of conflicting rights and interests and more weight being attached to these other rights and interests. Although sometimes rather intrusive from a privacy perspective, monitoring people with a mental disorder or intellectual disability in institutions or in foster families is not considered to conflict with the right to privacy. As with many of the other rights discussed in this report, there is no case-law exploring the meaning of the right to privacy of/for people with a mental disorder or intellectual disability.
- [51]. Health information is, under the 2000 Data Protection Act (*Wet bescherming persoonsgegevens*), considered 'particularly' sensitive information in need of enhanced privacy protection (Article 16). It follows that the automatic procession of information on one's health status, including a mental disorder or

¹ The council, part of the judiciary system but not administering justice itself, has taken over responsibility over a number of tasks from the Minister of Justice.

intellectual disability, is generally forbidden save in precisely defined exceptional situations.

- [52]. In the health care sector, patients with a mental disorder or intellectual disability are equally entitled to the confidential treatment of medical information (Article 7:457 Civil Code) and access to their medical file (Article 7:456 Civil Code). A health care provider is, according to the law, not allowed to deny access to one's file under any conditions, except for situations where information included in a medical file touches on the private life of a third person. A patient also has the right to have his or her medical file being destroyed (Article 7:455 Civil Codes).
- [53]. Enjoyment of the right to have his or her medical file being destroyed is not always considered to be beneficial to persons with a mental disorder or intellectual disability. The destruction of valuable medical data may hamper the (continuation of) good care to the person concerned and imply that diagnostic studies have to be performed again.
- [54]. Currently, an Act on Electronic Patients Files is pending in the Senate. If adopted, patients will have, besides their medical file administered by their health care provider, a (selective) digital file with medical data that can be of importance for other health care providers. These digital files can be accessed by a limited number of health care providers in possession of a unique personal card. Also under this Act, patients – with or without a mental disorder or intellectual disability – remain the right to refuse the exchange of information, to access their own digital file and to have this file being destroyed.

2.7. The right to marry, to found a family and to respect of family life

- [55]. Same and opposite sex couples above the age of eighteen have the right to marry under Dutch law (Articles 1:30-31 Civil Code). Under certain conditions, individuals above the age of sixteen years can exercise the right to marry.
- [56]. Individuals who lack the competency to consent to marriage due to a disturbance of the mental or intellectual capacities are prohibited from marrying (Article 1:32 Civil Code). The prosecutor general is required to bring to a halt the intention of a couple to marry, once such a disturbance becomes known to him or her. The civil servant leading the wedding ceremony is entitled to withhold his or her approval of a marriage when it becomes clear to him / her that one of the marriage candidates is unable to consent. In case such a disturbance comes to light only after the wedding, the marriage will be declared null and void. We have not come across any case-law on these issues with respect to people with a mental disorder or intellectual disability.

- [57]. Dutch law foresees in similar provisions on registered partnership, a civil union between two persons of the same or opposite sex similar to marriage (Article 1:80 et al. Civil Code).
- [58]. Being marriage or being registered as partners is not a prerequisite for being entitled to found a family and for respect to family life. This equally holds true to people with a mental disorder or intellectual disability (see also under 3.8). Parents exercise parental authority over their children (Article 1:245 Civil Code). Parental authority is the right and duty of parents to care for and educate their children (Article 1:247 Civil Code). Parents enjoy a margin of appreciation with respect to the way they want to exercise this authority.
- [59]. Parents placed under custodial care (*curatele*) (a legal regime aimed at protecting property and financial interests and/or interests regarding care and treatment) as well as parents suffering from a mental disorder to the extent that they are unable to duly exercise parental authority are, however, legally incompetent to comply with this task (Article 1:246 Civil Code). In those family situations where the interests of children are being challenged or otherwise at stake, the law foresees in three types of intervention: placing a child under supervision (*ondertoezichtstelling*), removal of parental authority (*onthefing*) and outplacement (*ontzetting*). The court can decide to place the child under supervision of the State, or more precisely the Office of Youth Care (*Bureau Jeugdzorg*) (Article 1:254 Civil Code). In such cases the Office of Youth Care can decide to appoint a family guardian (*gezinsvoogd*) to give (mandatory) assistance to the family concerned. Such and other forms of interference with family life is provided for by law (Act of Youth Care, *Wet op de jeugdzorg*) and considered necessary in a democratic society to protect the health, rights and freedoms of children.

