Permanent Representation of
the Kingdom of the Netherlands
to the United Nations Office and
other International Organizations
in Geneva

NV: GEV-PA 370/2013

The Permanent Representation of the Kingdom of the Netherlands to the United Nations Office and other International Organizations in Geneva presents its compliments to the United Nations Office of the High Commissioner for Human Rights and, with reference to letter "AL Health (2002-7) G/SO 214 (53-24) NLD 2/2013" dated 8 October 2013, has the honour to herewith submit the response of the Kingdom of the Netherlands to this joint allegation letter.

The Permanent Representation of the Kingdom of the Netherlands to the United Nations Office and other International Organizations in Geneva avails itself of this opportunity to renew to the Office of the High Commissioner for Human Rights the assurances of its highest consideration.

Geneva, 5 December 2013

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06 DEC 2013

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Communication from Special Procedures

Reply of the Government of the Netherlands

to joint allegation letter

AL Health (2002-7) G/SO 214 (53-24)

NLD 2/2013

Introduction

1. On 8 October 2013, Mr Anand GROVER, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and Mr Juan E. MENDEZ, Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, forwarded to the Government of the Netherlands ('the Government') a joint allegation letter concerning the case of Ms Johanna Christina SANTEGOEDS.

2. In their letter the Special Rapporteurs asked the Government the following questions:

1. Are the facts alleged in the summary of the case accurate?

2. Has a complaint been lodged?

3. Please provide the details, and where available the results, of any investigation, medical examinations, and judicial or other inquiries which may have been carried out in relation to this case. If no inquiries have taken place, or if they have been inconclusive, please explain why.

4. What measures have been undertaken by the Government of the Netherlands to revise the legal provisions that allow detention on mental health grounds or in mental health facilities, and any coercive interventions or treatments in the mental health setting without the free and informed consent by the person concerned? What steps have been undertaken to replace forced treatment and commitment by services in the community that meet needs expressed by persons with disabilities and respect the autonomy, choices, dignity and privacy of the person concerned, with an emphasis on various alternatives for mental health care, including peer support, awareness-raising and training of mental health-care and law enforcement personnel and others?

5. What steps have been undertaken to develop alternative measures to reduce the number of forcibly interned persons with mental and psychosocial disabilities and ensure that involuntary internments in places of deprivation of liberty, including psychiatric and social care institutions, are done on the basis of a legal decision, guaranteeing all effective legal safeguards in line with the Recommendations issued by the Committee Against Torture (6-31 May 2013)?

6. What measures have been undertaken to impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities,

including the non-consensual administration of psychosurgery, electroshock and mind- altering drugs such as neuroleptics, the use of restraint and solitary confinement, for both long-and short-term application?

The individual situation of Ms Santegoeds

3. The first three questions put by the Special Rapporteurs pertain to the individual situation of Ms Santegoeds. The Government first of all wishes to reiterate its full support for the respective mandates of the Special Rapporteurs mentioned above. These mandates provide for close cooperation with the treaty bodies established under the relevant UN human rights conventions. In the Government's view, this is particularly relevant in the context of allegations of human rights violations in individual situations, since the treaty bodies are explicitly mandated to examine such allegations. The Netherlands is a party to the individual complaints procedures under the International Covenant on Civil and Political Rights, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the Convention on the Elimination of Racial Discrimination and the Convention on the Elimination of Discrimination against Women. In addition, the Netherlands is a party to various regional complaints mechanisms, most importantly the individual right of petition to the European Court of Human Rights under the European Convention for the Protection of Human Rights and Fundamental Freedoms. The Court's judgments are binding on the state.

4. The Netherlands has for many years been confronted with individual complaints under each of these mechanisms and currently has over two hundred cases pending. These complaints are taken extremely seriously and addressed in a most thorough and coordinated manner, involving all relevant Government services. Thus, if Ms Santegoeds is of the view that her rights were not respected by the Government, several legal and quasi-legal avenues were or are open to her at international level, provided of course that domestic remedies have been exhausted. To the best of the Government's knowledge, however, Ms Santegoeds has never availed herself of any of those avenues.

5. One important aspect of the available individual complaints mechanisms is that they remove any doubt about the complainants' approval of the sharing of personal data with the international body concerned. This does not apply in the present case, where the Government is not aware of Ms Santegoeds having given her approval for any transfer of private information to the Special Rapporteurs. For that reason alone, the Government is prohibited from answering the Special Rapporteurs' first and third questions.

