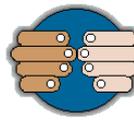
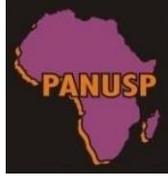


Submission on the Netherlands to the Committee Against Torture for the 50th session of the CAT-committee (6 May – 31 May 2013)



World Network of Users
and Survivors of Psychiatry

Torture and ill-treatment in mental health care in the Netherlands.

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- **This submission only focuses on human right violations by clinical mental health services in the Netherlands in Europe.**
- **Unfortunately, the situation on *the Antilles* (the islands in the Caribbean) is not included due to the absence of local contacts.** Rumours tell us that the situation in mental health care over there is horrible, and rather similar to other countries in that region. We are very worried about the rights of persons with disabilities at *the Antilles*. Unfortunately, we are only able to say: The situation on *the Antilles* is worse than the Netherlands in Europe.

Still, the situation in the Netherlands need to be addressed as well, to enable good practices to be developed and possibly spread out a form of true developmental support.

- Note that there are also many complaints about child-care-services/youth-care (“Jeugdzorg”), which are about malfunctioning, wrong decisions, and destroying many families. The violations of the “Right to family life” by crisis-care and community based services are out of the scope of this submission, because it is only sideways related to the mental health care advocacy against coercion. Only the forced treatments on children in residential mental health care institutions are included.
- Human rights and mental health in migrant-detention is also off the scope of this submission.

Proposed recommendations to the State Party:

- Increase the efforts to respect, protect and fulfil the human rights and fundamental freedoms of persons with psychosocial and intellectual disabilities on an equal basis with others without discrimination of any kind on the basis of disability. Ensure and promote, through training and awareness raising with the involvement of representative organisations of persons with disabilities, a social and human rights based approach which sees persons with psychosocial and intellectual disabilities as equal human beings entitled to enjoy and exercise their human rights on an equal basis with others..
- Take steps to ratify the CRPD and its Optional Protocol, without reservations.
- Take all appropriate measures for the absolute prohibition of forced treatment including forced detention on the basis of disability, forced administration of mind-altering drugs¹ and the absolute ban on all coercive and non-consensual measures, including body cavity search, restraint and solitary confinement of children and adults with psychosocial or intellectual disabilities in all places of deprivation of liberty, including in psychiatric and social care institutions². Take steps to repeal laws which authorise forced treatment and institutionalization for psychiatric treatment, such as the *Wet Bijzondere Opnamen in Psychiatrische Ziekenhuizen* (“law on special admissions in psychiatric hospitals”) and to cease legislative reform proposals such as the *Wetsvoorstel Verplichte geestelijke gezondheidszorg* (“law proposal on mandatory mental health care”) and *Wetsvoorstel Zorg en Dwang* (“law proposal on care and coercion”) which authorise forms of torture and ill treatment of persons with psychosocial and intellectual disabilities on the basis of "individual necessity" which is in conflict with recommendations of the Special Rapporteur on Torture (Special Rapporteur on Torture’s report on torture in the context of healthcare, [A/HRC/22/53](#), February 2013, paras 85(e), 89, and the [oral statement](#) on the report made to the Human Rights Council, 4 March 2013)³
- Take all appropriate measures to modify or abolish existing laws, regulations, customs and practices that constitute a full or partial deprivation of legal capacity of persons with disabilities. Take measures to ensure the legal capacity of persons with psychosocial and intellectual disabilities, and provide access to support that persons may require in exercising their legal capacity. Ensure that all services for persons with disabilities are based on the free and informed consent of the person concerned.
- Take steps to prevent isolation and exclusion of persons with disabilities, by ensuring access to adequate support and care services, including readily available humane and non-medication based treatment alternatives in acute and complex situations.

¹ Nowak

² Mendez

³ “Deprivation of liberty on grounds of mental illness is unjustified. Under the European Convention on Human Rights, mental disorder must be of a certain severity in order to justify detention. [the Special Rapporteur on Torture] believes that the severity of the mental illness cannot justify detention nor can it be justified by a motivation to protect the safety of the person or of others. Furthermore, deprivation of liberty that is based on the grounds of a disability and that inflicts severe pain or suffering falls under the scope of the Convention against Torture”. Statement by Juan E Méndez, Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment, 22nd session of the Human Rights Council, Agenda Item 3, delivered on 4 March 2013 (see Annex III), also at <http://www.panusp.org/wnusp-statement-on-un-sr-torture-mendez-report-of-4-march-2013/>

- Ensure that individuals have access to supports, accommodations and services that may be necessary to leave institutions and live in the community, or to avoid institutionalization, including assistance in securing affordable housing, an adequate standard of living and meaningful work, and that services are accessible in the community to meet the needs of persons with psychosocial disabilities that meet the expressed needs of individuals and that respect the individual's autonomy, choices, dignity and privacy, with an emphasis on alternatives to the medical model of mental health, including peer support.
- Ensure effective protection of the rights and freedoms of persons with psychosocial and intellectual disabilities, such as effective access to justice and effective preventive mechanisms. Ensure that allegations of human right violations, ill-treatment or torture provoke a prompt and impartial investigation by competent authorities in accordance with articles 12, 13 and 16 of the CAT, and ensure that ill-treatment and other abuses in the mental health system are remedied and prevented, including by imposing criminal sanctions on perpetrators and by redress to victims and survivors.
- Ensure that persons with psychosocial or intellectual disabilities who have committed a crime are not forcibly treated or detained in institutions for indefinite periods of time – without knowing when they would be released. Ensure that the right to be free from forced psychiatric and medical interventions also applies in detention settings to prisoners with disabilities and all prisoners, and ensure that mental health services in prison, and housing within mental health units in prison (PPC) or transfer to a mental health facility from prison ("TBS-kliniek"/ FPC/FPK) can only be provided based on the free and informed consent of the person concerned. Ensure that a wide range of services including alternatives to the medical model of mental health such as peer support is made available to prisoners with psychosocial and intellectual disabilities, through the appropriate allocation of budget, appropriate legislation and provision of training.
- Actively expose the intimate link between deprivation of legal capacity, stigma and human right violations, and promote and ensure a paradigm shift by criminalizing all practices in health care that are coercive or contribute to segregation, and ensure that only supportive, inclusive and recovery-oriented practices are part of health care services.

Summary

Forced psychiatric treatments are torture and ill-treatment.

Mental health problems are generally stigmatized as “mental illness” but are mainly a social issue. Life is dynamic and recovering wellbeing is possible. Mental health care should be about social support and creating inclusion. There is tension between the social model of mental health care and the medical model of mental health care in the Netherlands.

Most persons are helped in a rather satisfying way by secondary line – voluntary ambulatory mental health care services. Most problematic areas are crisis-care and residential care, especially regarding acute and more complex crisis situations, with a high support need.

A person in a mental health crisis in the Netherlands can be exposed to forced treatments. (18.000 persons a year)

Several laws in the Netherlands allow for substitute decision making by a court order regarding forced treatments. Under Dutch laws (BOPZ, PIJ, OTS) both for children as for adults, the practice of forced treatments is legally connected to forced admission to a (specialized) mental health institution.

Mental health crisis-care services in the Netherlands are part of a widespread maze of deformed “bureaucratically-restrained” services and often lack the necessary time for intensive individual social support in the community. Their job is basically “to intervene” with pre-defined interventions and have too little time for contact with the persons involved. The dominating medical model has caused a narrow mind-set and neglect of the social dimension. Often the only given choice to a user is to accept treatment either voluntary or involuntary. This is substitute decision making in practice.

A court order, is the only acute measure available in the field of mental health care. Otherwise people have to wait on a waiting list for mental health care. The number of court orders for forced treatment is rising annually.

Thousands of innocent children with psychosocial problems have been placed in child-prison-settings without having a criminal sentence, but due to a lack of mental health care-services and an existing court order to be placed “somewhere supervised”.

Inside mental health care institutions there is basically a structural lack of social attention for the life of users, and in many occasions there are no adequate services to deal with mental health crisis situations. Once admitted, the psychiatrist and/or nurses have the power to decide to use forced interventions.

Coercion is traumatizing and doesn’t help to bring safety or wellbeing, even on contrary.

In the Netherlands there are various forms of solitary confinement in use in mental health care: Seclusion (Separatie), Segregation (Afzondering), confinement in a regular room (Kamer) and High/Intensive Care-units (“upgraded” secured areas with technological attributes).

Forced medication is the “second choice” (after confinement) in dealing with crisis situations. The majority of forced medication is administered to persons in seclusion. Generally the same persons are subjected to several forms of coercive interventions.

Fixation (physical restraints) is less used in mental health care, but relatively “preferred” in the care for persons with intellectual disabilities and elderly persons.

It is unclear whether forced body cavity search (“visitatie”) on children with psychosocial disabilities has fully stopped. Data on this are rather rare.

A few hundred persons each year in the Netherlands, are subjected to long term solitary confinement inside mental health care institutions, and long term fixation (physical restraints) in facilities for persons with intellectual disabilities and elderly care.

When the major media pay attention to an individual case of long term coercion, it suddenly appears that solutions can be found quickly.

Projects to reduce seclusion generally resulted in a reduction of the duration of seclusion, rather than the number of seclusion episodes. Currently the attention for reducing seclusion is fading away again. The national project-funding will end in June 2013.

Alternatives to coercion are found in a social approach, with more social support, prevention and a better handling of crisis situations.

Unfortunately, standardized frameworks (bureaucracy) in mental health care generally do not provide for intensive individual social support.

Physical adjustments of confinement facilities in mental health care are no real solution. Contact in crisis situations has much more of a scientific basis than coercion.

The mass of systemic errors in mental health care creates powerlessness and burn out among persons who want to change this.

Support for the social movement by a higher authority could enable a social break-through.

The State of the Netherlands has not been playing a key role in banning coercion from mental health care in the Netherlands. A new law proposal on “Mandatory mental health care” and a law proposal on “Care and Coercion” both aim to expand the options for forced treatments.

The language in the law proposals is, like many State-supported documents, generally smoothing, substitutive and misleading, covering up the real practices, reaffirming stigma and based on an outdated medical model, which is allowing for large-scaled torture and ill-treatment.

Torture prevention mechanisms seem either to decline any responsibility for mental health care practices, or are lacking authority to act against bureaucracy.

Coercion in mental health care in the Netherlands still exists because of political neglect, wrongfully medicalized perceptions and bureaucracy.

If more efforts were made by the State of the Netherlands, forced treatments and substitute decision making could probably have been already banned from mental health care in the Netherlands, but somehow the sense of priority seems to be lacking at the policy levels.

Resources, knowledge and all kind of structures are available in the Netherlands, therefore the State of the Netherlands is to be held fully accountable for the ongoing practices of human right violations, torture and ill-treatment in mental health care in the Netherlands.

Forensic Care combines a criminal sentence with a court order for mental health care. Forensic mental health care is gradually moving away from care-concepts towards extremely severe sentences.

Once sentenced to TBS-treatment in a Forensic Psychiatric Clinic, **there is no set end-date**, and evaluation of the measure takes place every 2 years. **The longest TBS-detention lasted over 50 years (1960-2011)**

Forced interventions in forensic care settings are comparable to general mental health care, although generally executed with more force.

The numbers on recidivism (relapse rates) show that recidivism/ relapse in crime is higher for persons who have been detained (almost twice as high)

1. Introduction on language and definitions

Human rights and mental health cannot be separated from social dynamics, including language. An integral social approach is needed in order to find the right solutions, and to move beyond covering up symptoms. This submission on torture and ill-treatment in mental health care in the Netherlands is rather large, because it is not a simply understandable domain for any outsider.

1.1 Scope of Mental Health care in the Netherlands

Generally in the Netherlands, care for persons who face **psychosocial problems, intellectual disabilities, addiction, youth and elderly persons** are seen as separate domains within the mental health care-sector. However eventually these domains are sharing the same header “mental health care” in many ways. The distinction is not always clear.

In this report these various domains are considered altogether under the broad header of mental health care and where needed highlighted separately. Mental health care in criminal detention is considered separately in this report, because of the fundamental differences compared to the public mental health care-sector. Guardianship on an outpatient basis is not specifically included.

There are a lot of good care practices in the Netherlands. Many persons who face psychosocial problems are helped in a satisfying way, especially by voluntary short-term ambulatory care.

But also the Netherlands is not perfect. This report is about some problematic areas in mental health care in the Netherlands, which constitute human right violations. The general nature of the human rights violations in various mental health care domains shows an overall correspondence, especially regarding shortcomings in crisis care and complex residential care.

1.2 Psychosocial disability, mental health and care

Mental health is wellbeing. Mental health is about coping with life and feelings. Mental health is highly related to the **social background** of a person. Unequal social, sexual, economic power relations are very strong factors in causing psychological and psychosocial problems. For example violence, power abuse, child abuse, sexual abuse, traumatising events, loss of job, loss of friends, poverty, drug abuse, lack of chances etc. are all social circumstances which can lead to an outburst of psychosocial problems. Coping with these problems is **a very personal process**.

Across different cultures and different ages a variety of ways of dealing with grief, loss, insecurity, anger etc. has been developed. In all populated areas there are certain codes of conduct. (e.g. No shouting at nights etc). In general, society defines the boundaries of **acceptance** and tolerance on this individual behaviour. A person with ‘mental health problems’ is generally in a way exceeding the favourable way of conduct and behaviour, which leads to a social problem. When this problem is linked to one’s personal state of mind it used to be called a “mental problem”, and by now it is called a psycho-social problem, manifesting on the cutting edge of a person’s psychological state and the interaction with the social environment.

Psychosocial problems are mainly social problems, closely related to one’s social background and social circumstances, featuring **social tension between the person and society**.

The CRPD preamble states:

- *“(e) Recognizing that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others”.*

Disability should be seen as the result of the interaction between a person and his/her environment, and disability is not something that resides in the individual as the result of some impairment.

The evolving concept of disability is further illustrated by the next examples, coming from the (generic) CRPD Handbook for parliamentarians.

“Disability resides in society, not in the person⁴

A person in a wheelchair might have difficulties being gainfully employed, not because his/her condition, but because there are environmental barriers, such as inaccessible busses or staircases in the workplace, that impede his/her access.

A child with an intellectual disability might have difficulties in school because of teacher’s attitudes towards him/her, inappropriate curricula and learning materials, inflexible school boards, and parents who are unable to adapt to students with different learning capacities.

In a society where corrective lenses are available for a person with extreme myopia (short-sightedness), this person would not be considered as having a disability. But someone with the same condition in a society where corrective lenses were not available would be considered as having a disability, especially if the person were unable to perform the tasks expected of him/her, such as shepherding, sewing or farming.”

It’s evident that the social environment has a crucial positive or negative impact on mental health.

What used to be called “mental illnesses” is now to be called psycho-social disabilities, which emphasizes that disability resides in the community and not in the person. (also see CRPD)

1.3 The Recovery-approach⁵

Social factors contribute largely to recovery from psychosocial problems. Recovery does not mean cure. The recovery-approach, which is flourishing since the 1990s, focuses on the personal journey to achieving a satisfying, hopeful, and contributing life even with limitations or barriers. There is no single definition of the concept of recovery, but the guiding principle is hope – the belief that it is possible to regain a meaningful life, despite possible barriers.

Understanding that people who face psychosocial disabilities are people who are interacting with their environment, and that life is dynamic is the cornerstone of understanding the concept of recovery and mental health.

Recovery from psychosocial disabilities involves being able to live a meaningful, fulfilling, satisfying life, which is not an isolated process of the person concerned, but merely an issue of **chances in life**.