2.8. The right to have children and maintain parental rights

- [60]. The question whether individuals with a mental disorder or intellectual disability are equally entitled to have children and maintain parental rights is highly topical in the Netherlands. It is generally acknowledged that parents should be competent to care for and educate children and that the interests of the child should always prevail. Both concepts, parental competence and the child's best interests, are very difficult to define. We have not come across any case-law where these concepts were further elaborated upon with respect to people with a mental disorder or intellectual disability.
- [61]. The law does not allow for forced anti-conception, let alone forced anti-conception, in order to protect the interest of a future child or any other second person. Forced treatment is, under very strict conditions, only allowed in the interest of the person concerned. At the same time, it is acknowledged that

people with severe mental disorders or intellectual disabilities should be actively prevented from procreations. In such cases, an analysis of the intellectual capacities, social network, availability of support etc of the persons with a desire to have children is being conducted and a support-program is started that might end in consent of using anti-conception measures. Physicians seek to inform and get the consent of the persons concerned for anti-conception measures. . Moreover in cases of persons with severe intellectual disability who are sexually active and do not have a desire to have children, anti-conception measures might be taken in consent with the persons themselves or their representatives; the interest of the future child is the leading principle. There are standards of the professional groups as well as from the Health Inspectorate on how to act

- [62]. Otherwise it should be emphasised that persons with mild mental disorders or intellectual disabilities, not affecting their parental competence, are fully entitled to procreate and to maintain their parental rights.

2.9. The right to property

- [63]. The right to own property is not directly dependent on a mental disorder or intellectual disability. The right to use, dispose of and bequeath lawfully acquired possession can, however, be lawfully restricted in case of a mental disorder or intellectual disability (see also below > 95). As mentioned before, the judge can decide to appoint a guardian / legal representative (e.g. a *bewindvoerder* or *curator*) in which cases the person concerned can not freely dispose over his or her belongings. Financial transactions are only valid when carried out by the representative. The representative can also decide that the person with a mental disorder or intellectual disability receives some pocket-money. Persons with a mental disorder or intellectual disability disagreeing with such measures have no access to a complaint procedure foreseen by law.
- [64]. We have not come across any case-law on the right to property specifically focussing on people with a mental disorder or intellectual disability.

2.10. The right to vote

- [65]. In the run-up to the 1983 Constitution there was a heated parliamentary and societal debate on the right to vote for persons with a mental disorder or intellectual disability. After ample discussion it was decided to deprive persons who were, because of their mental disorder or intellectual disability, placed under custodial care (*curatele*) of the right to vote (Article 54 para. 2 Constitution).

- [66]. In 2003, the Administrative Jurisdiction Department of the Council of State held that this general exclusion provision was – although not its application in the pending case – in violation of the International Covenant on Civil and Political Rights (Afdeling bestuursrechtspraak van de Raad van State 29 October 2005, *LJN* AM5435; can be retrieved – but only in Dutch – via www.rechtspraak.nl). Following this decision and the advice of the Electoral Council (*Kiesraad*), the Constitution was changed in 2008. The provision was taken out of the Constitution as a result of which individuals with a mental disorder or intellectual disability and placed under custodial care can now equally enjoy the right to vote. This change applies since the elections for the European Parliament on 4 June 2009.
- [67]. Similar restriction did not (and do not) apply to persons placed under the two other forms of guardianship foreseen in the Civil Code, *bewindvoering* (aimed at protecting the property and financial interests of the person) and *mentorschap* (aimed at protecting the interests of the patient regarding care and treatment).