6. As to the Special Rapporteurs' second question, which would appear to be best addressed to Ms Santegoeds herself, the Government is nevertheless able to provide the following

information. On 4 January 2004 Ms Santegoeds lodged a complaint with the complaints commission of the *"Reinier van Arkel Group"*, concerning the period running from October 1994 to May 1996. During that period she was committed to the *Herlaarhof*, an institution under the Reinier van Arkel Group. The complaint was formulated in general terms and concerned the treatment received in the institution. On 27 April 2004, the complaints commission declared the complaint to be unfounded. To the best of the Government's knowledge, no other complaints have been lodged by Ms Santegoeds.

7. It should be noted in this respect that the facts of the case now date from as long as sixteen to nineteen years ago. Even the procedure before the complaints commission of the Reinier van Arkel Group dates from nearly ten years ago. That being so, the Government fails to see why the need for an examination of these facts has arisen after such a lengthy period.

Dutch law and policy in the area of mental health care

8. In reply to the Special Rapporteurs' fourth question, the Government would state the following. The current Psychiatric Hospitals (Committals) Act (*Wet bijzondere opname in psychiatrische instellingen*; BOPZ), which applies both to psychiatric patients and to people with an intellectual disability or suffering from certain geriatric syndromes, will in the foreseeable future be replaced by new legislation: the Compulsory Mental Health Care Act (*Wet verplichte geestelijke gezondheidszorg*; WVGGZ) and the Care and Compulsion (Psychogeriatric and Intellectually Disabled Patients) Act (*Wet zorg en dwang psychogeriatrische en verstandelijk gehandicapte cliënten*; WZD). Given the subject of the Special Rapporteurs' questions, the Government will focus on the WVGGZ, which is currently before Parliament. The aim is for the Act to enter into force on 1 January 2015.

9. The WVGGZ sets out strict criteria for compulsory care. The general principle is that sufficient opportunities for voluntary care should first be offered. Compulsory care and its most far-reaching form, involuntary admission or committal, can only be ordered if, as a result of a psychiatric disorder, the behaviour of the person concerned leads to a considerable risk of serious harm to the person him/herself or to another. That a person has a psychiatric disorder can therefore never be the sole grounds for depriving them of their liberty.

10. The WVGGZ stipulates that compulsory care may only be ordered if an independent physician has drawn up a medical certificate establishing the necessity for such care, there is no longer any possibility of voluntary care, the provision of compulsory care is proportionate to the aim and the care can reasonably be expected to be effective. Even if these conditions have been met, only the least coercive form of compulsory care may be applied. The Act will also introduce less intrusive forms of compulsory care, such as personal care, treatment and

counselling, and the opportunity for compulsory care to be given in the home as well as in an institution. This will enable the care that is needed to be given at an earlier stage, to avoid escalation. At all stages of the process, care providers must remain aware of the need to encourage the patient to participate in society.

11. In preparing, issuing, implementing, amending or ending a care order (*zorgmachtiging*) or crisis measure (*crisismaatregel*), the authorities must always assess the proportionality, subsidiarity, effectiveness and safety of the proposed care. The forms of compulsory care that may be given are listed in the care plan, drawn up in consultation with the patient and his/her close relatives or an authorised person. The patient is asked to state his/her wishes and preferences and where possible they are complied with. The aim of all these conditions is to avoid involuntary admission where possible, but if compulsory care is unavoidable, to ensure that the least coercive form is imposed.

12. Furthermore, the Act strengthens patients' legal status. For example, patients are offered the opportunity to first draw up their own plan to deal with the problem, either alone or with their own network, in order to prevent compulsory care being imposed. This suspends preparation of the care order and may even make an application for a care order unnecessary. These are new provisions, i.e. not in the current BOPZ.

13. As pointed out above, at all stages of the process of applying for a care order, especially when a care plan is being drawn up, the authorities must identify the conditions necessary to promote the patient's participation in society once the care order has ended. If these conditions are absent, the municipality must be notified so that the necessary measures can be taken. Escalation and the imposition of compulsory care can be avoided if people receive appropriate assistance in their own social environment, possibly after drawing up their own plan including agreements with family and other people close to the patient.

14. Compulsory care is always based on a court order. The only exception is when emergency care is required. In such cases the mayor may impose a crisis measure, which must be reviewed by the courts within three days. Before deciding on a care order, the court will hear the patient, who is assisted by counsel. Unlike the current situation under the BOPZ, the court's decision can be appealed. Since a crisis measure imposed by the mayor is also subject to possible review, access to the courts is always guaranteed. In addition, the WVGGZ also contains the necessary safeguards to prevent abuse and arbitrary application of the power to order compulsory care.