“All people must have the opportunity to reach their full potential”

⁴ CRPD Handbook for Parliamentarians <http://www.ipu.org/PDF/publications/disabilities-e.pdf>

⁵ Recovery is a journey of the heart, Deegan 1996 <http://www.bu.edu/cpr/repository/articles/pdf/deegan1996.pdf>
Conspiracy of Hope, Deegan 1987 https://www.patdeegan.com/sites/default/files/files/conspiracy_of_hope.pdf
Recovery... the guiding vision in the 1990s <http://128.197.26.36/cpr/repository/articles/pdf/anthony1993.pdf>
Wellness Recovery Action Plan (WRAP) : <http://www.mentalhealthrecovery.com/wrap/>
research on WRAP <http://www.mentalhealthrecovery.com/wrap/research.php>

1.4 Backgrounds and paradigms of Mental health care in the Netherlands

Mental health is not static, and coping with psychosocial barriers is highly related to the social context. **The general task of care is to support persons** in various areas of health, wellbeing and self-realization, in order to positively influence the wellbeing of the persons concerned.

Care does not mean cure. Care should facilitate recovery.

Ideally, the overall aim of mental health care, with a recovery-oriented view and a CRPD-based approach, is to support an **optimal symbiosis in life in the community** where persons can reach full potential while participating in an inclusive environment which respects diversity and offers meaningful chances to achieve a happy and fulfilling life.

In practice, the development of a specialization called **“social psychiatry”** was established in the Netherlands even before 1950⁶, and the original concept of this movement was to focus on a more social approach, aimed on inclusion and wellbeing.

However the movement of social psychiatry is not really prominent in psychiatric care developments anymore. Since in the past decennia, the **biomedical approach** has dominated in the Netherlands, and caused a severe narrowing of the view on mental health, by putting the primary focus on the brain as the part where psychological attributes (of the mind) are located, which is meaningless because the proper subject matter can only be the whole human being (in the context of life) and the mind and its psychological attributes have to be considered as a process and not as an object-like entity. An excessive focus on statistics and materialization undermines a social approach.

Tensions in Dutch mental health care between a social model versus medical theories last already many decades. This tension polarized around the 1980s, and is still unresolved.

Nowadays, a part of the society calls for more repression of persons with mental health problems, which shows there is a lack of general awareness on equality, universal respect, human rights, and not enough understanding of mental health, recovery and chances.

Media often reaffirms the misperceptions and **stigma**, very often presenting persons with mental health problems as *“a burden to society”*, such as: *“dangerous, causing harm and damage, cost-expensive, too weak or incapable to manage life”*.

Despite the harmful public stigmatization, the Dutch government is not actively promoting the freedoms, rights and equality for persons with psychosocial disabilities, but instead resources and governmental powers are used to legalize and facilitate certain types of mental health care which are not focussed on creating inclusion, but facilitate coercive segregation and cause suffering.

Of course, mental health care in the Netherlands is obviously not the worst on Earth, but still, many people are traumatized by forced interventions, such as forced admission in psychiatric hospitals, forced treatments and interventions such as solitary confinement, fixation, forced medication and forced body cavity search, even on children.

So unfortunately, human right violations also happen in mental health care in the Netherlands.

⁶ A. Querido, social doctor (1901-1983) <http://www.historici.nl/Onderzoek/Projecten/BWN/lemmata/bwn3/querido>

1.5 General introduction on human right themes and misperceptions in mental health care in the Netherlands

This submission is mainly about forced treatments in mental health care in the Netherlands.

This includes substituted decision making and various outdated practices, such as seclusion, forced medication, physical restraints (fixation) and even forced body cavity search on children in mental health care in the Netherlands.

1.5.1 Substituted decision making in mental health care in the Netherlands

In the Netherlands there are several laws in place which arrange for substitute decision making for persons with psychosocial disabilities ⁷.

Based on outdated (medical) perceptions of “mental illness”, psychiatry in the Netherlands often denies the person and its role of moral agent with words like “*incapable*”, or “*unable to consent*”, which is the most serious offence against human rights; **taking away the right to legal capacity** ⁸. Incredibly complex jargon and diagnoses for the so-called “mental illnesses” is used by these professionals, and the labels mainly create distance and stigma, which surely isn’t increasing personal wellbeing, but facilitates exclusion and dehumanization.

- The CRPD moves away from a medical model to a human rights based approach. Taking away legal capacity based on disability is a serious human rights violation and cannot be accepted.
- **Mendez (2013) A/HRC/22/53, IV.D.4: “Fully respecting each person’s legal capacity is a first step in the prevention of torture and ill-treatment”** ⁹

1.5.2 Forced interventions in mental health care in the Netherlands

Also, some shockingly primitive practices such as forced admission in psychiatric care institutions, seclusion, restraint and coercive medication have not been banned, and still exist as a daily practice in residential mental health care services in the Netherlands.

The use of these forceful measures are an old-fashioned habit, a left over from the past. Despite previous human right treaties and many user-protests, these measures never got fully banned from mental health care in the Netherlands.

These coercive care practices are dehumanizing and very traumatizing for the persons involved.

- A Dutch seclusion cell may look well-painted, but still, solitary confinement isn’t increasing wellbeing. On contrary...
- **Mendez (2013) A/HRC/22/53, IV.D.2 “Any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment.”**¹⁰ It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions.” ¹¹

⁷ for example: *wet BOPZ, wetsvoorstel Verplichte GGZ, wetsvoorstel Zorg en Dwang*, see 2.2.2 Organisation of legal measures allowing for forced treatments in the Netherlands

⁸ Mendez, A/HRC/22/53 – IV.D.4: “Fully respecting each person’s legal capacity is a first step in the prevention of torture and ill-treatment”

⁹ Mendez (2013) A/HRC/22/53, IV.D.4

¹⁰ See CAT/C/CAN/CO/6, para. 19 (d); ECHR, *Bures v. Czech Republic*, Appl. No. 37679/08 (2012), para. 132.

¹¹ Mendez (2013) A/HRC/22/53, IV.D.2. 63

1.5.3 Humane care is possible in mental health care in the Netherlands

The legal excuse for coercive interventions in mental health care in the Netherlands is based on **“providing safety when the person is causing a danger to self or others”**.

But the concept of using force to deal with a mental health crisis is wrong and unnecessary:

- The use of forced interventions is based on the assumption that coercive interventions increase safety and wellbeing, which is not the case. Coercive interventions are **harmful and traumatizing** and lead to more psychosocial problems, which can easily lead to more escalations and **more crisis**. Also subjecting persons to treatments against their will induces resistance, struggle and a breach of contact, which undermines further care relations. This altogether leads to **unsafety** (risk). Coercion does not help.

Violence is never a solution. It’s always a problem.

When adequate care is available, forced interventions are un-necessary:

- **Non-violent de-escalation is possible.**
In psychosocial crisis situations, escalations often result from powerlessness, fear, distress and despair. De-escalation means to bring back peace, which can be done by contact and communication, providing comfort, building up trust, involving dear ones, new chances, empowerment, support, which are all aimed at reducing powerlessness, fear, distress and despair, and at improving wellbeing of the person(s) concerned. (also see 2.6 Alternatives).

De-escalation is not cure. There is no single definition of de-escalation. It can be seen as “calming down” which involves a highly personal process, which resembles to recovery.

- **Prevention of a crisis is possible**
In coercive practices there is hardly any attention for any deeper meaning of behaviour. However so-called “crisis situations” generally develop over time, when gradually the interaction between the person and the environment exceeds the level of acceptance of the social environment, until it’s referred to as a “crisis situation”. This course of development offers opportunities to **prevent crisis situations on various ends in an early stage**. (also see 2.6 Alternatives)

Unfortunately prevention of psychosocial crisis situations in the Netherlands falls short (see next chapter). And due to a lack of sense of urgency the primitive coercive practices still exist in mental health care. This would not be the case if more efforts were made to prevent this. Unfortunately mental health is often “not on the agenda”, which results in (residential) services with primitive systematic errors and a lot of shattered lives.

If more efforts were made by the State of the Netherlands, coercion and substitute decision making could probably have been already banned from mental health care in the Netherlands, but somehow the sense of priority seems to be lacking at the policy levels.

Resources, knowledge and all kind of structures are available in the Netherlands, therefore the State of the Netherlands is to be held fully accountable in the severest way for the ongoing practices of human right violations, torture and ill-treatment in mental health care in the Netherlands.

2. Human rights violations in mental health care in the Netherlands

2.1 Worrying signs in the Netherlands indicating human rights violations in mental health care

2.1.1 User experiences

Many persons in the Netherlands who face psychosocial problems and intellectual disabilities are helped in a satisfying way by voluntary mental health care services. However at some levels of mental health care **persistent complaints** exist on human rights violations. (see annex 2 User experiences indicating human rights violations in mental health care in the Netherlands)

The most common heard complaints on Dutch mental health care are generally about 3 major issues:

- **Getting no help:** Community based care is often not available when needed, leading to a lack of prevention of mental health crisis and a high number of suicide (see 2.1.2 Mental health and suicide in the Netherlands).
- **Impersonal life in institutions:** There is often a relatively poor quality of care in crisis-care and in many types of residential mental health care institutions, leading to an impersonal and rather repressive approach, with too little attention for personal development.
- **Coercive care practices:** Especially involuntary measures (substitute decision making, forced institutionalization, seclusion, fixation, body cavity search and forced medication) are traumatizing, and causing debate.

User experiences indicate that most problematic areas of mental health care are in crisis care and residential care, which are generally the more **acute or complex-care situations**.

2.1.2 Mental health and suicide in the Netherlands

- Suicidality is an expression of severe suffering.
- 80% of persons who commit suicide suffers from psychosocial problems^{12, 13}
- In 2011, 1.647 persons committed suicide in the Netherlands.¹⁴ (population 16,7 million) That is 1 suicide per 10.113 inhabitants, almost 5 persons each day. In 4 years (2007-2011) the number of suicides has grown with 18%.
- Suicide is the main cause of death for persons in the age of 15-30.¹⁵ In 2010 almost 25% of all deaths between age 15-30 are suicides (197 of 840), which is more than the number of deaths by traffic-accidents (146) and cancer (131).
- 50% of successful suicides followed after a previous suicide-attempt.¹⁶ About 120.000 suicide-attempts take place every year.¹⁷
- About 1/3 of persons who did a suicide-attempt had never reached out to any form of mental health care (including informal care) before the attempt.
So 2/3 of persons who did a suicide-attempt did reach out to any form of mental health care (including informal care) before the attempt.

2.2 Organization of mental health care and legal measures in the Netherlands

¹² http://www.psychiatrieweb.mywebhome.nl/pw.spoed/files/docs/070901_behandelingsucidalepatient.pdf

¹³ Netherlands Mental Health survey and Incidence Study-2 (Nemesis-2), 2011

<http://www.nemesis-2.nl/~media/Themasites/Nemesis2/Files/Rapport%20suicidaliteit.ashx>

¹⁴ CBS <http://www.cbs.nl/nl-NL/menu/themas/gezondheid-welzijn/publicaties/artikelen/archief/2012/2012-3668-wm.htm>

¹⁵ CBS <http://www.cbs.nl/nl-NL/menu/themas/bevolking/publicaties/artikelen/archief/2011/2011-3456-wm.htm>

¹⁶ RIVM: Let op letsels: preventie van ongevallen, geweld en suicide, 2008 http://www.rivm.nl/Images/270102001_tcm4-54077.pdf

¹⁷ http://www.psychiatrieweb.mywebhome.nl/pw.spoed/files/docs/070901_behandelingsucidalepatient.pdf

2.2.1 Overall organisation of care levels in mental health care in the Netherlands

In the Netherlands mental health care is organized in several “lines” of care:

1. Mental health care in the “**First line of care**”(Eerstelijns-zorg) comprises a general segment of knowledge in the generic health care, such as the family doctor and first aid centres.
2. The “**Second line of care**”(Tweedelijns-zorg) comprises specialized care services on an ambulatory basis.
 - 840.000 persons receive second-line specialized mental health care. 42% of them end the second-line specialized care within 3 months. Many are on a waiting list. On 31-12-2009, over 101.000 persons were waiting for application, assessment or treatment.
3. **Crisis-care** comprises acute and urgent care such as emergency service for mental health crisis situations, such as *Crisis-dienst*, (F)ACT-teams and acute admission (both voluntary as involuntary)
4. **Specialized long-term and residential mental health care settings**, such as mental health institutions and social care homes.
 - About 9% of care-receiving persons with mental health problems receive residential mental health care: clinical treatment or living in a protected living environment. (about 84.000 persons)¹⁸

Many mental health services in the “second line of care” have long waiting-lists (average in 2009 is about 5 weeks for any of the steps: application, assessment or treatment, and in total getting through the process from application to treatment often takes longer than 14 weeks) and many services impose bureaucratic barriers, which results in a lack of prevention of mental health crisis.¹⁹

The problematic barriers in secondary care (community based care) have a negative impact on the care-demands in crisis-care and residential care.

Crisis-care and residential care are currently the levels of mental health care, where involuntary, non-consensual and forced treatments mainly happen.

This submission focusses on human right violations in crisis-care and residential care in the Netherlands (acute and complex care-situations).

- In the near future forced treatment in the community may be expected in the Netherlands, as this is proposed in the new draft law on mandatory mental health care (wetsvoorstel verplichte GGZ - also see 2.7 on law reforms).
 - A pilot project with Community Treatment Orders seems to have started, which mainly seems to be aimed at the forced administration of medication to persons in the community against their will.

Future worries about Community Treatment Orders will be addressed in paragraph 2.5.3 Forced medication and also 2.7 Related law reforms in the Netherlands.

The next paragraphs describe the actual current practice.

¹⁸ Data derived from : general information on the mental health workfield, GGZ Nederland:

<http://www.ggz nederland.nl/de-ggz-sector/het-ggz-werkveld.html> and <http://www.ggz nederland.nl/feiten-en-cijfers/sectorrapport-2010.pdf>

¹⁹ <http://www.ggz nederland.nl/feiten-en-cijfers/sectorrapport-2010.pdf>

2.2.2 Organisation of legal measures allowing for forced treatment in mental health care in the Netherlands

The current Dutch national law which allows for involuntary, non-consensual and forced treatment in mental health care (psychiatry) is:

- Wet Bijzondere Opnemingen in Psychiatrische Ziekenhuizen (BOPZ); Law on Special Admissions in Psychiatric Hospitals

The law BOPZ links involuntary treatment inherently to a mandatory stay in a specialized mental health care institution.

The law BOPZ arranges the procedure based on criteria under which forced treatment is either allowed or not allowed. Under the law BOPZ **“forced treatment” is a generic description.**

The application of forced treatment is based on the non-binding (and outdated) **MI-principles**²⁰, which imply that 2 independent psychiatrists have to give their expert-judgement on “dangerousness to self or others caused by mental illness” and a judge in court will make the final decision whether “forced treatment” is legitimate under Dutch law. Generally most court-hearings on forced treatments (for adults as well as for children) comprise a ‘rubber stamp policy’ (“yes, unless...”), which is basically due to the fact that the medical doctrine also exists in court settings in the Netherlands.

Under BOPZ “forced treatment” should be **“the least restrictive intervention possible, when there are no other means to prevent danger to self or others caused by a mental disorder”**. Additional criteria are: *“proportionality, target-relation and subsidiarity needs to be taken into account”*.

BOPZ measures are court orders, which are divided in 2 main types: IBS and RM;

- IBS (In Bewaring Stelling) is relatively a short term measure (5 days up to 21 days).
- RM (Rechterlijke Machtiging) is for longer term (generally from 3 months up to 2 years)

Procedures and criteria are generally the same for both of these BOPZ measures (IBS/RM).

Number of people annually subjected to forced treatment/forced admission:

- Over 10.000 persons obtained an RM-measure in 2009.²¹
- Over 8.000 persons obtained an IBS-measure in 2009.
- The total number of persons obtaining an RM or IBS is rising every year.