3. Involuntary placement and Involuntary Treatment

- [68]. The chapter (pages 117-122) on the Netherlands in the 2002 Report on *Compulsory Admission and Involuntary Treatment of Mental Ill Patients* (editors Salize, Dreßing and Peitz) provides very general information on the Dutch legal framework regarding involuntary placement and involuntary treatment. With regard to the present legal regulations the information is still up-to-date but very limited. In the sections below much more information is provided about the present legal situation in the Netherlands.
- [69]. Recent reports of the *United Nations Committee against Torture* do not deal with the issue of involuntary placement and involuntary treatment in the Netherlands.
- [70]. During the preparation of its 2002 Report the *European Committee for the Prevention of Torture and Inhuman or Degrading Treatment* (CPT) visited two nursing homes accommodating elderly persons with dementia. Most persons were admitted to these nursing homes on the basis of the 1992 Psychiatric Hospitals (Compulsory Admissions) Act. In its 2002 report (<http://www.cpt.coe.int/documents/nld/2002-30-inf-eng.htm>) it is stated that the CPT heard no allegations of deliberate ill-treatment of residents in either home visited. According to the CPT the material conditions in both of the nursing homes were of a very high standard. The level of nursing and other care provided to residents appeared to be of a very good standard, but it transpired that difficulties as regards the recruitment and retention of trained staff at times interfered with the aim of offering the optimal quality of care. The CPT asked for further information in this regard. The CPT delegation was able to verify that where resort to means of restraint (e.g., wrist bands, closed bed cot, etc.) was considered necessary for safeguarding the interests of a resident, the advice of a doctor was sought before implementation. In its 2007 Report (<http://www.cpt.coe.int/documents/nld/2008-02-inf-eng.htm>) the CPT did not address institutions which are regulated by the Psychiatric Hospitals (Compulsory Admissions) Act.

3.1. Legal Framework

- [71]. Presently, the involuntary placement and involuntary treatment in the Netherlands is regulated by the 1992 Psychiatric Hospitals (Compulsory Admissions) Act. This Act came into force in January 1994. Between 1997 and 2007 the Act and the way it is used in actual practice have been evaluated three times. Over the years these evaluations have resulted in various amendments,

one of which broadened the criteria for involuntary treatment. The present Act is not limited to psychiatric hospitals, but also applies to institutions for persons with intellectual disabilities and nursing homes for persons with dementia. On the basis of the third evaluation of the present Act the Dutch government decided to replace the Act by two new pieces of legislation: the Care and Coercion Act (*Wet zorg en dwang*) (dealing with institutions for persons with intellectual disabilities and persons with dementia) and the Act on Compulsory Mental Health Care (*Wet verplichte geestelijke gezondheidszorg*) (dealing with psychiatric hospitals). The Care and Coercion Bill was introduced in Parliament in July 2009. The Compulsory Mental Health Care Bill will probably be introduced in Parliament in the beginning of 2010. If both Bills are going to be adopted by Parliament this will result in major changes in the Dutch legal framework regarding involuntary placement and involuntary treatment.

- [72]. The 1992 Psychiatric Hospitals (Compulsory Admissions) Act does make a distinction between involuntary placement and involuntary treatment. Different criteria apply. The decision to involuntarily admit a patient to an institution does not automatically justify involuntary treatment. However, as a result of the amendment mentioned earlier (see section 70) the criteria for involuntary treatment have been broadened and the importance of the distinction between involuntary placement and involuntary treatment has been diminished.
- [73]. The 1992 Psychiatric Hospitals (Compulsory Admissions) Act does not see involuntary placement without treatment as a goal in itself. The assumption is that involuntary placement will result in treatment (on a voluntary basis or, under certain circumstances, as an involuntary measure). However, due to the distinction between involuntary placement and involuntary treatment that is incorporated in the Dutch Act situations of involuntary placement without treatment may occur.
- [74]. The 1992 Psychiatric Hospitals (Compulsory Admissions) Act has two official objectives: (a) to clarify and strengthen the rights of persons with a mental disorder (including intellectual disabilities and dementia) and (b) to protect individuals and society from dangerous acts performed by persons with a mental disorder). In actual practice other objectives play a role as well (rehabilitation, restoring self-determination etc.).
- [75]. The 1992 Psychiatric Hospitals (Compulsory Admissions) Act only to a limited extent stipulates adequate aftercare following involuntary placement. The Act lays down that if the person is granted a leave or is discharged the institution has to contact the health care providers who cared for the person before the involuntary placement was effectuated. More specific requirements regarding aftercare are not mentioned in the Act.
- [76]. The 1992 Psychiatric Hospitals (Compulsory Admissions) Act applies to persons with mental disorder aged 12 years or older. If such a person does not agree with the admission to or treatment in a psychiatric institution the

provisions and procedures of the Act apply. In case of children below the age of 12 the general rule is that the parents or guardians have the authority to decide about care and treatment (including the admission to a psychiatric hospital). However, if the parents of a child below the age of 12 disagree with one another, the provisions of the present Dutch Act apply as well.