15. The Special Rapporteurs' question of whether steps have been taken to 'replace forced treatment by services in the community' can be answered in the affirmative. In the Netherlands the aim is to provide outpatient or community treatment as far as possible.

Patients must therefore be enabled to retain as much control as possible over their own lives and to be full members of society. In the case of people with serious psychiatric problems this often requires care and counselling in a number of areas including mental and physical health, accommodation, work or daily activities, sense of purpose and social contact. That is why it is important to create coherent and integrated care and support packages for patients. This requires cooperation with municipalities and other social organisations such as housing associations, the Employee Insurance Agency (*Uitvoeringsinstituut Werknemersverzekeringen*), police and the criminal justice authorities, educational institutions, reintegration agencies, debt counsellors, GPs and home care providers.

16. People tend to be happier and more open to participating in society if they receive treatment in their own environment. It has long been realised that as part of the effort to reduce the use of compulsion, involuntary admissions and use of coercion, for example when patients are placed in seclusion (*separatie*, or isolation in a specially designed room), should be avoided as far as possible. Effective measures to prevent circumstances that might otherwise lead to compulsory care are essential, and this involves early identification of potential problems. The Netherlands is therefore investing in an early warning system: improving the support provided to GPs in this area will better enable them to recognise symptoms and organise their caseload of people with psychiatric problems. Early identification can also be performed by the mobile teams providing outpatient care as well as assistance in other areas of life. Assertive Community Treatment (ACT) is an approach that offers community care and counselling to people with long-term, serious psychiatric disorders. In addition to mental problems, they often have issues such as addiction, homelessness, unemployment, inability to manage money, and sometimes criminal behaviour. Their problems are so complex that their lives are seriously disrupted. ACT teams take a proactive approach to identifying these patients. The Netherlands has developed a variant on the ACT model known as FACT, which targets the entire group of people with long-term, serious psychiatric disorders who are not institutionalised. The aim is to counsel, treat and support the recovery of patients who require continuous care. Currently, there are 150 (F)ACT teams and that number continues to grow. In addition, there are mobile teams specialised in areas including youth and addiction care. This development has led to a shift of expertise and quality in the direction of community care.

17. The shift towards community care is a gradual process of change that will take several years. Current developments show that the mental health sector is embracing and supporting the changes. Targets have been agreed with government.

18. In reply to the Special Rapporteurs' fifth question, the Government would make the following observations. The Dutch Association of Mental Health and Addiction Care (GGZ Nederland) and its member organisations play an important role in reducing the use of compulsion and developing alternatives. Between 2006 and 2013 the Minister of Welfare, Health and Sport

made €5.5 million available annually for projects with this aim. In 2010 a common vision was developed together with professionals in the field. Many individual mental health services then launched their own projects aimed at reducing compulsion, in particular the number of patients placed in seclusion and the length of such placements, and to improve the quality of care in situations involving compulsion. In late 2011, this led to a survey of best practices that can be helpful in reducing the use of compulsion and developing alternatives. Current policy in this area is laid down in a voluntary agreement entitled *The Future of the Mental Health Services*, concluded by the Minister of Health and the mental health care sector in 2012.

19. Good alternatives to compulsion have been developed by various professional bodies in the field. Examples include the 'relapse prevention plan' (*signaleringsplan*) which helps patients identify the early signs of a relapse and take steps to prevent it, the deployment of hands-on experts on projects to reduce the use of compulsion and the uniform registration of the use of seclusion and physical or other forms of restraint (Argus). Another important issue is the need to improve expertise in dealing with aggression. Over the years, GGZ-Nederland has introduced a series of initiatives and measures to counter aggression and violence towards mental health workers. Indeed, this is one of the priorities of its patient safety programme, and it is included in the voluntary agreement concluded by the police and the mental health services in 2012.

20. Professionals working in the field are developing High Intensive Care (HIC) units and have written a manual detailing procedures in these units. The aim is for the patient to receive a short course of intensive treatment within the institution, keeping the duration of admission to a minimum. In other words, outpatient treatment is the norm, admission is the exception. During the patient's time in the unit it is possible to intensify the treatment they are receiving, based on their needs. That does not mean seclusion (alone in a specially designed room which the patient is prevented from leaving) but intensive one-to-one counselling.

21. In addition, steps are being taken to further professionalise the care provided. Quality and patient safety will be promoted through guidelines, practical norms and care standards. The medical professions involved are currently preparing multidisciplinary guidelines on compulsion, funded by the Ministry of Security and Justice. The Dutch Psychiatric Association (*Nederlandse Vereniging voor Psychiatrie*; NVVP) currently has monodisciplinary guidelines available entitled 'Guidelines on decisions on compulsion: admission and treatment' (*Richtlijn besluitvorming dwang: opname en behandeling*).