- Once institutionalized to a mental health hospital, according to the law BOPZ, all other kind of coercive care practices can be legally executed on demand of the psychiatrist. The BOPZ-measure allows for “forced admission/ forced treatment” and only limits the time frame in which the psychiatrist can execute his/her power.
(see 2.4 and further for more information on the substance of forced treatments)

2.2.3 Organisation of mental health care for children and youth

Mental health care for children and youth also comprises

1. First-line care (at the family doctor and general health care centres)
2. Secondary-line care, (specialized ambulatory mental health care)
3. Crisis-care, (interventions by child care services and child-protection)
4. Residential specialized mental health care facilities for children and youth (voluntary or involuntary).

²⁰ MI-principles : Ten Basic Principles on Mental Illness, WHO 1991,

²¹ Resource: RIVM zorgatlas: <http://www.zorgatlas.nl/zorg/geestelijke-gezondheidszorg/gebruik/toegekende-rechterlijke-machtiging-per-gemeente/#breadcrumb>

The current Dutch laws which arrange court orders for forced institutionalization / forced treatment of children and youth are:

- The law BOPZ (as described in the preceding paragraph)
- PIJ: Plaatsing in Jeugdinrichting (Placement in Youth institution) a court order for treatment used in criminal sentences (forensic child-care)
- OTS: Onder Toezicht Stelling (Placed Under Observation) a court order for placement out of the family home, indicated on various grounds by child-care-services (Bureau Jeugdzorg/ Centrum Jeugd en Gezin)

PIJ and OTS measures for children/youth are not exactly the same as BOPZ-measures, but apart from a slightly different legal procedure and certain other criteria, the result is the same. **These legal measures arrange whether it is allowed or not allowed - to subject a particular child to involuntary, non-consensual or forced institutionalization/treatment.**

Residential placement and clinical treatment in an institution for child-/youth-mental health care can also imply coercive care interventions.

- Generally once a child is institutionalized into residential child-mental health care-services (whether it's with PIJ, OTS or BOPZ measure) the child loses legal capacity, and all kind of coercive care practices can be legally executed on demand of the child-psychiatrist.
- In some occasions the parents have to give permission for starting a forced intervention to a child underage.
- In many occasions parents protest against the practise of coercion on their child, but also they have no say in what happens in daily life inside a mental health care institution.
- Note that for a child it's is extremely hard to raise a disagreeing voice, because as a child you learn to obey to the adult, and the child is not yet in a position of questioning the parent/adult, which is also easily misinterpreted as 'disobedience'. Therefore **children need active protection against involuntary treatments.**
 - In the Netherlands there are thousands of children institutionalized against their will. Unfortunately, there are no actual numbers on involuntary detention in child care to be found in the public domain.

Summary 2.2: Under Dutch laws, both for children as for adults, the practice of forced treatments is legally connected to forced admission to a (specialized) mental health institution.

2.3 Problems of mental health crisis-interventions in the Netherlands

When a person is having a mental health crisis in the Netherlands, the persons often faces: **(1) waiting lists, (2) superficial practices of the crisis-care-services and (3) several 'shortcut-constructions' to avoid the waiting lists.**

2.3.1 Waiting lists: Support in a mental health crisis in the community is often not available

When a psychosocial problem arises, it is manifesting on the cutting edge of a person's psychological state and the interaction with the social environment. So-called "crisis situations" generally develop over time, when gradually the interaction between the person and the environment exceeds the level of acceptance of the social environment, until it's referred to as a "crisis situation".

Psychosocial crisis situations are generally accompanied by psychological suffering and social isolation of the person involved (often referred to as “*sliding down*”), and on the other hand, a society which demands for intervention, because **social support is exhausted or just not there**. On top of that, there are waiting lists and various bureaucratic and practical barriers for specialized ambulatory mental health care services as well as for residential mental health care. So before/in a crisis-situation, **professional support is also not there**.

The lack of adequate care in the first phase of psychosocial problems is serious **neglect**, which causes more serious psychosocial problems.

2.3.2 Superficial practices of crisis-interventions by mental health care services in the Netherlands

Sadly, in the Netherlands psychosocial problems are still often seen as “biomedical mental illnesses” (residing in the person), which leads to old-fashioned practices of trying to manage and modify behaviour by “interventions” either voluntary or involuntary, based on ideas coming from the era of the medical model, which sees person who face disabilities as objects of charity and pity, and not primarily as human beings entitled to the right to make their own choices in life.

The existing services in Dutch mental health care are not demand-based but rigidly **offer-based and pre-defined**. Generally the care-service decides “what is to be done” as they consider themselves the experts, and there is hardly any room for legal capacity since the person who is labelled as “mentally ill” almost automatically is stigmatized as “a person who can no longer make sensible decisions by him/herself, and needs to be managed by another person”.

Also the organizations operate nowadays as islands in the neoliberal market of health care, which creates concurrence in the field of mental health care (and a need for clients as a profitable source of income for organizations), instead of cooperation and the ultimate goal of ‘having no more patients’.

These social-political background dynamics have a harmful impact on the attitude and practices of mental health crisis-care:

- **Too little contact / the intervention is already decided:** It appears that a crisis team generally has only about one hour average for approaching and making overtures to a person in a crisis situation, where carers often wish to proceed to a concrete intervention to end the impasse or crisis, if need be voluntary or involuntary... In crisis-care there is very often too little attention for the person and his/her will, which is closely related to the medical approach and “the objected productivity capacity” of e.g. the crisis-care service.
- **Intervention is the norm / Hardly a choice:** Generally there is a firm widespread belief that “intervention is necessary for health or social protection”. (*“good intentions / best interest”*)
 - The dominating biomedical approach in the Netherlands does not allow much attention for a social scope, and in fact it does not allow for legal capacity or a free and informed choice of the person concerned. The biomedical approach devalues personal experiences and reduces persons to a set of chemical processes, which is dehumanizing in itself. On top of that the biomedical approach introduced a design of “normal persons”, and judges on personal intrinsic characteristics, which is a blunt discriminatory practice in itself. The persistent misconceptions that “interventions are needed to make someone normal” are clear and obvious violations of fundamental human rights. In this way the dominating medical approach is undermining diversity and human rights.

Often the given choice is to accept treatment either voluntary or involuntary. This is substitute decision making.

A very harmful effect of commercial neoliberalism in health care is a shattered coherence of social services leading to narrowed goals of various mental health organizations, causing a very superficial and production-based approach “on their own domain”, and the general big picture gets out of sight:

- **Intervention is the duty and goal of crisis-care services:** The task-description of crisis-care is generally *“to intervene in a crisis situation, and to mediate/move the persons towards specialized mental health care, because of the so-called need for treatment”*. Bureaucratic regulations prevent organizations from working outside of their core domain, which limits the options for individual support. In the Dutch mental health care field market-orientation and concurrence has arisen, which causes organizations to operate as islands, leaving gaps in the social system.
 - In the Netherlands, caregivers can even be prosecuted if they do not intervene in certain situations (called “neglect”), which causes another motivation for carers to intervene one way or another. (see forced medication)
 - The dynamics of ‘carers providing care on a compulsory basis, and intervening almost regardless of the person’s perception, in order to be perceived as a hero who saves lives’ is also described as the *“carers-syndrome”*.²²

Carers face many unjust motivations to intervene with force.

2.3.3 Avoiding waiting lists by increasing court orders

As explained before, often there are waiting lists for specialized mental health care. So it happens that a person who faces a crisis and asks for **voluntary** mental health care gets no support at all. Then, **the only acute measure which can be urgently arranged in a crisis situation is forced admission/forced treatment** (due to a court order that supersedes certain bureaucratic procedures).

- ***“Forced treatment on Own Request”*** is a theoretical construction to avoid waiting on a waiting list, by requesting a court order for forced treatment, which is always executed immediately and supersedes waiting lists.

The language and construct of “voluntary forced treatments” is inappropriate (like a square circle), and indicates **inadequate management**. This strange legal deformation is not solving the real problems of a lack of access to voluntary mental health care.

Children with psychosocial problems get detention instead of care

Also in child care services, there used to be an even worse trend of dealing with waiting lists by increasing the heaviest court orders, or even placing innocent kids in child-prison-settings.

- Children with a OTS or BOPZ maatregel (court order for treatment, without a criminal aspect) are placed on waiting-lists, while a court order for treatment within a criminal sentence is executed immediately, at the expense of all other placements. The waiting lists lead to a situation where children get a PIJ-measure more often (forensic child care), to avoid the waiting lists for general residential admission²³.
- Also during the practice of various forms of “care” many children are placed in criminal detention and not in specialized mental health care institutions, and not in individual necessity, but based on availability.
- **Also many already thousands of children (4.000 in 2009 alone) have been placed in detention facilities even without being criminally sentenced, but due to a lack of mental health care-services and an existing court order to be placed “somewhere supervised”.**²⁴

²² Hulpverleners-syndroom:

<http://books.google.nl/books?id=UiyzplHs8O4C&pg=PA26&lpg=PA26&dq=hulpverlenerssyndroom+appelo&source=bl&ots=tWor7AN-qk&sig=bvb-Sx7J-kD37DKQv7iMlnh5Jk&hl=en&sa=X&ei=3RQiUbXCHMyUOQXP4oEQ&ved=0CCKQ6AEwAA#v=onepage&q=hulpverlenerssyndroom%20appelo&f=false>

²³ <http://mens-en-samenleving.infonu.nl/diversen/37234-pij-maatregel-plaatsing-in-een-inrichting-voor-jeugdigen.html>

- In 2009, it was decided that 5 child-detention-centres would be turned into closed mental health care facilities for children. Adjustments in the law on Youth Care should prevent the placement of innocent children in prison-settings for the future.
- There are no recent data found in the public domain.
- **As far as we know, these kids never got proper excuses nor were compensated for this tragedy in their lives.**

The trend of increasing court orders to cover up problems with the waiting lists, means in fact that the child or adult gets punished for having a disability, because there is a lack of appropriate care.

The waiting lists also show there is a lack of prevention of mental health problems in earlier stages of care. This means the demand for acute and complex care will keep on rising, which leads to more of the same problems concerning access to mental health care.

The State of the Netherlands is responsible to secure a good quality of care and fundamental freedoms on an equal basis for every person. Increasing court orders to cover up a bad management of mental health care throughout the Netherlands is an appalling practice, which constitute fundamental human right violations.

2.3.4 Pressuring for voluntariness at forced interventions

The construct of “voluntary forced treatment” is further deformed and is abused in the context of all forced treatments; During the execution of any forced intervention, the carers repeatedly ask for **permission and cooperation** of the user, because the intervention will have to be registered as *“voluntary”*, *“under resistance”* or *“no resistance/no approval”*

This false distinction between three types of unwanted interventions is then further abused to **disable complaints** about so-called “voluntary forced treatments”, because of supposed “agreement” at the time of the execution. Resistance is officially interpreted as “active resistance”.

Carers often try push to be able to **register formal agreement** with the user, not only because of the nicer sound, and the legal implications (less registration), but also because resistance is perceived as a symptom of illness, which means: “the more resistance, the worse the mental health condition is thought to be, cumulating to a so-called inability to accept help”. So when a user accepts help, this is seen as a sign of cure and recovery, while rejecting help is perceived as the person being *“too sick to understand ‘healthy’ decisions”*, which is then leading to more pressure and eventually to concrete forced interventions, such as forced admission (BOPZ)

- In the Netherlands in recent years, *Coercion* and *Pressure* are both recognized as forms of forced treatments. It is also combined in the name “Project Dwang en Drang”. However, there is not any formal registration of **“pressured decision making”**, and filing complaints about voluntary (forced) treatments has typically a very low chance on success.

The current construction of “voluntary forced treatments” creates a gap in the protection of user rights, by decreasing the possibility to complain, and by structurally neglecting the need to provide a good quality of care and to prevent torturous forced treatments.

Summary 2.3:

In many crisis-situations, the intervention of crisis-care-services results in involuntary or pressured admission. Forced institutionalization is always a result of a lack of community based support. Being forced to live in a mental health institution for a shorter or longer period, is in violation of human rights, and puts the person at risk of further abuses and human right violations.

²⁴ <http://www.nrc.nl/rechtenbestuur/2009/02/10/uitspraak-23-een-lastige-puber-in-de-cel/>

2.4 Forced admissions in mental health care institutions in the Netherlands

A mental health crisis in the community in the Netherlands can quite easily lead to forced admission. It is legally only possible to start “forced treatments” after admission.

2.4.1 Dutch mental health care institutions

In the Netherlands many institutions may seem well-maintained, clean and well-ventilated, and human rights violations are -fortunately- not a direct experience for each individual mental health care service-user. Many persons are quite satisfied, especially in voluntary outpatient services.

But inside residential mental health care facilities there is often a **lack of appropriate and sufficient support, a lack of time/attention for users**, due to a wrong patient-staff ratio, and an inappropriate setting, a wrong system, a lack of knowledge (the Dutch mental health care is still dominated by the medical model, even despite the official governmental signature preceding the ratification the UN CRPD), there is still a structural underinvestment in real solutions, and a lack of legal protection of users rights and so on.

Especially the ‘closed wards’ of psychiatric hospitals/mental health institutions are experienced as a generally unpleasant up to horrific (described as “a chain of empty Sundays”, every day seems the same, with a lot of boredom, and living a scheduled life from meal to meal without any deeper meaning in life). The general attitude of social neglect is also related to the medically oriented mind-set of the mental health care, which basically doesn’t leave room for a personal social approach, but falsely presumes the person’s main need is “the right medication” (and then wait until it works). And talking about the social context generally only gets a secondary position, and is very often regarded as a “random occupational activity” or at best as a “complementary therapy”.

On long term wards there is a general lack of hope.

Inside Dutch mental health care institutions, **users have no real legal capacity**. They are not free to leave or to make free decisions. Most users are having “**limited freedoms**” –corresponding with the margins of individual appointments and treatment plans. (such as: being institutionalized but allowed to handling certain amounts of money – or: being obliged to take forced medication, and after fulfilling that condition, allowed to go outside on appointment).

Persons living in institutions in the Netherlands face a marginalized and impersonal life, with a **minimal social dimension**, and lacking many of the social chances which are needed for recovery. Due to a lack of time and attention for users, recovery is harder, and a new mental health crisis may evolve. This cannot be called good or effective mental health care.

2.5 Forced treatments in mental health care institutions in the Netherlands

- Very often there is not sufficient appropriate care inside residential facilities, which then generally easily leads to an unmanageable situation, and then carers resort to the use of ‘**emergency measures**’ (repressive forced treatments /interventions).
- **Repressive coercive interventions (such as so-called forced treatments), are a very primitive way to try to maintain order in a group of persons.**

The most wide-spread coercive care interventions used in the Netherlands are:

- A. Seclusion** (and other forms of solitary confinement)
 - B. Forced medication**
 - C. Fixation** (physical restraints)
 - D. Body cavity search on children** (which is less common)
- **(Involuntary admission is a legal condition for applying any of the above interventions).**
 - (Guardianship is not included in this submission)

Note: Coercive interventions are misplaced measures in mental health care

Generally coercive care interventions in the Netherlands are claimed to be used as:

a measure of last resort to prevent danger to self or others. (“ultimum remedium”)

In our relatively small country (about 16,8 million inhabitants) each year many thousands of persons are subjected to forceful and degrading, traumatizing interventions inflicted by mental health care.