- [77]. The 1992 Psychiatric Hospitals (Compulsory Admissions) Act addresses persons with mental disorders (including intellectual disabilities and dementia). The Act is applied in cases in which such a person poses a danger to himself or to others as a result of the mental illness. Under certain circumstances the 1992 Psychiatric Hospitals (Compulsory Admissions) Act may also be applied to persons with addictive behaviour (if the addiction is related to a mental disorder). Offenders with mental disorders are dealt with in the criminal justice system, on the basis of specific legislation (criminal law). In most cases this will result in the placement of the offender in a institution within the criminal justice system. In a number of situations offenders with mental disorders may be transferred to an institution that is governed by the provisions of the Psychiatric Hospitals (Compulsory Admissions) Act. In such case the provisions of this Act apply, with the exception of the provisions concerning leave of absence and discharge (about which in such a case the Ministry of Justice has to decide). Provisions regarding persons under guardianship can be found in the Dutch Civil Code. However, under Dutch law a guardian does not have the power to order the involuntary placement or treatment of the person under guardianship. If such a person requires involuntary placement and/or involuntary treatment the criteria and procedures of the Psychiatric Hospitals (Compulsory Admissions) Act have to be met.

3.2. Criteria and Definitions

- [78]. Involuntary placement under the Psychiatric Hospitals (Compulsory Admissions) Act is possible when all of the following criteria are met:

- the person involved poses a danger to himself or to others as a result of a mental disorder;
- the person involved does not consent to the admission;
- there is no less intrusive way to avert the danger caused by the person involved.

When involuntary placement is carried out the person involved is asked to consent to a treatment plan. This treatment plan may be applied without the person's consent (> involuntarily) in case one of the two following situations occurs:

1. if involuntary treatment is absolutely necessary to avert a danger to himself or to others the person involved causes within the institution (short term objective);

2. if without involuntary treatment it is not possible to take away the danger caused by the person's mental disorder within a reasonable period of time (longer term objective).

In case of situation (2) the authority to order the treatment is in the hands of the responsible therapist. The period of involuntary treatment may not be longer than three months. If within six months after this period ended another involuntary treatment on the basis of criterion (2) is necessary, a written order of the medical administrator of the institution is required.

[79]. In case of a combination of two or more of the above mentioned criteria the same criteria apply (see above under 77).

[80]. With respect to less intrusive measures before deciding an involuntary placement or involuntary treatment, the criteria regarding involuntary placement (see above under 77) explicitly mention that less intrusive alternatives should be taken before an involuntary admission is justified. The criteria for involuntary treatment do not mention such a requirement. However, also in these situations the concept of the less intrusive alternative ('subsidiary') has to be applied, since this is a general legal concept. In actual practice complaint committees and courts which have to decide about involuntary treatment quite regularly refer to the concept of the least intrusive alternative.

[81]. The Psychiatric Hospitals (Compulsory Admissions) Act does not explicitly mention the opinion of the patient as an element of the criteria for involuntary placement or involuntary treatment. However, several elements of the criteria mentioned in this Act can only properly be assessed and judged after having learned what the opinion of the patient is:

- one of the criteria for involuntary placement is that the person involved does not consent to the admission (see 77);
- the Psychiatric Hospitals (Compulsory Admissions) Act makes it possible to grant a 'conditional court order' when the person involved has agreed to comply with the conditions or when it is reasonably certain that he will comply with the conditions;
- an involuntary treatment is defined as a treatment to which the person involved objects;
- to be able to assess the least intrusive alternative in case of involuntary treatment it is necessary to know the preferences of the person involved.

In all of these cases the opinion of the person involved should be known before a decision can be made.

[82]. The Psychiatric Hospitals (Compulsory Admissions) Act does mention certain specific danger thresholds. Article 1 of the Act mentions the following situations.