22. As a result of the initiatives described above, the use of compulsion in mental health care has declined in recent years. Current policy on reducing compulsion will therefore continue.

23. The Special Rapporteurs further ask what steps have been undertaken to ensure that 'involuntary internments' are done on the basis of a legal decision, guaranteeing that all legal safeguards are in line with the recommendations issued by the Committee Against Torture (CAT).

24. First, under the current Act (BOPZ) it is only possible to commit a person to an institution (i.e. against his will) on the basis of a court order. To issue an order, the court needs to see a medical certificate establishing that the order is necessary in view of the person's current state of health. The certificate must be drawn up by a psychiatrist who is not involved in the person's treatment. Compulsory treatment within an institution is only possible if the patient is a danger to him/herself or to others. The compulsory treatment must be included in the treatment plan and be absolutely necessary to protect the patient or others. Compulsion should only be applied as a last resort. If it is used, it should be used humanely and be of limited duration. The same principles are adopted in the criteria that the Healthcare Inspectorate (*Inspectie voor de Gezondheidszorg*; IGZ) follows when it inspects healthcare institutions. The WVGGZ focuses on treatment, not on hospitalisation, and allows for treatment at home. All possible alternatives must be explored, and only when they have been deemed inappropriate is it possible to resort to more coercive measures. These aims are already incorporated in the BOPZ. But as stated above, initiatives were launched to develop a greater range of options, which are now being successfully applied in the field.

25. Second, the WVGGZ aims to strengthen the legal status of psychiatric patients, as explained above, allowing them to express their personal preferences for treatment and those of their family. The least coercive form of treatment will be prioritised, thus avoiding compulsion as much as possible. The possibility of appeal is introduced in the new Act. There are sufficient legal complaint mechanisms, including of course for people who have been committed. In this respect the Bill meets the recommendations of the Committee Against Torture.

26. Third, the Government would point out that the responsible ministers have ordered a thematic evaluation of the legislation relating to compulsory care for young people and adults. One of the main questions to be addressed by the evaluation is the extent to which, taken as a whole, the legislation covering mental health care, young offenders' institutions, secure youth care and forensic care provides a consistent and effective statutory framework for compulsory care and what scope there is for improving this framework. The investigators have been specifically asked to take account of international legislation and recommendations – including, of course, the CAT recommendations – in their findings and recommendations. The report is expected in June 2014, following which the ministers will consider whether the statutory framework should be amended and if the legal status of persons receiving compulsory care can be harmonised.

27. Finally, in response to the Special Rapporteurs' sixth question, the Government would repeat its earlier statement that compulsion can only be used as a last resort and if it proves necessary, should be humane and of limited duration. Seclusion should be avoided wherever possible.

28. The IGZ monitors compliance with the Act. In recent years it has closely supervised the quality of compulsory care and will continue to do so. Every year, around 150 incidences of compulsory treatment are investigated thoroughly at the location where they occurred, particularly those where seclusion in specifically designed rooms or normal rooms appears to have taken place. The IGZ also visits forty to fifty admissions units annually in order to monitor how policy on reducing the use of seclusion is being implemented. In 2013 the IGZ visited all the institutions that use seclusion, evaluating the measures taken on the basis of an assessment framework entitled 'Reducing the use of seclusion'. The report on these visits will be published early in 2014. The IGZ has set extremely strict criteria for the use of seclusion, with the ultimate aim of abolishing it completely. Mental health facilities must provide care without the use of this method unless they can demonstrate that in the case of a particular patient, there was no alternative at the time. Every conceivable measure must have been taken to end seclusion as quickly as possible. Mandatory internal and external consultation plays a crucial role in this.

29. In line with the basic principles of the WVGGZ, the IGZ is already observing the 'qualified no' principle when it comes to compulsory measures in general and seclusion in particular. Besides the criterion that compulsion and seclusion must be avoided as far as possible, the IGZ examines whether everything possible has been done to prevent seclusion becoming necessary and, in cases where it becomes necessary, to ensure that it does not entail 'solitary confinement'. In other words, if seclusion is necessary, the patient may never be left alone. They must always have contact with a care provider or be able to contact the care provider directly. In its oversight of compulsory care, the IGZ observes the principle that you never leave a sick person alone.

30. The professional standards published in 2013 state that no new rooms may be built for the purpose of seclusion and that mental health patients may in the future only be locked up in a high-security room when they are receiving intensive psychological care. The IGZ supervises compliance with these standards.