Using coercion in mental health care is based on many misinterpretations. It is counterproductive and is illegal under international law²⁵

Misperceptions:

- **A “last resort” implies there are first resorts too.**
 - In the community there is a lack of care and a lack of prevention due to waiting lists (over 100.000 persons were waiting on 31-12-2009)
 - In residential care: lack of attention and an impersonal approach, and therefore also lack of care and prevention
 - The standardized practice in an attempt to maintain order is “intervening”, either on a voluntary or involuntary basis. Due to limited contact and attention, low staffing and a lack of skills and expertise, often the quick answer to a crisis situation is the use of force.
 - **Invest in first resorts, not in last resorts:** Knowledge and alternatives to forced interventions are available in the Netherlands, although still on a small scale (see 2.6). Good practices need to be made available for everyone.
- **In unmanageable situations, everything easily becomes an emergency situation.**
- **Danger and safety are subjective perceptions.**
 - For example: physically big persons are more at risk of being perceived “dangerous”.
 - Previous experiences in other situations with other persons, have an impact on the experience of safety and threat.
 - Risks may as well be chances. (Care is not punishment. Care is care).
 - Safety is related to peace, and overpowering another person does not bring peace.
 - Preventive restrictions of freedom, and preventive forced interventions, to prevent so-called “danger to self or other” are based on stigma and other subjective factors, and are to be called discrimination on the basis of disability.
- **Using force is not an effective way of creating safety, peace or wellbeing, but the contrary.**
 - Safety and wellbeing are related to peace. Coercion is not related to real peace.
- **Coercive interventions cause suffering and trauma for thousands of persons who face psychosocial disabilities, intellectual disabilities and their relatives.**
 - Even many professional carers cannot bear the practice of forced interventions²⁶, and many good-hearted caregivers left the mental health care field²⁷, because they couldn’t cope with the daily primitive practices in the Netherlands, and they got no room for changing the entire system.
 - The coercive care practices never ceased to be a subject of public debates.
 - Coercive care practices are not “life-saving”, but “life-destroying”. Coercion creates trauma, resistance and a risk of new escalations (unsafety). This is contrary to the goals of mental health care.
 - **Eventually, coercion is helping nobody, but it only creates more suffering.**

²⁵ CRPD and A/HRC/22/53

²⁶ TV-testimony of Iris Mourits, Brandon’s carer: <http://www.youtube.com/watch?v=se82tE1KOPs>

²⁷ TV-testimony, Jolanda de Mooij, elderly care

http://www.eenvandaag.nl/binnenland/36379/verpleeghuizen_schieten_tekort

- **“Dignity” is interpreted as a norm, not as an intrinsic human experience.**
 - In the Netherlands, the word “emergency” is being misplaced in the context of “dignity”, as a justification for forced interventions based on “social protection”. (such as forced hospitalization, forced medication and forced showering)

- **Mental health care was established to provide an alternative to emotional neglect, confinement and restraints, which used to be the primitive practices. Coercion cannot be allowed as ‘professional care intervention’.** ²⁸

2.5.1 Decision-making regarding coercive care interventions in the Netherlands

Generally, in all residential mental health services in the Netherlands, the power over concrete forced interventions is centred at the psychiatrists, who are legally the decision-makers on starting or ending any forced intervention or treatment once the person is institutionalized with a legal measure

- However in daily practice the psychiatrist is generally not present, and decisions to start a coercive care intervention are commonly taken by nurses, who then have to ask for “permission” of the psychiatrist. The request for permission of a psychiatrist to start a forced intervention should formally be done on the forehand, but in practice is often done afterwards.
- Nurses are also the ones who execute the forced intervention in practice. Sometimes with back-up from security personnel or in some situations with support from the police.

A study ²⁹ shows that in mental health care (based on extrapolation):

- **“In 59% of emergency cases the person gets secluded”**
- **“In 22% of emergency cases the person gets forced medication.”**
- **“25% of seclusions is followed by “Afzondering/Segregation”.** (see next paragraphs)
- **Exact numbers on fixation in mental health care are unknown.** It varies a lot per location.
 - In mental health care fixation is not used as much as seclusion and forced medication.
 - However, fixation is relatively “preferred” as an emergency measure in the care for persons with intellectual disabilities, elderly persons and in general hospitals (see. 2.5.4). The total number of persons subjected to fixations is unknown.
- **“65% of all forced medication is administered to secluded patients”.** ³⁰
- **“18% of secluded patients get forced medication”**
- In 2005 a difference was found between registration of national health care inspection (IGZ) which showed that about 25% of all forcefully-admitted persons was subjected to forced interventions, while interviewing the persons themselves about forced treatments (including the number of “voluntary forced treatments”) led to a rate of about 80% of persons involuntarily institutionalized who had been subjected to forced treatments. ³¹ (explanation: 25% is the number of persons who actually show physical resistance, while the majority of persons doesn’t cross that line, but are exposed to “voluntary forced treatments”)
- Since a few years, seclusion is no longer allowed as standard observation-policy at admission.

²⁸ CRPD, Mendez A/HRC/22/53

²⁹ Research Erasmus Universiteit, 2012, <http://www.erasmusmc.nl/perskamer/archief/2012/3766785/?lang=en>

³⁰ Argus registration, see report at the right column at http://www.ggznederland.nl/beleid-in-de-ggz/beleidstemas/kwaliteit-van-zorg/dwang-en-drang/congres-6-jaar-terugdringen-dwang-en-drang_ggz-bouwt-separatie-verder-af_ook-zonder-subsidie.html?year=2012

³¹ Bronnen Symposium alternatieven voor separatie- 2005- Bert van de Werf.

<http://tekeertegendeisoleer.wordpress.com/2005/06/17/16-juni-05-symposium-alternatieven-voor-separatie/>

2.5.2 Seclusion and other forms of solitary confinement in mental health care in the Netherlands

There are several forms of solitary confinement in use in mental health care in the Netherlands, such as:

- (A) **Seclusion/Separation** in bare prison-like cells.
- (B) **High/ Intensive Care – units (HIC-units)** upgraded cells, often with technological support
- (C) **Afzondering/Segregation** in a variety of basically-empty or specialized secured rooms.
- (D) **Confinement in a regular room.** Generally any non-specific room, such as own bedroom, meeting-chamber and so on – this practice remains largely unmonitored.

In the Netherlands **seclusion (solitary confinement) is the most-used method of crisis intervention** in residential mental health care settings.

A. Seclusion (“separatie”) is solitary confinement in a bare cell (“separeerocel”)

“The Netherlands has the highest use of seclusion in mental health care of North-West Europe”

- *“Annually 5.500 to 6.000 seclusion episodes are registered in mental health care”.*³²
- *“Average seclusion period in mental health care in 2003 was 294 hours. (12,3 days)”*
*“Average seclusion period in mental health care in 2010 is 63 hours (2,6 days)”*³³
(obviously a lot of money goes to statistic research, and the general BOPZIS-registration is currently being replaced by a more specific ARGUS-registration system)
- According to the legally binding “national construction and operational guidelines”:
*“all ‘closed’ psychiatric settings are obliged to have a minimum of 2 seclusion cells, in order to be called a “specialized mental health care hospital”.*³⁴
 - Recent revision of national guidelines has caused this prescriptions to change into “presence of a HIC/High Care unit”, which allows institutions to develop their own concept of confinement-spaces more freely.

B. High/ Intensive Care - units (HIC-units) are so-called “upgraded, comfortable cells with a so-called evidence-based infrastructure aimed at positive impact on the mental health” ...

A new substitute for traditional solitary confinement in seclusion cells, is by solitary confinement in a locked room/cell with some additional technological facilities, such as coloured lights, a toilet, a table or a digital touch screen inside seclusion, claiming that these are more humane. At a few places in the Netherlands (Eindhoven, Maastricht) they have installed a very solid glass door instead of a common cell-door, to enable “presence of persons”, but nevertheless these rooms are still locked from the outside.

- These **“High-Care/ Intensive-Care- isolation cells”** are euphemistically called: *Sensory support rooms, Extra Secured Rooms, or High-Care or HIC-units (High/Intensive Care)*. These developments are dangerous, because it’s basically misleading and covering up the real abuse: the person is still locked up, but now it’s an expensive cell, so it doesn’t seem so inhumane, but it still is.
- **High Care concepts are misused to justify new forms of seclusion/solitary confinement.**
 - Philips (a big electronics concern based in Eindhoven, the Netherlands) cooperated in the development of these high-tech forms of solitary confinement in mental health settings. Urgent action is needed against developments like these, especially since the commercial technological lobby is so well-resourced and will likely try to sell this equipment to the world.

³² http://www.igz.nl/Images/Preventie%20van%20separeren%202009_tcm294-274819.pdf

³³ Research Erasmus Universiteit, 2012, <http://www.erasmusmc.nl/perskamer/archief/2012/3766785/?lang=en>

³⁴ *bouwnorm IGZ*

C. “Afzondering” (“Segregation”) is solitary confinement in a secured, slightly furnished room.

Another form of solitary confinement in Dutch mental health care is when a carer locks a person in a “secured but slightly furnished room” for Afzondering/segregation, which can be a basically-empty room, often called a “crisis room”, or a special segregation room (Afzondering/ Afzonderingskamer). According to the law (BOPZ), Afzondering needs to be registered as forced treatment.

- **“25% of seclusions is followed by “Afzondering/Segregation”.**

Not all forms of solitary confinement in mental health care are registered in the Netherlands, such as confinement in the own bedroom.

D. Regular room /any other room: Unmonitored forms of solitary confinement in the Netherlands

An additional concern regarding solitary confinement is that, in institutions in the Netherlands there is an easy option to **lock people up in their regular bedrooms**. This is a hidden form of solitary confinement, and often a totally uncontrolled, unmonitored and ‘accepted’ practice, often without proper registration or safeguards. The existence of these illegal ‘room-confinements’ also troubles the interpretation of the reduction rate of seclusion and afzondering(segregation). By far most of the sleeping rooms in institutions have locks on the door which can be locked from the outside by staff, and it happens that seclusion cells are substituted by confinement in the own sleeping room, or an empty “crisis-room” (even when a High Care unit is present but considered “too much efforts”).

- Solitary confinement in a regular room is about as bad as seclusion in a seclusion cell (separeer cel), because of social exclusion, deprivation and dehumanization.

Variety of practices of solitary confinement in mental health care in the Netherlands:

Carers in mental health care in the Netherlands generally claim the need for Afzondering, Seclusion, High Care or confinement in a regular room for:

- **Short term measures** as being “*emergency-measures, obliged resting moments, Time-outs*”.
- For **longer periods of solitary confinement** generally other language is used, such as: “*providing intensive support/intensive treatment / necessary safety/ stabilisation / offering a clear framework / avoiding emotional overloading*”, or a “*individual treatment-programme /Room-policy/ Room-care*”.

Solitary confinement is sometimes bluntly called “High Care/Intensive Care”, because carers sometimes feel like they “do a lot for this individual patient”.

- Generally, solitary confinement is: **Quickly in – slowly out:** getting out of seclusion/afzondering/or a room-programme is generally regarded as a “longer term process” (as in: once a risk, always a risk..)
- In 2013 a new debate is arising, especially in closed youth-detention-settings, where “locking all doors at night” is a policy, and the need for individual registration is questioned. It seems like the outcome will be that in future registration, the “night hours” will be deducted from the total number of hours of confinement, but only when “night-detention” is a common overall policy or house-rule. (This may create the image of reduced confinement)

There are enormous differences in the quality of care and the use of coercive care practices, between various residential mental health care settings, and even between various wards of the same setting.

- Some wards in the Netherlands haven’t changed for many years, and have regular, rather primitive seclusion cells in use.
- Some new/renovated wards have a High/Intensive Care-unit (HIC-unit) with hypermodern technological space-attributes in lockable, secured areas.
- A few residential mental health care wards in the Netherlands already run without seclusion cells, such as admission ward, Siependaal Tiel.³⁵ This is “**seclusion-free**” mental health care.

³⁵ <http://www.psy.nl/meer-nieuws/dossier/Artikel/we-weten-inmiddels-hoe-je-separeren-moet-voorkomen/>

E. National projects to reduce seclusion by 10% annually (2008-2013)

Projects to reduce and abolish seclusion and coercive care interventions (project Dwang en Drang) started since 2002³⁶, and gained a national and mandatory character since 2008³⁷.

As a result of these projects throughout mental health care institutions in the Netherlands, the average duration of seclusion decreased significantly, although the number of seclusions reduced less.³⁸ (In the years before the projects started the numbers on seclusion were all on a rise).

- *“Seclusion (duration) has been reduced by 10% over 2010-2011”*
- *“Afzondering/segregation has been reduced by 23 % over 2010-2011”*
- *“Fixation has been rising with 5% over 2010-2011”³⁹*

The primary focus of Project Dwang en Drang was to prevent seclusion, and the prevention of other coercive treatments was often off the scope. A fundamental guideline of project Dwang en Drang is that one form of force cannot be substituted by another form of force, and the aim was to find real alternatives.

- In 2008 national health care inspection stated that *“The practice of seclusion appears to exist for so long and is often so rooted in the practices inside psychiatric admission wards, that many institutions don’t experience seclusion as an uncommon or unwanted intervention. It is therefore very much needed that mental health institutions prolong the projects to reduce coercion”*.⁴⁰
- **During the national projects to reduce coercion between 2008 and 2013 the concept of High Care was established, and eventually recently deformed.**
Originally the idea of High Care/ Intensive Care meant to provide real social and personal support for persons in mental health crisis situations. But now the High Care-concept is already being materialized again (by technological and so-called scientific influences), and the social dimension of attitude, social approach and social support seems to get a secondary position again, in the shadow of some pretty useless but visible technological options.
- In June 2013 the projects Dwang en Drang to reduce seclusion and coercion will stop to receive funding from the Ministry of Health, and budgets need to be integrated in general quality and innovation policies of mental health services
- The formal ending of the national projects to reduce coercion (Dwang and Drang) may cause a spin back in old patterns, which would be dramatically.
- **Currently, the specific attention for reducing seclusion and other coercive practices in mental health care seems to fade (again).**

F. Long term seclusion still happens

- In 2009 the minister of health provided a data table, in response to media coverage (Nova 7 April 2009) on long term seclusion in 2009:⁴¹
 - **594 persons were secluded in Afzondering (a locked room), of which 17 for longer than 1 year.**
 - **5794 persons were secluded in Separatie (seclusion cells), of which 134 for longer than 1 year.**

With a note that these data aren’t fully reliable nor fully complete.

³⁶ Kwaliteitscriteria Dwang en Drang, 2002

³⁷ Overview 1998-2013 http://dare.ubvu.vu.nl/bitstream/handle/1871/39314/abstract_english.pdf?sequence=5

³⁸ http://dare.ubvu.vu.nl/bitstream/handle/1871/39314/preliminary_matter.pdf?sequence=3 and http://dare.ubvu.vu.nl/bitstream/handle/1871/39314/end_matter.pdf?sequence=2

³⁹ ARGUS registration, presentation 2012/2013

⁴⁰ <http://www.rijksoverheid.nl/documenten-en-publicaties/rapporten/2008/12/03/onderzoek-separatie.html>

⁴¹ <http://www.rijksoverheid.nl/documenten-en-publicaties/kamerstukken/2009/04/08/uitzending-nova-7-april-2009.html>

G. Public outrage in 2008 on seclusion in mental health care in the Netherlands

- Media-coverage causing public debates on solitary confinement:
 - 2 September 2008: **Wim Maljaars** (47) died in a seclusion cell in SPDC Oost in Amsterdam. After 7 days of solitary confinement he was found dead in the morning. He had suffocated in a piece of bread and was found hours later the next morning. It appeared he had gotten a double doses of medication (due to mismanagement), causing severe swallowing problems, which caused him to die in complete solitude.
 - Nova TV: 19-09-2008: “*Drastic measures after patient died in isolation cell*”⁴²
 - Nova TV: 22-09-2008: “*Psychiatric clinic closes after second patient dies in 2 weeks*”- after another person died in the same setting SPDC Oost. She did a suicide attempt in her room and died the next day in hospital.⁴³
 - Nova TV: 10-10-2008: “*A lot wrong at SPDC Oost in Amsterdam*”⁴⁴
 - Holland doc “*The decision of Wim Maljaars*” -documentary about Wim’s life⁴⁵
 - All documents have been indexed at Wim’s website
<http://wimmeljaars.nl/dossier/>
R.I.P. Wim Maljaars
 - 25 September 2008: **Alex Oudman** (50), an autistic man “lives” for 3 months naked and solitary confined 24/7 in a seclusion cell in AMC de Meren in Amsterdam. We see an utterly neglected non-violent man, counting and mentioning the number of times that he has screamed. His family made the video with their cell phone.