- the danger that the patient will kill himself or cause severe bodily harm;
- the danger that the patient will completely ruin his social position and circumstances;
- the danger that the patient will seriously neglect himself;
- the danger that annoying behaviour of the patient will incite aggressive acts of others;
- the danger that the patient will kill somebody else or will cause severe bodily harm to another person;
- danger to the mental well-being of others;
- the danger that the patient will harm a person who is under his/her care.

This set of situations is not limitative. Other situations of dangerousness as a result of a mental disorder may qualify as well.

3.3. Assessment, Decision Procedures and Duration

[83]. In the case of the emergency procedure a medical certificate written by a physician is required. This should preferably be a psychiatrist. If it is not possible to find a psychiatrist in time that certificate may also be issued by a physician who is not a psychiatrist. In all others cases (the regular procedures for involuntary commitment) a medical certificate written by a psychiatrist is required.

[84]. The general rule is that the expert opinion has to be given by a psychiatrist who is involved in the treatment of the patient (the psychiatrist who has written the medical certificate as mentioned under 78). In addition to that the judge also receives information from the patient's therapist (psychiatrist, psychologist, general practitioner etc). In specific cases the judge may appoint an additional independent expert. This rarely happens.

[85]. In the case of the emergency procedure the initial decision is made by the mayor (burgomaster) of the municipality in which the patient is residing at the time of the decision. A few days later a judge has to decide about the extension of the emergency commitment. In all others cases (the regular procedures for involuntary commitment) the decision is made by a judge.

[86]. The normal situation is that the medical administrator of the psychiatric hospital and / or the responsible psychiatrist decides about the termination of the involuntary placement or involuntary treatment, when the legal criteria are not

longer met. Apart from that a patient may ask for the termination of the involuntary placement or involuntary treatment. If such a request is denied by the hospital the patient may ask the judge (involuntary placement) or a complaint committee (involuntary treatment) to end the placement of treatment. The decision of both the judge and the complaint committee can be appealed by the patient to a higher court.

- [87]. When a voluntary placement becomes an involuntary placement all criteria and aspects mentioned above apply.
- [88]. In the Dutch system there always has to be a psychiatric assessment (or, in the case of the emergency procedure, at least a medical assessment) before an involuntary placement can begin.
- [89]. In the emergency procedure the initial decision is made by the mayor (burgomaster) of the municipality in which the patient resides at the time of the decision. This decision authorises the involuntary placement until the moment at which a judge decides about the extension of the emergency commitment. This usually happens 3 of 4 days after the mayor's initial decision. The judge may extend the emergency commitment for a period of maximum 3 weeks. If before the end of this extension a regular involuntary placement is requested another extension for a 3 weeks period is possible (to give the judge the time to decide about the request for a regular involuntary placement).
- [90]. The initial regular involuntary placement has a duration of maximum 6 months. This initial period may be followed by (court ordered) renewals with a duration of maximum 12 months. If a person has been involuntarily committed to psychiatric hospital without interruption for at least five years (court ordered) renewals for a period of maximum 24 months become possibly. This is very exceptional. If a person has been involuntarily committed to a nursing home for demented patients or an institution for persons with intellectual disabilities and it is to be expected that the patient's situation will not change for the better a (court ordered) renewal for a period of maximum 60 months is allowed.
- [91]. The Psychiatric Hospitals (Compulsory Admissions) Act regulates psychiatric treatment, but does not mention or forbid specific treatment modalities. The system of the Act is as follows. The starting point is that the patient who is involuntarily placed should agree with a treatment plan proposed by the responsible psychiatrist. If the patient lacks the competency to consent to the proposed treatment plan a representative of the patient may do so on his behalf. If either the patient or his representative rejects the proposed treatment plan it may be executed against their wishes in one of the two following situations (= involuntary treatment):
- a. if necessary to avert a danger the patient poses to himself or others within the hospital;

- b. if it is to be expected that without the treatment the (disorder related) danger the patient causes can not be taken away within a reasonable period of time.

Each involuntary treatment had to be reported to the Health Inspectorate. After the involuntary treatment had ended the Inspectorate has the legal duty to examine the case.