Alex Oudman

- Network TV: 25-09-2008: “*Shocking images from isolation cell*”⁴⁶ **video material from Alex in seclusion – watch here:** (starts after 1:30)
<http://www.youtube.com/watch?v=Vx8laZG3zR4>
- Network TV: 30-09-2008: “*Alex Oudman – part 2*”⁴⁷ - **Alex was released from the cell shortly after media broadcast**, and got a regular room⁴⁸
- The psychiatrist of Lentis (Zuid-Laren) got prosecuted for the solitary confinement for months in a row of Alex Oudman.
 - He got a rebuke, which he appealed against.

This media-coverage lead to public debates in parliament, and 5 million annually was reserved to stop these practices : “*we don’t want this in the Netherlands*” (L. Bouwmeester, PVDA)

It’s rather typical in the Netherlands, that when a coercive care practice makes it to the media, it suddenly appears to be resolvable, while before that there was said to be “no other option”.

⁴² <http://www.novatv.nl/page/detail/uitzendingen/6349/Drastische+maatregelen+na+dood+pati%EBnt+in+isoleercel>

⁴³ <http://www.novatv.nl/page/detail/uitzendingen/6353/Psychiatrische+kliniek+dicht+na+dood+tweede+pati%EBnt+in+twede+weken>

⁴⁴ <http://www.novatv.nl/page/detail/uitzendingen/6549/Veel+mis+bij+SPDC+Oost+in+Amsterdam#>

⁴⁵ <http://www.hollanddoc.nl/kijk-luister/documentaire/b/de-beslissing-van-wim-maljaars.html>

⁴⁶ <http://www.network.tv/uitzending/2008-09-25/schokkende-beelden-uit-isoleercel-0>

⁴⁷ <http://www.network.tv/uitzending/alex-oudman-deel-2>

⁴⁸ (video at 17:00) <http://www.youtube.com/watch?v=Jo79a3leq8g>

H. International jurisprudence on Dutch seclusion

Material degrading conditions in seclusion have been addressed by CPT previously, such as:

- Seclusion clothing was found degrading.
- Card-board “hats” in seclusion (serving as a disposable toilet) were also found degrading.⁴⁹

However note that the entire practice of seclusion and coercion in general is wrong under the recent UN-standards, and not only the material conditions under which “coercive care treatment” is executed.

Special Rapporteur on Torture: “Forced psychiatric interventions are torture and ill-treatment”
“any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment.”⁵⁰ It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions.”⁵¹

2.5.3 Forced medication in mental health care in the Netherlands

In emergency situations seclusion is used more often than forced medication.

However, the general idea in the mental health profession is that medication is the ONLY adequate and effective treatment of an episode of psychosis or a severe mental health crisis .

Within the mental health profession there is also a deeply rooted biomedical belief that *“untreated psychosis leads to altering of the brain structure, and “not-intervening” would be considered inhumane/neglect”*. This falsely creates the idea that “intervening with forced medication is “live-saving”. This is a very typical argument from the medical-model, where **forced medication is aimed to alleviate or correct a disability without the free and informed consent of the person concerned**, which is illegal under international human right standards⁵².

- The implicit argument *“persons in a psychotic episode can’t consent because they are too psychotic, distressed, euphoric or whatever”* is not right, because also persons with psychosis are persons who can talk and have an opinion. Every person is a unique human being, with personal goals, aspirations, feelings, character, social roles and so on. The experiences of persons who face psychosocial problems can no longer be neglected.
- *“Persons in a psychotic episode can’t converse” / “communication is useless”* Isn’t that THE worst thing that humans can do to each other.. imagine being excluded from any conversation... This is one of the most serious human right violations, touching at the core of the very basic values of existence.

A. “Pressured decision making”

“Pressured decision-making” is a big issue regarding forced medication: Taking medication is often pressured and bargained for, with rewards such as: after medication allowing for freedom of movement, social contacts and so on. Also “taking medication” is wrongfully perceived as a start of recovery, because it is falsely explained as *“a step towards acceptance of the consequences of mental illness”*. (rejecting medication is often perceived in a negative way, such as “unwilling to accept care”, “unwilling to be cured”, (implicit: general disappointment on “not doing what is right”, “making a mess of life on purpose”).

⁴⁹ CPT report Netherlands, 2007, 2011

⁵⁰ See CAT/C/CAN/CO/6, para. 19 (d); ECHR, *Bures v. Czech Republic*, Appl. No. 37679/08 (2012), para. 132.

⁵¹ Mendez (2013) A/HRC/22/53, IV.D.2. 63

⁵² Nowak

The domination of the medical model in mental health care in the Netherlands creates a situation where many users are supposed to take medication. After admission, endless bargaining and pressure may follow, and in the meantime crisis/emergency situations are handled by seclusion.

At any point the psychiatrist/nurses can decide to administer medication by the use of physical overpowering/force (**substitute decision making and actual coercion**).

Registration of forced medication only allows for registering one of the three categories: “voluntary”, “under resistance” or “no approval/no resistance”.

- The voluntariness of “voluntary medication” needs to be closely scrutinized.
- This means the numbers on forced medication are probably misleading.

There is no specific focus on reducing forced medication, and registration of numbers is unreliable. The following numbers are to be interpreted as indicative:

- *“The number of coercive administration of medication stayed about the same over the past years”* (Argus)
- ***In 22% of all emergency interventions forced medication is used as a first choice.*** (Georgiva)
- ***“65% of all forced medication is administered to secluded patients”.***⁵³
- ***“75% of people who experience forced medication also experience seclusion”.***⁵⁴
- *“18% of all secluded patients get forced medication”*

(obviously: doing too much statistical research creates confusion and distraction from the very real issues in mental health care, also a lot of “risk research” is discriminatory in nature)

Generally, there is significant overlap between seclusion and forced medication, and forced medication appears to be a “second choice of intervention”.

Very often the same persons are exposed to various types of coercion. These are generally typically the persons with more complex care needs, such as persons with mixed and severe disabilities and/or behavioural problems.

This indicates that mental health care in the Netherlands falls short for dealing with persons with more complex care needs, such as persons with mixed and severe disabilities and/or behavioural problems.

It very much seems that the use of coercion (repression) is still the standardized answer to mental health crisis situations in the Netherlands.

B. Community Treatment Orders in the new law proposal “Mandatory mental health care”.

In the Netherlands, a new law proposal is under construction (and currently under adjustment). The new draft law on “*Mandatory mental health care*” is supposed to follow-up for the current law on forced admissions/forced treatments (BOPZ). A new option will be “forced administration of medication to persons living in the community”

- A pilot project with Community Treatment Orders (CTO’s) seems to have started. The main goal of Community Treatment Orders in the Netherlands seems to be to have a **court order for “continuous mandatory medication”, - and coercion can then in theory last a life-time**, and if the orders are not followed the person will be placed in a mental health institution, and subjected to forced interventions. This is of course a horrible proposal with a very paternalistic and medically-oriented approach, which is obviously lacking any understanding of human rights, social dynamics and real care for human wellbeing.

⁵³ Argus registration, see report at the right column at http://www.ggz nederland.nl/beleid-in-de-ggz/beleidsthemas/kwaliteit-van-zorg/dwang-en-drang/congres-6-jaar-terugdringen-dwang-en-drang_ggz-bouwt-separatie-verder-af_ook-zonder-subsidie.html?year=2012

⁵⁴ resource: 5 years of Argus

C. International jurisprudence on forced medication

Special Rapporteur on Torture: “Forced psychiatric interventions are torture and ill-treatment”
“any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment.”⁵⁵ It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions.”⁵⁶

“Psychiatric interventions such as electroshock and mind-altering drugs including neuroleptics are among the intrusive and irreversible medical treatments aimed at correcting or alleviating a disability that may constitute torture or ill treatment if enforced or administered without the free and informed consent of the person concerned.”⁵⁷

2.5.4 Fixation / physical restraints in mental health care in the Netherlands

Fixation (physical restraints) is used less frequently in mental health care than seclusion, but it is used as a primary coercive practice in :

- General Hospitals (esp. medical/psychiatric wards (“PAAZ / PUC”), for example delirium is commonly treated with fixation, also fixation is still in use in epilepsy centres)
- Care for elderly persons (for example to prevent persons with dementia from wandering off)
- Care for persons who face intellectual disabilities (although at some institutions for persons with intellectual disabilities also seclusion cells are in use.)

Fixation consists of strapping a person with belts or other lockable equipment, which happens in many varieties, such as fixation with so-called **“Swedish belts” on a bed, or with a belt to a chair, special harnesses which can be attached to anything.**

Also quite some **lockable and/or disabling furniture** is in use, like deep chairs for elderly which prevents them from getting up and wandering off. In elderly care also turning very much heating on can be a way to restrain persons. However, only traditional belts and alike are registered as forced treatment/fixation. Registration of fixation is known to be incomplete.

The total number of persons subjected to fixation is unknown.

Even in institutions there is/was often no overview of the current actual use of fixation. (which is changing now due to the more specific ARGUS-registration, which is showing an increase of 5% of the use of fixation in the year 2010-2011)

- **In 2008 seven persons were reported (IGZ, national health inspection) to have died in fixation (suffocation/strangulation). These were elderly people, who lacked the strength to keep breathing or free themselves when they moved and got stuck in the belts.**⁵⁸
 - There has been a debate in parliament, however up to today this measures are still in use.
- Persons who are restless, which is the general reason for fixation, are at risk of suffocating/strangulation in restraint-belts, which makes the use of it very unsafe.

⁵⁵ See CAT/C/CAN/CO/6, para. 19 (d); ECHR, *Bures v. Czech Republic*, Appl. No. 37679/08 (2012), para. 132.

⁵⁶ Mendez (2013) A/HRC/22/53, IV.D.2. 63

⁵⁷ Nowak (2008), paras 40 and 47.

⁵⁸ <http://www.bndestem.nl/algemeen/binnenland/al-zeven-doden-door-vastbinden-1.604799>

A. Public outrage in 2011 on fixation of children with disabilities in the Netherlands

- Media coverage on fixation (also causing public debates):
 - January 2011 **Brandon van Ingen** (18), a young person with mild intellectual disability tied to a wall for already 3 years, in an institution for persons who face intellectual disabilities in 's Heeren Loo in Ermelo, the Netherlands. The video material of Brandon is taken by his mother with a cell phone. There has been international media coverage (CNN, BBC). This boy is now released from the chains and placed somewhere else (and away from media).



Brandon van Ingen spent 3 years of his childhood on a leash

- **BBC 21 January 2011: "Tethered teenage psychiatric patient shocks Netherlands"** (incl.video) <http://www.bbc.co.uk/news/world-europe-12256811>
- CNN 23 January 2011: "Case of young man tied to wall sparks national debate in Netherlands"⁵⁹
- EO Uitgesproken: 18-01-2011: "Handicapped Brandon chained to wall for 3 years"⁶⁰
- EO Uitgesproken: 19-01-2011 "At least 10 cases as Brandon"⁶¹
- EO Uitgesproken: 19-01-2011 "**Care to Brandon meets the norm" (an estimated 40 persons live in similar circumstances)**"⁶²
- EO Uitgesproken: 20-01-2011 "Brandon gets new place"⁶³
- EO Uitgesproken: 20-01- 2011 "**Chained? It's not necessary!**"⁶⁴
 - with video material of Sebastian: "another way is possible",⁶⁵
- EO Uitgesproken: 23-03-2011: "Brandon, without harness, moved to another institution"⁶⁶ including: "Brandon visits the petting zoo"⁶⁷
- EO Uitgesproken: 23-03-2011: "The other Brandons"⁶⁸

- Report of national health care inspection (IGZ) 28-11-2011:⁶⁹
A study in (long-term) residential care for persons facing intellectual disabilities concludes that **28 persons live in continuous seclusion or fixation in these facilities.**

- EO Uitgesproken: 01-12-2011: "Inspection finds 28 other Brandons"⁷⁰

- Again it's rather typical in the Netherlands, that when a coercive care practice makes it to the media, it suddenly appears to be resolvable, while before it was said to be "no other option".

⁵⁹ <http://edition.cnn.com/2011/WORLD/europe/01/22/netherlands.documentary/index.html>

⁶⁰ <http://www.uitgesproken.nl/reportage/gehandicapte-brandon-al-drie-jaar-vastgeketend-aan-de-muur/> watch here: <http://www.youtube.com/watch?v=se82tE1KOPs>

⁶¹ <http://www.uitgesproken.nl/nieuwsbericht/nog-zeker-10-gevallen-zoals-brandon/>

⁶² <http://www.uitgesproken.nl/nieuwsbericht/zorg-brandon-voldoet-aan-norm/>

⁶³ <http://www.uitgesproken.nl/nieuwsbericht/brandon-krijgt-nieuwe-plek/>

⁶⁴ <http://www.uitgesproken.nl/reportage/vastgeketend-het-hoeft-niet/>

⁶⁵ watch here: http://www.youtube.com/watch?v=1O_qctGKbfs&feature=share&list=UUCzGkN8IIfnJbNRZNi49TPw

⁶⁶ <http://www.uitgesproken.nl/nieuwsbericht/brandon-zonder-tuigje-verhuisd-naar-nieuwe-instelling/>

⁶⁷ <http://www.youtube.com/watch?v=FByYcEQyt2Y&feature=share&list=UUCzGkN8IIfnJbNRZNi49TPw>

⁶⁸ <http://www.uitgesproken.nl/reportage/de-andere-brandons/>

⁶⁹ <http://www.igz.nl/actueel/nieuws/terugdringenvrijheidsbeperkingnietzonderdialoogmetdeclint.aspx>

⁷⁰ <http://www.eo.nl/tv/devijfdedag/artikel-detail/inspectie-vindt-nog-28-brandons/>

B. Still no solution in 2013!

The public attention for banning fixation as in 2011, is fading away again – to the despair of many:

- Media coverage 16 January 2013:
*EenVandaag, 16-01-2013: “Still no solution for Dex and Brandon children”*⁷¹

- **In 2013 : “in every institution there are about 10 -15 persons who face these kind of ‘Brandon- situations’ – so it is about hundreds of these type of children”**⁷²

- January 2013, a shocking TV-documentary about the situation of Mick, Youp and Dexter, three children with profound and mixed disabilities, comparable to the situation of Brandon.

Mick (14) is diagnosed with severe autism, intellectual disabilities and suffers from psychosis. He can hardly speak. He has “unpredictable behaviour” and “aggressive and self-harming anxiety attacks”. Youp (11) is a blind boy who suffers from hearing voices, psychosis and anxiety and “a complexity of behavioural problems”.

Youp and Mick were both taken out of the care institutions by their parents, because in the institutions the kids got fixated (tied up) because their needs were too high for the available services, and the kids were deteriorating quickly and severely while being fixated and abandoned. The parents couldn’t bear and took their children home, and quit their job to be able to care for their kid full time. These families are off the radar. There is no alternative to institutional care for these people, and **they are on their own. If the institution doesn’t help, there is nothing.** (*parents say: “it’s like taking care of a terminal patient, but it never stops. There is no future”*)

- **The parents are so exhausted from providing 24/7 care all alone, and witness their child going through so many emotional problems, that they became longing for death**
 - *“a deadly accident together would end all suffering.. I don’t have a choice: I can’t find humane care, I can’t give up, I can’t end life by myself, so.. ”,*
and it was even publically discussed whether euthanasia would be more human than this suffering
 - *“If there is no care arranged soon, then please create a law for euthanasia,.. [ironically] obviously it seems like a funeral is easier to arrange than good support”.*
 - Stretching the laws for euthanasia to end suffering which is caused by a lack of provisions to meet complex care needs, would mean an end of social civilization in the Netherlands.

Dex (14) is diagnosed with autism, intellectual disabilities and has behavioural problems. Also his parents took him out of the institution, because the care was too horrific and damaging.