[92]. The Psychiatric Hospitals (Compulsory Admissions) Act specifies the circumstances under which certain coercive measures may be applied outside the scope of a treatment plan. This is allowed in emergency situations and for a maximum period of 7 days. These criteria apply to the following coercive measures: seclusion, isolation, fixation, forced medication, artificial feeding (fluid and/or nutrition). If it is necessary to apply these measures for a longer period than 7 days they have to be incorporated into the treatment plan (that can be applied on the basis of the consent of the patient or his representative or as involuntary treatment in the situations mentioned under 90)

[93]. In the Psychiatric Hospitals (Compulsory Admissions) Act the reviews and appeals concerning the lawfulness of involuntary placement are regulated at two levels:

- Each decision resulting in involuntary placement is limited to a maximum time period (in most cases 6 months or one year, see under 89. That period can only be extended if a court review the case again and is satisfied that all legal criteria for involuntary still apply. If not, the involuntary placement ends with the expiration of the applicable time period;
- Under the Psychiatric Hospitals (Compulsory Admissions) Act a person who is placed involuntarily has the right to request his discharge from involuntary placement. If the medical administrator of the institution turns down this request, the patient may ask the public prosecutor to ask the decision of the court. The court decides “as soon as possible”. During any given time period (6 months, one year) the patient may use this procedure as often as he likes. However, if the patient already filed a request during the previous four months and the circumstances have not changed, the public prosecutor may decide not to ask the court’s decision again. This system implies that the patient may ask for a court review of his case every four months.

Any decision of a court under this system may be appealed by the patient or the public prosecutor to the *Hoge Raad* (the High Council of the Netherlands). This happens regularly (approximately 30-40 cases each year).

With regard to involuntary treatment another system of reviews and appeals applies. It is the responsible therapist (mostly a psychiatrist) who has the authority to order an involuntary treatment. If the patient objects to this

treatment he can file a complaint with the hospital's complaint committee. This committee has the legal power to stop the involuntary treatment. The committee has to decide within 14 days, unless the complaint is filed after the involuntary treatment has already ended (in which case the committee has to render a decision within a month). If the committee rejects the patient's complaint the patient can appeal the committee's decision to a court. The court has to decide within four weeks. The patient may appeal a negative court decision to the Dutch *Hoge Raad* (the High Council of the Netherlands).

- [94]. The Psychiatric Hospitals (Compulsory Admissions) Act regulates that in any procedure in which a judge has to decide about involuntary placement the patient has to be offered free legal support. Almost all patients accept this offer. The legal support is offered by trained and specialized lawyers, who are organized in local or regional groups. They operate under a duty solicitor scheme. In the case of a complaint against an involuntary treatment (see under 92) free legal support is offered to the patient when his complaint reaches to court. In the preceding phase of the complaint procedure (the hospital's complaint committee) almost all patients are supported by a patient advocate (para-legal). The Psychiatric Hospitals (Compulsory Admissions) Act obliges every hospital to offer the patient the services of an independent patient advocate. These patient advocates operate in the hospital but are employed by an independent national foundation. The specialized lawyers and patient advocates mentioned in this section have access to all relevant information and materials.

4. Competence, Capacity and Guardianship

- [95]. The *Comparative Study on the Legal Systems of the Protection of Adults Lacking Legal Capacity* (2008) does not include the Netherlands. The *Second Disability High Level Group Report* (2009) does include the Netherlands. However, the chapter on the Netherlands in this report does not contain information that is relevant to the questions answered below.
- [96]. The Dutch Civil Code contains provisions with regard to the management of affairs of persons with a mental disorder or intellectual disability if they are unable to do so. A distinction can be made between four options:
1. The Dutch Patients' Rights Act of 1995 (incorporated in the Civil Code) contains provisions with regard to incompetent patient. If a patient is incompetent (see under 96) one of the persons specifically nominated in the Act may decide, on behalf of the patient, about the issues relating to the care and treatment of the patient. The nominated persons are (in this order): a court appointed representative, a person nominated by the patient, the patient's spouse or partner, a parent, child, brother or sister of the patient. Similar provisions can be found in other health related legislation (including the present Psychiatric Hospitals (Compulsory Admissions) Act of 1992. The nominated persons are not appointed by a court. They derive their authority to decide directly from the Act.
 2. The Dutch Civil Code contains three general procedures with regard to persons who, as a result of mental health problems or intellectual disability, are not able to take care of their own affairs: *bewindvoering* (aimed at protecting the property and financial interests of the person), *mentorschap* (aimed at protecting the interests of the patient regarding care and treatment) and *curatele* (aimed at protecting property and financial interests and/or interests regarding care and treatment). In all three of these cases the court appoints a person whose task it is to act on behalf of the incompetent patient. Which of these three procedures is applied depends upon the circumstances of the case. Of these three possibilities *curatele* limits the possibilities of the person involved to make his own decisions the most. For that reason it is common practice to apply for *bewindvoering* or *mentorschap*. *Curatele* is seen as a legal measure of last resort (As a result of *Curatele* the person involved cannot perform legal acts without the permission of the curator; in the case of *bewindvoering* and *mentorschap* the person involved may perform legal