- In response to the media attention about Brandon in 2011, these parents launched a campaign to expose abuse versus care, and explaining the need and demand for social, humane and supportive care, with their organisation called: Dex-foundation :
<http://www.dexfoundation.nl/>

The Dex-foundation, supported by a care-institution, even made a concrete proposal for a specialized care-farm with animals and social support. **Political promises in 2011 were made that “situations similar to Brandon would be solved – whatever it takes” . A “think-tank” was established, however this has led to nothing concrete** (not even a grant for the care-farm-proposal of the Dex-foundation), so the Dex-foundation launched another campaign using photo-shopped photo-series, illustrating the difference between support and abuse.

⁷¹ http://www.eenvandaag.nl/gezondheid/42443/nog_steads_geen_oplossing_dex_en_brandon_kinderen

⁷² Gijs van Gemert, professor in the care for persons with intellectual disabilities – in EenVandaag 16-01-2013

Elderly care:

- TELEAC (documentary): “Jo was tied up 24 hours a day” (on the days to a chair, and at nights to a bed – he had a form of dementia) ⁷³

Meanwhile in the community:

- NOS news: 28 September 2012: “Creche closed because of tying up a child” ⁷⁴

C. International jurisprudence on physical restraints (fixation)

Special Rapporteur on Torture: “Forced psychiatric interventions are torture and ill-treatment”
“any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment.” ⁷⁵ It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions.” ⁷⁶

2.5.5 “Visitatie”: Forced body cavity search (on children)

The use of forced body cavity search (“visitatie”) appears quite rare in literature or testimonies, however, in the Netherlands there are **thousands of children** who may have experienced this.

There are roughly some different experiences:

- (1) **The difference between being touched or seen.**
- (2) **Manual body cavity search with physical force.** (like a group-assault)
- (3) **“voluntary co-operation” to inspections of body cavity, generally without excessive physical force** (pressured-decision-making).

A. Body cavity search/ physical force/ being touched in mental health care in the Netherlands

The author has personal experiences with long term forced body cavity searches with physical force and being touched, as part of seclusion-policy in a child-/youth psychiatric hospital in Vught in the Netherlands in 1994-1996 (at age 16-18). see annex 3. Personal experiences of the author.

- **A number of staff physically overpowered me and checked my intimate parts** for possession of harmful materials, for I was suicidal at that time.
- *“It felt like rape, or like a group-assault. They took the rubber gloves, and grabbed me to force me lying flat on the floor or the bed in seclusion. They undressed me with force, while still restraining me. Of course, I tried to resist. I had always learned that I should defend myself. And I didn’t want to accept it, because then my spirit would be broken. I couldn’t let it happen. But I couldn’t prevent them from doing it. And it was often done by females too, I didn’t understand any of it.. I felt like I was in another world where I didn’t belong. After the forced body cavity search I felt like an object, like I was dead on the inside, I didn’t want to feel female anymore. I frankly didn’t want to feel anything anymore. They left me in the seclusion cell. And I really wanted to die. I did a lot of suicide attempts, and they said all their measures were for my own best interest, but it made life a living hell for me. For almost 2 years I was stuck in this seclusion-policy which included forced body cavity searches. That is not care. I call that molest”*
- **“If my parents would have done that to me, or any other person in the community, they would have been arrested”.**

⁷³ <http://www.youtube.com/watch?v=Xjg6LPzogX0>

⁷⁴ <http://nos.nl/artikel/423741-creche-dicht-na-vastbinden-kind.html>

⁷⁵ See CAT/C/CAN/CO/6, para. 19 (d); ECHR, *Bures v. Czech Republic*, Appl. No. 37679/08 (2012), para. 132.

⁷⁶ Mendez (2013) A/HRC/22/53, IV.D.2. 63

B. Body cavity search on (innocent) children in detention

During the past 5-10 years, many more young children have become victims of confinement and forced body cavity search – as a result of their need for support !!

Sadly, there have been more reporting of forced body cavity search on under-aged children in the Netherlands. Their situation differs from mine (for them it was basically not an individual policy, but a group policy).

- **In 2007 over 1.000 children, and in 2009 over 4.000 children** were waiting for residential mental health youth-care, and because their home-situation wasn't safe, they were 'temporarily' placed in youth prison, as a kind of "emergency placement". Sometimes 'temporary' lasted up to a year. These kids had no criminal records, but still were in prison.
 - It was said that "whenever possible these children would be excluded from the stricter prison rules, and allowed as much freedoms as possible", but the practical organization resulted in the same treatment for them as for other children detained. Even body checks, such as **frisking, and bending over with your pants down** were (according to the detention centre) "*necessary, because the kids with more freedoms could be used as drug-traffickers, because these children were vulnerable to peer pressure*".
- **The total number of children who have been imprisoned on grounds of mental health problems, and subjected to very degrading and inhuman treatment, is likely to be several thousands, since the practice of "emergency-care-placement in youth-prison" lasted at least several years.**

There is no guarantee that this has been fully stopped.

At the moment no actual data are published on this.

Putting innocent children in prison because they need care and attention is not a sign of civilization, and needs to be addressed as a human right violation.

Resources and structures are available in the Netherlands, and it's just a matter of good management to realize human rights in mental health care in the Netherlands. The fact that even innocent children are not properly protected from serious human right violations cannot be ignored!!! **The State of the Netherlands must be held fully accountable for this torture and ill-treatment.**

Children being forced to undress in the presence of adults, and being touched in their private parts (sometimes even by the use of physical force) seriously disturbs their development, and is torture and ill-treatment.

In a country where technology is used everywhere, there is no acceptable ground to use manual searches, and especially not on children! Note that at Schiphol Airport nobody has to undress themselves.

*** As far as known no compensation was ever arranged for these children.**

C. Manual body cavity search with physical force still happens in prison settings in the Netherlands

A TV-documentary "Buch in de Bajes", 04-04-2013 ⁷⁷ shows that manual body cavity search with a lot of physical overpowering is still done in prison settings, such as the Penitentiary Institution (PI) in Vught, the Netherlands, which is said to be the heaviest secured prison of Europe.(see chapter 3. Forensic psychiatry).

⁷⁷ <http://www.rtl.nl/xl/#/u/515b8bfa-1811-4a50-8020-ddd0c30ad0ab>

2.5.6 Special concerns about Dutch residential elderly care institutions

In the Netherlands, there are quite some complaints and other worrying signs in the public domain about **serious neglect, and involuntary/forced interventions in residential elderly care institutions (elderly homes): Most commonly used forms of repression are: medication and fixation.**

- TELEAC (documentary): *“Jo was tied up 24 hours a day”* (on the days to a chair, and at nights to a bed – he had a form of dementia)⁷⁸
- **In 2008 seven persons were reported (IGZ, national health care inspection) to have died in fixation (suffocation/strangulation). These were elderly people, who lacked the strength to keep breathing or free themselves when they moved and got stuck in the belts.**⁷⁹
- Een Vandaag TV-documentary : 14-09-2010: *“Elderly homes fall short”*⁸⁰
 - Radboud University Nijmegen concludes: **“1 out of 3 persons with dementia in elderly care get psychiatric medication to keep calm (dipiperon, haldol). Often this results in persons hanging numbed in their chairs”.**
 - *“Haldol is a very concentrated substance and is given in drops (generally 3 to 5 drops), and any drop makes a difference. 1 or 2 more may cause severe overmedication, but it is hard to manage. So it may happen that an extra drop falls on the spoon, and the person gets overmedicated, drowsy or even in a coma-like sleep. The question is if this if by accident or on purpose”.*
 - *(most of the nurses wouldn’t but there are some who would)*
 - In some elderly institutions the number of drugged persons is 7%, while in others it is 70%
 - Persons also often get **fixated unnecessary**. At some institutions a lot of fixation is used, while in other similar institutions fixation hardly is used, while dealing with comparable care needs.
 - And they are **neglected**: There is too little attention, and persons are not cared for, they smell, have very dirty feet. They may lay sit on the toilet for hours waiting for help to come off, or lay in bed equally helpless. And staff is running around to try to manage a large group of needy elderly persons with a small number of staff.
 - In elderly care medication is present and often quite poorly monitored. It happens that persons get medicated without consent of them or their family. This is done to restrain those persons who need to much attention. In some care institution left-overs of medication, or falsely ordered medication is used for this cause. Bad administration and a lack of social involvement facilitates this.
- **Exact numbers on fixation and involuntary medication are not available, and practices vary a lot between different locations.**
 - Elderly care institutions and (complex) mental health care, generally show a similar **social neglect towards hard-to-manage-situations.**

Experiences of nurses in elderly care:

- *“Basically everything needs to be improved”*

- *“You choose to become a carer, because you think you can do the job in a certain way, but then you see the resources aren’t there. We don’t want to tie people, but there are no resources to do it otherwise; there are no low beds, there are too few people, and there are no sensors to detect movement, and then- as a carer – I have to choose for safety and tie the person up”*

- *“The work pressure results in a work speed in which original education gets lost, and that seems to be accepted. –I’m still upset by the practice at a place, where insulin was shot through the clothes to save time”.*

⁷⁸ <http://www.youtube.com/watch?v=Xig6LPzogX0>

⁷⁹ <http://www.bndestem.nl/algemeen/binnenland/al-zeven-doden-door-vastbinden-1.604799>

⁸⁰ http://www.eenvandaag.nl/binnenland/36379/verpleeghuizen_schieten_tekort

2.6 Alternatives to coercive care interventions

Many good care practices have been developed and put in place, and mental health care in the Netherlands surely is not the worst on Earth. But still, solitary confinement, restraints, forced medication and body cavity searches in mental health care are very serious human rights violations, even when they may be masked with 'good intentions'. (see Nowak)

In many complex situations, there is an overall lack of prevention, lack of personal attention and a lack of skills and expertise in mental health care. The true skills for non-violent de-escalation are not well-developed, due to the bad cultural habit of restraining, secluding, and forced medicating of persons in mental health care.

- **The practice of coercion has caused destruction to the learning process of how to deal with persons in crisis situations.**

Psychosocial problems are mainly social problems, closely related to one's social background and social circumstances, featuring social tension between the person and society. So-called "crisis situations" generally develop over time, when gradually the interaction between the person and the environment exceeds the level of acceptance of the social environment, until it's referred to as a "crisis situation". Prevention of crisis situations is possible.

Psychosocial crisis situations are generally accompanied by psychological suffering and social isolation of the person involved (often referred to as "*sliding down*"), and on the other hand, a society which demands for intervention, because **social support is exhausted or just not there.**

2.6.1 Alternative: more social support

In the Netherlands, a lot of care-quality projects in mental health care have started, aiming to reduce the use of coercion. All these projects put an emphasis on social relations, nearness, involvement, contact and trust and true negotiation, where the will and wish of the user is centralized in the social process of care on demand. This asks for bigger efforts, more time and attention than the previously regular way of fighting a crisis.

Alternative approach : Dealing with dangerous behaviour and crisis situations

- **There is no "one size fits all"-solution. Mental health is personal.**
- So-called "*dangerousness caused by mental illness*" does not exist.
- The actual crisis situation is caused by an overwhelming powerlessness, fear, anger, panic, despair, grief etc. experienced by the person, and a lack of support and social chances.
 - **The crisis situation will pass anyway, once the energy and emotion is replaced, and wellbeing is restored.**
 - **Any behaviour has a reason or cause, and results from personal and social experiences, character, surroundings and so on.** Also problematic behaviour always has a reason of any kind, social or intrinsic, such as pain, abuse, fear, powerlessness, lack of chances, lack of social understanding and social support and so on.
 - Support and assistance can be provided in solving the cause of the interaction-problem or negative experience (relief), and/or to act the energy out in a 'safer' way in order to come to another state of mind (transforming the energy).
 - The first step is always to find out what's going on, what causes the negative experience, and to try to relieve the tension.

(also see 1.5.3 Humane care is possible in mental health care in the Netherlands)

2.6.2 Alternative approach: More prevention of crisis-situations in mental health care

It is possible to prevent unsafe, unmanaged crisis-situations in various ways:

1. To prevent a mental health crisis: Take care of the cause, not just the symptoms
There is no mental health crisis when there is wellbeing.
2. To prevent forced interventions: **Provide good care and real support**
Forced interventions are unnecessary when the right care (right social approach) is available.
3. Early warning / Early de-escalation: **Don't wait till it's too late.**
Smaller problems are easier to handle than when problems get out of hand.
(waiting lists need to disappear)

2.6.3 Alternative approach: Better handling of crisis situations in mental health care

Stimulate de-escalation in a crisis situation : Take care of the cause, not just the symptoms

- Do not postpone wellbeing and recovery-processes
- Find out what's going on: Psychosocial problems are highly related to social circumstances:
Enable social contact and communication
- Provide support to solve the psychological and social tensions
- Do not proceed to forced interventions.
- Take time and attention
- **Create safety by stimulating peace.**
- Think outside the box, be flexible and enable support on an individual level.
- Focus on chances
- **Never let go of hope: Every person can experience wellbeing, and crisis will pass.**
Social inclusion and peace are possible.
- If you cannot relate to the person involved, ask someone who can
- Don't stop looking for solutions

Wellbeing is not that complicated (but medical mental health care often makes it complicated)

The power of a good conversation, of feeling understood, feeling loved, feeling you are not alone, the hope that bad times will pass, the feeling of growth, challenges, recovery and the glory of overcoming trouble, having new chances, and social meaningfulness all can have tremendous positive impact on someone's life.

Contact in crisis-situations has much more of a scientific basis than coercion.

2.6.4 Barriers to the actual implementation of alternative and social approaches:

- "There is no budget available for intensive individual social support"
- Carers have no time for individual attention and support.
- The entire mental health care system seems inadequate and individual solutions generally don't fit into the standardized frameworks , how to make something go right?
- There is a general lack of knowledge on the practice of de-escalation
- Attitudes are often based on stigma and the dominating medical model

Coercion in mental health care in the Netherlands still exists because of political neglect and bureaucracy.

It's a final responsibility of the State of the Netherlands to prevent torture and ill-treatment.

2.6.5 Projects to reduce seclusion in mental health care in the Netherlands

Project Dwang and Drang (“Coercion and Pressure”) (2002-2008-2013) aimed to make a culture-shift from control to intensive care. In the Netherlands, various improvements and a slight reduction in the use of seclusion were made with a range of sub-projects in clinical psychiatry.

Here is a list of the main identified good practices of project Dwang en Drang:

It all starts with Awareness and Motivation

- Often the call to abolish paternalistic laws, to unlock doors and enable free and informed consent, sounds like anarchy to the care-professionals (as an oversimplified *Laissez faire*).
 - It may be hard for some persons to imagine another world, especially after a lifelong education on the medical model of pity and repairing defect human beings. But cultures change, and professions change too.
 - After all, many carers are glad to get the chance to “really care”.
- The core vision of mental health care should be based on support and recovery.
- The guiding principle is hope – the belief that it is possible to regain a meaningful life, despite possible barriers.

We all need to join forces to make a change together.