acts, but under certain circumstances these can be revoked by the representative).

There is no legal duty to apply for a court nominated representative in case of an incompetent patient. If a person (partner, family member, neighbour etc) is willing to take care of the patient's interests and does so in an adequate way, there is no need to file a request for a court nominated representative. This option is usually limited to specific circumstances (the person involved will never regain competence; a decision has to be made about a very important matter, within the family there are differences of opinion etc.).

- [97]. Dutch legislation does not provide a definition of competency or capacity. The legislation stipulates that persons are incompetent or incapacitated if they "are not able to make a fair judgment regarding their interests". The general opinion is that persons are incompetent or incapacitated if they are not able to understand relevant information and to assess the implications of the information.
- [98]. It is generally accepted that a (severe) mental disorder may negatively influence the patient's capacities to make a competent decision. As a result of their mental illness some patients are incompetent (regarding specific decisions > see under 98). However, this has to be proven in each individual case. It is not accepted to equate mental disorder with incompetency.
- [99]. All procedures mentioned under 95 operate on the basis of the presumption of competency. This implies that a representative of the patient (court ordered or not) can only exercise his or her authority if the patient is actually incompetent. If not, the patient may make his own decisions, despite the fact that a representative has been nominated. Furthermore, the legislation recognizes that incompetency may be partial and/or temporary. A person who is incompetent regarding Decision A (e.g. property and finances) may still be competent regarding Decision B (e.g. health matters).
- [100]. All procedures mentioned under 95 part 2 (*bewindvoering, mentorschap, curatele*) require the decision of a court about the question whether or not the person involved is able to take care of his or her own affairs. If not, the court will appoint a representative. If necessary the court will define and / or limit the representative's mandate. The legislation stipulates that the representative has to act as "a good representative" and has to take into account the wishes and opinions of his ward as much as possible. Anyone who is dissatisfied with the way in which the representative performs his duties may ask to court to look into the matter. In ultimate cases the court may decide to replace the representative. The legislation does not limit the appointment of a representative to a certain maximum period of time, although it is possible to appoint a representative for a fixed period. If the person involved regains the capacity to manage his own affairs a request can be filed to terminate the *bewindvoering, mentorschap* or *curatele*. In actual practice this rarely happens, because most

court nominated representatives are appointed in situations in which the person involved, as a result of his/her mental or physical condition, is not expected to regain full competence (due to intellectual disability, progressive dementia etc.).

- [101]. The basic features of the present legal protective regime are:
- a. A finding by a court that a person is not able to manage his own affairs;
 - b. The appointment by a court of a representative who will act on behalf of the person involved;
 - c. The requirement that the representative has to honour as much as possible the wishes and opinions of the person involved;
 - d. Supervision of the court with regard to the suitability and performance of the representative
- [102]. The central criterion is that a person is not able to adequately manage his own interests, as a result of mental illness, financial extravagance or excessive drinking (*curatele*) or as a result of his “mental or physical condition” (*bewindvoering, mentorschap*).
- [103]. There are no minimum or maximum time limits of the measures that can be ordered by a court. However, the court may decide to appoint a representative for a limited period of time, if the circumstances of the case indicate that.
- [104]. *Curatele, bewindvoering* and *mentorschap* can be requested by a family member or the Public Prosecutor. *Mentorschap* can also be requested by the institution in which the person involved permanently resides.
- [105]. With regard to all options (*curatele, bewindvoering* and *mentorschap*) only the court has jurisdiction to deal with the issues mentioned (a. to d.).
- [106]. The legislation with regard to *curatele, bewindvoering* and *mentorschap* does not contain the possibility to appeal a decision of the court to a higher court. In
- A. Under the Patients’ Rights Act of 1995 a physician may decide that a patient is not competent to decide about care or treatment. The patient start a procedure against this decision, either by filing a complaint with the complaint committee mentioned in the 1995 Health Care Complaints Act (*Wet klachtrecht cliënten zorgsector*) of 1995 or by asking the decision of a court;
 - B. Under the Psychiatric Hospitals (Compulsory Admissions) Act the responsible therapist may decide that a patient who is involuntarily committed is not competent to consent to the proposed treatment plan. In such a case the patient may file a complaint against the decision of the therapist with the complaint committee mentioned under [92]
- [107]. Only individual persons can be appointed as a patient representative. It is not possible to give this authority to a body or institution. The general requirement

is that the person who is to be appointed is willing and suitable to perform this task. If possible, courts will appoint somebody who is close to the person involved. The known preferences of the person involved regarding who should be appointed as his representative should be taken into consideration.

- [108]. The scope and extent of powers of the entrusted person has to be derived from the goal and provisions of the applicable legislation. A representative under the Patients' Rights Act (see under 95 part 1) is authorized to decide about care and treatment on behalf of an incompetent patient. Entrusted persons appointed under the more general schemes (*curatele*, *bewindvoering* and *mentorschap*) have a broader authority, which is defined by the goals and scope of the applicable measure.
- [109]. The Dutch legislation does not contain an appeal procedure against a decision of a court to appoint a certain person as a representative. If a patient objects to the representative who acts on the basis of the Patients' Rights Act of 1995 or the Psychiatric Hospitals (Compulsory Admissions) Act of 1992 the complaint procedure of the Health Care Complaints Act of 1995 applies.
- [110]. The Dutch legislation does not contain the explicit requirement to periodically review a decision of incapacity. However, the legislation stipulates that a system of protection has to be terminated when the person involved regains his competency to manage his own affairs. This implies that the person's competency is reviewed at a regular basis.
- [111]. The Dutch legislation does not contain the explicit requirement to periodically review the need of a guardian. See under 95, final part.

Annexes-Case Law

In different Sections of the Guidelines, experts have been asked to refer to case law. Please present the case law reference in the format below

| | |
|--|---|
| Case title | X v. Bloemendaal |
| Decision date | 29 October 2005 |
| Reference details (reference number; type and title of court/body; in original language and English [official translation, if available]) | Administrative Jurisdiction Department of the Council of State (Afdeling bestuursrechtspraak van de Raad van State), <i>LJN AM5435</i> |
| Key facts of the case (max. 500 chars) | The case concerned the right to vote. Depriving persons who, because of their mental disorder or intellectual disability, were placed under custodial care (<i>curatele</i>) of the right to vote, was found to be in violation of Article 2 in combination with Article 25 and Article 26 of the International Covenant on Civil and Political Rights. |

| | |
|---|---|
| <p>Main reasoning/argumentation (max. 500 chars)</p> | <p>The general denial of the right to vote for people under custodial care is in contradiction with various provisions of the International Covenant on Civil and Political Rights as well as the Universal Declaration of Human Rights. In this specific case, the city authorities did not err in dismissing the application to grant the right to vote given the specific circumstances.</p> |
| <p>Key issues (concepts, interpretations) clarified by the case (max. 500 chars)</p> | <p>Right to vote</p> |
| <p>Results (sanctions) and key consequences or implications of the case (max. 500 chars)</p> | <p>The Constitution was changed afterwards and people under custodial care (<i>curatele</i>) are no longer systematically denied the right to vote.</p> |

| | |
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| Proposal of key words for data base | Right to vote. |
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Please attach the text of the original decisions in electronic format (including scanned versions as pdf). Text can be found under www.rechtspraak.nl