- Users, user advocates, carers and relatives may sometimes have clashing ideas, but after all, we all work on the same goal, mental health and universal wellbeing

Prevention:

- Attitude & contact (gentle presence and approaching)
- Hospitality-concept (first impression/ 5 minutes)
- Abolishing house-rules (make individual appointments)
- Early warning, early de-escalation (prevent rather than wait for escalation – gut feeling)
- Presence at the ward : Breaking down the nursing staff office at wards
- Knowing what’s going on
- Crisis-card (advance directives)

De-escalation techniques

- Social approach (not medical) – focus on recovery, not on risks
- Don’t fight panic with panic, don’t fight fire with gasoline, bring peace!!
- Early signalling, early de-escalation
- Non Violent Resistance (non threatening approach)
- Flexibility & creativity – to find and enable individual solutions
- Cooperation and consultation

Approaching:

- User-involvement
- Family, friends and peers to maintain/restore contact before/during/after crisis
- Unwilling to accept care = the offer of care is inappropriate
- seducing : If care is helpful then it’s often welcome. (such as shelter for drug users, but not taking over their lives)
- Connections with other care (intersectional)

Evaluate & Learn:

- Evaluate coercion and learn to improve
- Qualitative research : user evaluation (cause of escalation and alternatives, wishes)
- Intervision and reflection – review of professional attitudes
- Quantitative research (registration)

2.6.6 Physical alternatives to seclusion cells: The limitations of sensory support

There are 3 forms of sensory support in use in mental health care in the Netherlands:

1.> Persons with highly reduced intellectual capacities : positive experience by sensory support

- Persons with highly reduced intellectual capabilities often respond to sensory situations directly, and often have little capacity to understand cause-result-reasoning⁸¹, which makes it harder to ‘understand’ or express for example feelings of pain or abuse, which can result in problematic behaviour.⁸²
 - **The first step is always to find out what’s going on, what causes the negative experience, and to try to relief the cause and the experience.** (e.g. pain relief).
 - “Sensory support” and positive stimulation can be additional to stop, counter and prevent the negative experience from being dominant.
 - Snooze-rooms (“snoezelkamers”) are being used in the care for persons with intellectual disabilities since the ‘80s, and have a lot of pleasant stimuli, such as lights, sounds and soft materials to support a positive experience of the person, in order to become calm and peaceful in times of stress, and even more to prevent stress. It’s often used in combination with personal assistance as a *“hugging room”*, meant to support a pleasant experience.

- Sensory support for persons with severe intellectual disabilities can be very useful and is considered as a **good-practice for persons who have a rather direct neurological link between sensation, experience and behaviour.**

2.> “Upgraded seclusion” and “High Care-cells” in mental health care: no supportive experience

The positive experiences of “snooze rooms” for persons with highly reduced intellectual capacities, probably form the basis of the recent “upgrading of seclusion cells” in mental health care (often called *“High Care-units”*, new since 2011/2012 , also see paragraph 2.5.2 Seclusion).

- However, most persons in mental health care have a higher level of problem-solving-capacities, which results in an **actual need for deeper interaction**.
 - Solitary confinement in “Sensory support cells” with lights, sounds and touch screens is not a solution. Even when the cell is beautiful, the reduction of social support and social chances by solitary confinement results in negative stimulation/ negative experience for the person concerned. The experiences of power imbalances, deprivation, exclusion, and a lack of social chances of getting along in society, increase psychosocial problems which can result in more barriers, and more crisis situations.

- **Upgrading seclusion cells to “sensory support cells” is no useful social alternative in general mental health care** – for persons with a higher level of cause-result-solving capacities it is only an upgraded substitute to the commonly used seclusion cells.
- Real alternatives are found in supporting social chances and psychosocial processes to find relief or transformation of energy. (by a recovery-approach).
“a psychosocial problem needs a psychosocial solution”

3.> “Comfort rooms” : voluntary sensory support can be a positive experience

Since a few years many institutions have a “comfort room” which is a place where persons can voluntary withdraw themselves. But eventually, every room should be a comfort-room.

Sensory stimulation of wellness and wellbeing is a useful concept – if used correctly

⁸¹ .. Neurological processing by less cognitive, and more sensory routines.

⁸² CCE dealing with problematic behaviour.

2.6.7 Alternative approach to prevent fixation /physical restraints

When fixation is used to prevent falling:

- Understanding that being restrained is worse than falling to the floor.
- Presence of persons to accompany.
- Creating a safe zone, for example low beds surrounded with cushions or mats.
- Sensors with alarm to warn when a person leaves a safe zone

When fixation is used to prevent distressed movement (banging walls, wandering off)

- Calm the person down: by comfort and support
- Create a safe way for the person to have the movement
- Support alternative expressions

2.6.8 Systemic barriers to the implementation of alternatives to coercion

What we need in the Netherlands is **more “real care” (social support on an individual social level)**. The entire chain of services in mental health care needs to be assessed and adjusted where needed, in order to establish adequate prevention and support to deal with mental health crisis situations and to prevent forced interventions.

User experiences, and projects to reduce coercion in mental health care clearly show that **successes in reducing coercion are achieved by social approaches**, and not by material solutions, such as upgrading seclusion cells. Repressing people does not stop psychosocial problems, but on contrary: psychosocial problems increase. A focus on wellbeing and the recovery-approach are crucial aspects for good care practices.

Changing old-fashioned primitive practices takes place after raising awareness. Real awareness is more than a set of rules. A real understanding of human rights and mental health is needed. Aspects as attitude, communication and a social approach with attention for social circumstances and dynamics have proven to be keys in changing the repressive practices.

Unfortunately, due to the fact that social attitudes, local dynamics and context are not suitable for **statistic research and an industrialized approach**, there is a tendency to neglect the social dimension in mental health care, and actually in all forms of care in the Netherlands.

The mass of systematic errors in mental health care creates powerlessness and burn-out among person who want to change this. It is therefore very much needed to move beyond fighting symptoms and implementing fake solutions, and to organize real solutions in order to bring hope and passion back to the public. It is needed to change the existing framework of services. The need for change is common public knowledge, but massive bureaucracy and the wide-spread systematic errors caused a mass of shattered malfunctioning services with systematic errors embedded, only allowing for **marginal change**, which is creating a common feeling of powerlessness and survival (and suicide).

The social movement against coercion in mental health care in the Netherlands is created by users, family, professionals and others. The traditional tension between the medical model and the social movement is still actual and very much heart-felt within in mental health care in the Netherlands. **Support for the social movement by a higher level of authority could enable a social break-through** in social good practices, and perhaps even lead to finally banning coercive practices for real.

The general line of the social movement and the findings of good-practices to ban coercion from mental health care (by replacing the paternalistic attitude with a social approach) corresponds with the CRPD paradigm shift, which moves away from viewing persons with disabilities as objects of charity, into viewing persons with disabilities as actual persons and holders of human rights, such as legal capacity.

2.7 Related law reforms in the Netherlands

Note that the State of the Netherlands has not been playing a key role in banning coercion. Only in 2008 an annual budget of 7 million euro was reserved for banning seclusion by 10% annually. Now after 5 years, the targets are not met, but the specific funding to ban coercion is stopped anyway.

If more efforts were made by the State of the Netherlands, coercion and substitute decision making could probably have been already banned from mental health care in the Netherlands, but somehow the sense of priority seems to be lacking at the policy levels.

Resources, knowledge and all kind of structures are available in the Netherlands, therefore the State of the Netherlands is to be held fully accountable in the severest way for the ongoing practices of human right violations, torture and ill-treatment in mental health care in the Netherlands.

Despite all the options for change, the State of the Netherlands seems to give preference to a rather repressive approach

2.7.1 Planned ratification of CRPD – and the strange reservation to allow torture

The State of the Netherlands did sign the UN CRPD, but did not ratify the UN CRPD yet.

The CRPD-ratification by the Dutch government is planned for 1 June 2015.

- One of the Dutch reservations upon signature before CRPD-ratification is referring to the European Convention on Human Rights and Biomedicine, and formulates a **reservation⁸³ to article 15 of the CRPD (freedom from torture)** for “persons unable to consent”, which is contrary to the principles of the UN Convention against Torture and the obligation to protect vulnerable groups from torture and cruel, inhuman and degrading treatment.
- **It is unclear which forms of torture the Dutch government has planned for persons with disabilities, and why this reservation was considered as a necessary exception to the human rights of persons with disabilities in the State of the Netherlands.**

2.7.2 Law reform on forced treatments : More options for forced treatments .

Despite signing before ratification of the CRPD (*signing creates an obligation to refrain from acts that would defeat the purpose of the treaty*) and ratifying previous human rights conventions which state the inherent dignity of any human being, there are several new Dutch law proposals which run counter to the provisions of the CRPD, CAT and other treaties.

Two law proposals directly relevant for protection of persons with disabilities from torture and other cruel inhuman or degrading treatment or punishment:

1. Wetsvoorstel Verplichte geestelijke gezondheidszorg (“law proposal on mandatory mental health care”)
 2. Wetsvoorstel Zorg en Dwang (“law proposal on care and coercion” , meant for persons who face intellectual disabilities)
- **The ever-increasing use of legally smoothing and substitutive language is covering up the real practices, and shattering the overview of what is really happening.** See for example the language used on various forms of solitary confinement, or the voluntariness around forced treatments, which create a misleading registration and impression. In the new draft law the use of misleading language is even becoming worse: **“forced treatments” are consequently referred to as “care” and even as “necessary care” (only the title says “mandatory care”)**. **This means that so-called “voluntary forced treatments” would in the future be euphemistically registered as “voluntary care” !!**
In this way, the State of the Netherlands is giving the image of having a proper organized mental health system, which obviously isn’t true.

⁸³ http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en#EndDec

These law proposals are opening up to a wider range of forced measures, and even literally allowing for **“any care intervention”** based on so-called **“individual necessity”** .

- **If these law-proposals get implemented there are no clear limits to forced treatments in mental health care anymore. (only forced body cavity search on children will be forbidden)**
- Expanding the options for forced treatments is unlikely to lead to a reduction of forced treatments.
- **A law about mental health care, should be about providing care**, and not about administration of forced interventions, which are to be considered as torture and other cruel inhuman or degrading treatment or punishment.
 - The law proposals also propose to legalize outpatient forced treatments in the community (*Community Treatment Orders*) which is very worrying. Experiences in other countries (such as UK)⁸⁴ show dramatic effects on users, such as: no experience of any safety, no end to the forced treatment, no real freedom (*“if you don’t take your medication you will be forcefully institutionalized”*) , and also an increased public stigma (as the person is perceived as *“not autonomous and of unsound mind”*).
 - Worries also arise to an expected increase of fixation at home ,⁸⁵ due to the law proposal *Zorg en Dwang*.
 - These worries were addressed by a political party in September 2011, in the weekly public question-session⁸⁶ to the minister.
 - Fixation (in distress) at home is not banned in the Netherlands⁸⁷

2.7.3 Alternative law-proposal: More social support (Family Group Conferencing)

The author of this submission was involved in law reform consultation on mental health care in the Netherlands, and the systematically wrong approach of crisis-situations, caused the undersigned to develop an alternative model (2009), based on using *Family Group Conferencing*⁸⁸ for supported decision making in mental health crisis situations (called “the Eindhoven Model”, based on Family Group Conferencing (which in Dutch is called: *“Eigen Kracht” /Own Strength*), which is now (2013) in the phase of a pilot project in 3 regions, with academic research (VUMC) included, and co-funded by the Ministry of Health.⁸⁹

- This alternative model is now “added to the margins” of the existing law proposal as a possible form of prevention. Unfortunately, the rest of the law proposal is still allowing for forced treatments, contrary to the CRPD and other international human right standards.

The current laws (such as BOPZ) and also the new law proposals ‘*Verplichte GGZ*’ and ‘*Zorg and Dwang*’ on forced treatments are not compliant with UN standards.

These laws and law proposals need to be replaced with disability-neutral laws that focus on care, legal capacity and supported decision making⁹⁰

⁸⁴ Charlotte talks about her community treatment order: www.youtube.com/watch?v=zFHaxa04pFY .

Depot injection robs artist of her creativity: <http://speakoutagainstpsychiatry.org/depot-injection-robs-artist-of-her-creativity>

⁸⁵ Experts fear a rise in fixation at home, due to the law proposal *Zorg en Dwang* (August 2011).

<http://www.skipr.nl/actueel/id8302-deskundigen-vrezen-groei-thuisfixatie.html>

⁸⁶ <http://www.rijksoverheid.nl/onderwerpen/dwang-in-de-zorg/documenten-en-publicaties/kamerstukken/2011/09/26/antwoorden-kamervragen-fixatiebeleid-thuissituatie-n-a-v-wet-zorg-en-dwang.html>

⁸⁷ Fixation-chair for ‘distressed patients’ - can be ordered by using Personal Assistance Budgets (PGB) to be used in the community : <http://www.pgbgids.nl/onruststoel-p-435.html>

⁸⁸ <http://www.eigen-kracht.nl/en/inhoud/what-we-do>

⁸⁹ <http://www.eigen-kracht.nl/nl/artikel/verplichte-zorg-binnen-ggz-te-voorkomen>

⁹⁰ CRPD art 12 ; substitute decision making needs to be replaced by legal capacity and supported decision making.

2.7.4 Torture prevention mechanisms in the Netherlands

Torture prevention mechanisms are generally comprising monitoring and complaint mechanisms. Due to several limits, the lack of access to justice for users of mental health care in the Netherlands is not described in detail, but just briefly mentioned in this submission. **Individual complaints on forced mental health care are rarely solved in a satisfying way.**

Offices such as National Ombudsman, and NHRI (College voor de rechten van de mens) are generally claiming that complaints on (forced) mental health care are not within their defined mission and scope as given by the State (assessment of public/governmental services, not on private parties). So apparently these organizations do not sense the need to protect the rights of persons with psychosocial or intellectual disabilities who are deprived of their liberty by the State-laws, because they are placed in commercially privatized mental health care facilities.

Only the **National Health Care Inspection (IGZ)** appeared to be quite supportive (at least not a barrier or counterforce) to the social movement against coercion in mental health care, although they are constrained within their margins, such as understaffing and the inability to deal with all complaints (the mess is too big and their capacity too low). Even the national inspection seems incapable to achieve a real authority and doesn't seem to take full responsibility for the quality of care.

- **This again shows that at all levels there is a wide-spread public understanding that the systematic problems are bigger than individual or organizational responsibility.**
- **And even courts seem sensitive to this argument of being powerlessness against bureaucracy.**

So in fact nobody takes responsibility for the mess in the mental health care sector.

In 2012/2013 the national health care inspection (Inspectie voor de Gezondheidszorg, IGZ) ⁹¹ is introducing a new set of norms for seclusion (“Toetsingskader Separeren” ⁹²), which comprise 4 basic guidelines to stimulate a bigger understanding and more coherence in reducing seclusion in mental health care services. These new norms (December 2012) are:

- Preventing seclusion: has every possibility been tried?
- Registering seclusion: is this done according to the minimal ARGUS-data set?
- No solitary confinement: does a seclusion comply to that?
- Consultation: does consultation comply with the norm respectively by a seclusion longer than 1 week, longer than 3 weeks, longer than 6 weeks, longer than 3 months?

This is a dramatically low ambition.

- Note that the National Health Inspection (IGZ) in several presentations states that the aim is to “abolish solitary confinement and seclusion cells”, but the same (future) documents prescribe “*High/Intensive Care-units*” and “*Extra Secured Rooms*” as an “alternative”, where **the person will not be confined “solitary”, but supervised by a person behind glass**, to enable “presence”, which would mean it’s not “solitary” anymore. (And even technological communication- means in High Care cells are causing certain groups to question whether this still should be classified as “solitary confinement”)

Coercion in mental health care in the Netherlands still exists because of political neglect and bureaucracy.

It's a final responsibility of the State of the Netherlands to prevent torture and ill-treatment.

⁹¹ http://www.igz.nl/Images/2011-12a%20Rapport%20incl.%20bijlagen%20Terugdringen%20separeren%20psychiatrische%20patienten_tcm294-315452.pdf

⁹² <http://www.veiligezorgiederszorg.nl/toetsingskader-terugdringen-separeren-igz.pdf>

3. Forensic care: Mental health care in detention in the Netherlands

3.1 Organization of mental health care in detention

Mental health care in detention settings comprises 2 main organizational levels: Prison mental health care and Forensic mental health care.

Prison mental health care takes place in a regular prison:

- At regular prison wards there is general services like counselling
- In some prison-settings there are specialized mental health care wards: **Penitentiary Psychiatric Centre (PPC)**

Forensic mental health care (TBS) is clinical mental health care combined with detention, generally taking place in a specialized secured mental health care setting (FPC/FPK) on the basis of a court order for TBS-Treatment. (TBS: “*Ter Beschikking-Stelling*”).

There are 2 forms of TBS-treatment-orders:

- A court order for “TBS with conditions” which contains certain conditions which apply to the person, while staying at a regular psychiatric institution (or ‘temporary’ at an FPC/FPK or PPC)
- A court order for TBS-Treatment means a mandatory stay in a **Forensic Psychiatric Clinic (FPC / FPK)**

3.2 Goal and scope of Forensic mental health care (TBS)

A court order for TBS-treatment is a severe measure in Dutch justice.

Official governmental descriptions of TBS/Forensic care show a **gradual deformation of the goal of forensic care and TBS, moving away from care towards extremely severe sentences.**

(1) DJI/ Ministry of Safety and Justice : Description of TBS/forensic care

*“Balance between punishment and care. Forensic care is balancing on the cutting edge of 2 worlds. The one of criminal-justice and the one of care. Forensic care is generally sentenced by a judge as part of a sentence and/or measure to someone who has a mental or psychiatric disorder who has committed a crime. The necessary combination of treatment and protection is centralized, Treatment takes place during or after the sentence, but can also replace the sentence. The goal of forensic care is that patients after their punishment and treatment will not commit any crimes anymore and can function normally in society. This is called “reduction of recidivism”. Forensic care is aimed to improve public safety.”*⁹³

(2) Rijksoverheid (national government) : Description of TBS/forensic care

*“Some perpetrators are (partially) “irresponsible”⁹⁴. They form a threat to society because of psychiatric disorders. To protect society against these persons, they can get sentenced (after punishment) to forced-treatment (“dwangverpleging”). That is called Terbeschikkingstelling (TBS). TBS prolongs until a judge decides that there is no more danger for relapse.”*⁹⁵

(3) Rijksoverheid (national government) : Description of TBS/forensic care

*“TBS means “Terbeschikkingstelling”. A judge can only sentence TBS, when the crime allows for a minimum-sentence of 4 years and when is proven that someone is (partially) irresponsible. Often in these cases there is a personality disorder and/or severe mental disorder. The goal of the measure is to protect society against unacceptable risks of relapse (recidivism): on short term by confining the person and on long term by treating the person”*⁹⁶

⁹³ <http://www.forensischezorg.nl/balans-tussen-straaf-en-zorg>

⁹⁴ irresponsible refers to “insanity-defense”

⁹⁵ <http://www.rijksoverheid.nl/onderwerpen/tbs>

⁹⁶ Forensische Zorg in getal 2006 - 2010 | 20 mei 2011

<http://www.rijksoverheid.nl/documenten-en-publicaties/brochures/2012/05/07/forensische-zorg-in-getal-2006-2010.html>

3.3 Court-orders for Forensic care (TBS)

As mentioned, there are 2 main forms of court-orders for Forensic mental health care (combining care and a criminal sentence) :

1. **Court-order for TBS-treatment**
2. **Court-order for TBS with conditions**

3.3.1 Court order for TBS -treatment

A court order for TBS-treatment is a severe measure in Dutch justice. The measure is meant for someone, “who cannot be accounted to the crime, because he or she suffers from a personality disorder and/or a severe mental disorder, and whose disorder has contributed to committing the crime”. In 2010 this measure was ordered by a judge **94 times**.

TBS with an order to treatment is sentenced for 2 years and as a rule it can be prolonged every time with 1 or 2 years. The judge will prolong the TBS-measure when he considers that necessary, on advice of the treatment-coordinators, according to the expected danger of severe relapse.

In case the crime can be accounted to the TBS-subjected, the judge can sentence him or her to imprisonment for that part of the sentence. In practice these are “combination-sentences”. After completing the detention, commonly the TBS-subjected will be institutionalized in a specialized institution called a **Forensic Psychiatric Centre (FPC or FPK, “TBS-kliniek”)**

3.3.2 Court-order for TBS with conditions

Another form of forensic care is TBS with conditions. TBS with conditions comprises that the convicted will be “released” on conditions. Such a condition can be that he or she accepts treatment in a regular psychiatric hospital. “Reclassering” will offer assistance to the TBS-subjected in these cases and will monitor the compliance to the set conditions. When he or she does not comply, the judge can- in correspondence with the Public Prosecutor- change the sentence from TBS with conditions into TBS-treatment-order. In 2010 the measure TBS with conditions was ordered **33 times**.

3.3.3 Combination-sentences of imprisonment and TBS-treatment

Commonly the TBS-measure starts after the TBS-subjected has completed a detention in prison. In case the suspect is held fully unaccountable for the criminal fact, the judge will refrain from ordering punishment and only order TBS-Treatment. In this case the TBS-subjected stays in a penitentiary institution (prison) until there is a place* in an Forensic Psychiatric Clinic (FPC/FPK).

(* waiting list/ procedures)

3.4 TBS-clinics / Forensic Psychiatric Centres^{97, 98}

- The total number of people currently placed in TBS/ forensic care facilities is between **2.100 and 2.200 persons**.
 - 95% is male.
 - The average age is between 30-40.
 - 60-70% has a Dutch nationality, and about 30-40% has another nationality.
- About all crimes who lead to TBS sentences have a component of violence, sexual crime, fire or property crime.
- **Average stay in TBS is about 9-10 years.**
 - *“In 2011 less than 50% of the population who started TBS in 2002 had flowed out”.*
 - Averagely, about 14% of TBS is ended because of death of the person concerned. (which means that over 1 out of each 10 persons does not survive TBS)

⁹⁷ DJI report: Forensische zorg in getal (2007-2011), May 2012: <http://www.dji.nl/Organisatie/Feiten-en-cijfers/index.aspx>)

⁹⁸ Forensische Zorg in getal (2006-2010), May 2011

<http://www.rijksoverheid.nl/documenten-en-publicaties/brochures/2012/05/07/forensische-zorg-in-getal-2006-2010.html>

3.4.1. Long-stay TBS in forensic psychiatric clinics in the Netherlands

- **The laws state that a TBS-treatment should be completed after 6 years.**
 - When after 6 years the risk for relapse (recidivism) has been reduced insufficiently, the care budget of the clinic will be cut down and the emphasis will shift from care to stay.
 - When treatment in 2 different clinics have insufficient effects (in a way that the risk for relapse has not or insufficiently been reduced and there is no perspective on improvement) then a TBS-subjected can be marked as **“long-stay-patient”**.
This decision is taken by the Ministry of Justice, after getting an advice and being informed by LAP, a board consisting of psychologists and psychiatrists. Although also during long-stay the TBS-measure is evaluated at least once per 2 years, this can lead to a life-time imprisonment in prison settings, institutions or forensic psychiatry.
- The longest TBS-subjected person in the Netherlands was Theo H., who spent from 1960 to 2011 **over 50 years continuously detained in a TBS-clinic.**
 - In 2004 there were 60 persons in longstay-TBS.
 - In 2007 there were 176 persons in longstay-TBS.
 - **In 2010 there were 202 persons in longstay-TBS⁹⁹**

- **The end-date of detention/institutionalization is unknown at the start or during TBS/forensic care. Prolonged TBS/forensic care can become imprisonment for life-time.**

Experiences with TBS/ Forensic care

Experts with lived experiences tell us that inside TBS/forensic care institutions there is too little attention for the mental wellbeing of the person, because the focus on preventing danger and exercising control leads to a lack of chances for personal development.

- **Focus on control:**
 - Forensic care (TBS) institutions itself are very disabling to live in, by the huge amount of bureaucracy and a full focus on control which is rooted in every daily activity (locks, checks, rules, procedures, protocols, registration and so on).
 - Sometimes ‘collective punishments’ are used, for example when one detainee escapes, it happens that all other leaves are put on a hold to be reconsidered. Collectively reconsidering all supposedly individually taken decisions when a small segment of the population shows rule-breaking behaviour is not an accepted form of punishment, and is certainly not a good care practice.

Lack of chances for personal development

- Persons with psychosocial or intellectual disabilities in detention, are often excluded from getting access to various evidence-based and experience-based care-resources, such as user movements, self help initiatives, peer support, complementary care, wellness, education, research and consultancy, and even access to general understandable information about mental health, care, rights and options is often hard to reach, due to structural limitations in communication (limited or prohibited internet access, limited freedom of movement, and so on). This seriously reduces the chances on recovery.
 - The legal position of persons placed in TBS/forensic care is much weaker than other persons with disabilities, while persons with psychosocial and/or intellectual problems in detention are an extremely vulnerable group at high risk of suicide, and facing a reduced chance on recovery.

⁹⁹ Forensische Zorg in getal 2006 - 2010 | 20 mei 2011

<http://www.rijksoverheid.nl/documenten-en-publicaties/brochures/2012/05/07/forensische-zorg-in-getal-2006-2010.html>

- The TBS/Forensic care system is currently solely coordinated by the Ministry of Justice (without the Ministry of Health, which partially explains why the care-component is falling more and more off the scope)

3.5 Forced interventions in Forensic care-settings in the Netherlands

In Forensic care-settings (PPC's in general prisons and the specialized "TBS-clinics" FPC/FPK) in the Netherlands, generally the same forced interventions are executed as in regular mental health care (see chapter 2), additional to generally common detention measures.

Also the way forced interventions are executed in forensic mental health care settings is quite similar to the practices in general mental health care, although generally accompanied by more physically overpowering forces (such as police teams with helmets and shields).

The most commonly used forced interventions are:

- **Locking a person into the own cell.**
- **Isolation** (in a "Punishment Cell" or in a "Observation cell").
- **(Forced) medication**
- **Physical restraints**, such as: hand cuffs, Swedish belts are used to a lesser extent.

3.5.1 Medication

Medication is used in many occasions, voluntary and involuntary.

- Persons subjected to TBS without a life perspective often 'accept the offer' of being numbed by medication. Also, in mental health crisis-situations in detention, persons are not granted legal capacity, rather similar to mental health care, and on top of that the control-aspect is even more dominant in detention, leading to a further neglect of the social dimension of life.
- **Only a very few persons in TBS do not use any medication.**

3.5.2 Isolation

- Solitary confinement (Isolation, "*isolatie*") in bare cells is quite common as a measure in general prisons, and is also used at large in TBS/ forensic care psychiatry.
- In TBS and forensic care settings placement in isolation is based on legal protocols and prescriptions which allow isolation cells to be used as an "**observation-cell**" (*Observatiecel*) or as a "**punishment-cell**" (*Strafcel*). This is physically the same cell.
 - Observation is generally referring to seclusion based on a mental health care-approach, where solitary confinement is used as a so-called measure of "*last resort in a crisis*". Observation can also be indicated when waiting for a specialized referral place, and can officially take up to 1 month (although practices may vary from that).
 - Punishment is referring to interventions based on the criminal-justice-approach, and is for example indicated for drug use (standard 3 days of isolation and up to 14 days at rehearsal).
 - Also solitary confinement in one's own cell (*insluiten*: locking-in) is very common during the nights, as well as during several hours of the day ("resting") or during incidents or other moments when there is a lack of staff available. This is so deeply rooted in the practices, that it often isn't even considered as coercive intervention or solitary confinement. The own cell is furnished and the detainee is generally allowed to have personal belongings and a TV.
 - Locking in at nights happens to all persons in detention.
 - However, **locking in during day-times for 'convenience'** is a rather unmonitored practice, and could be happening continuously.

There are no numbers in the public domain available on the use of coercive interventions in TBS/forensic care.

3.6 Recidivism (relapse-rate)

- Detention always creates a risk for mental health, due to power imbalances, social exclusion, sensory deprivation, detachment and dehumanization.
- Recidivism (relapse) is **higher for persons who have been detained** (almost twice as high).¹⁰⁰

After a period of 2 years:

Children/youth:

- Recidivism of general youth with mixed sentences (including fines and labour):
very severe 5%, severe 21%, general (any crime) 36%
- **Recidivism after youth-detention:**
very severe 14%, severe: 47%, general: 52%

Adults:

- Recidivism of general adults with mixed sentences (including fines and labour):
very severe 4%, severe 19%, general 27%
- **Recidivism of adults after detention:**
very severe 8%, severe 40%, general 48%

TBS recidivism after a period of 2 years¹⁰¹:

"TBS-worthy crimes" 5%, very severe 5%, severe 17%, general 21%

Note that the category "TBS-worthy crimes" are suggested in an official report¹⁰² - published by the Ministry of Safety and Justice - as the worst category (additional to severe and very severe crimes), and the goal of TBS is described in this report as: ***"The TBS-measure is primarily meant to prevent severe forms of recidivism. (...) In practice the majority of TBS-detainees gets sentenced to this measure for a severe violent or sexual offence"***.

(this language/ attitude hardly has anything to do with mental health care anymore)

- A more social approach in prison-settings, with a focus on social chances and investments in a "crime-free future" by supporting recovery and future autonomy such as by education, mental health care and social restoration, is proven to be more effective and contributes to a lower rate of crime and detention^{103, 104}

¹⁰⁰ Recidivebericht 2002-2008: <http://www.wodc.nl/onderzoeksdatabase/actualisering-recidivemeting-sancties-2011.aspx>

¹⁰¹ Recidivism in TBS 1974-2008, 2011-6: <http://www.wodc.nl/onderzoeksdatabase/actualisering-recidivemeting-tbs-2011.aspx>

¹⁰² "Recidivism in TBS (1974-2008), 2011-6 "

¹⁰³ Lower recidivism and crime rates in Scandinavia, due to a more socially supportive approach: <http://www.rnw.nl/nederlands/article/water-en-brood-versus-flatscreen-en-badkamer>

¹⁰⁴ <http://walravenszorgadvies.nl/>

- Annex 1: Introduction on relevant international standards
- Annex 2: User experiences
- Annex 3: Personal experiences of the author

Annex 1: Introduction on relevant international standards

The current international human rights standards moved away from a medical model or charity perspective into a rights-based approach. This paradigm shift in attitudes and approaches to persons with disabilities moves from viewing persons with disabilities as ‘objects’ of charity, medical treatment and social protection, towards viewing persons with disabilities as ‘subjects’ with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society.

The UN Convention on the Rights of Persons with Disabilities (CRPD) is the most recent international human rights standard. The Netherlands did not ratify the CRPD yet, but did sign with the intention to ratify. The ratification of CRPD by the Netherlands is planned on 1 June 2015. However:

“Signing creates an obligation to refrain from acts that may defeat the purpose of the treaty.”

- Note that forced psychiatric interventions are a violation of the CRPD

The Netherlands ratified the Convention Against Torture (CAT) in 1988 and the Netherlands ratified the Optional Protocol to the Convention Against Torture (OPCAT) in 2010

- **Forced psychiatric interventions are not only a violation of the CRPD, but are also forms of torture and ill-treatment**, as first established by Peter Kooijmans, the first Special Rapporteur on Torture in 1986.¹⁰⁵
- Mr Nowak has followed this by devoting a report to these and other abuses perpetrated against persons with disabilities and setting out a more detailed analysis of forced psychiatric interventions under the framework of torture and ill-treatment. In particular, he recognized that **psychiatric interventions such as electroshock and mind-altering drugs including neuroleptics¹⁰⁶ are among the intrusive and irreversible medical treatments aimed at correcting or alleviating a disability that may constitute torture or ill treatment if enforced or administered without the free and informed consent of the person concerned.**¹⁰⁷

Mr Nowak emphasized the discriminatory character of forced psychiatric interventions when committed against persons with psychosocial disabilities and called attention to the express prohibition of infliction of suffering for reasons based on discrimination under Article 1 of the Convention against Torture.¹⁰⁸ He found that **discrimination based on disability sufficed to demonstrate both intent and purpose required under CAT Article 1, notwithstanding the claims of “good intentions” on the part of medical professionals.**

- In March 2013 the UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E. Méndez, presented a **thematic report A/HRC/22/53 on torture in health care settings, together with an Oral Statement** presented at the 22nd session of the Human Rights Council at 4 March 2013, which also stresses that:
 - *“provisions allowing confinement or compulsory treatment in mental health settings, including through guardianship and other substituted decision making, must be repealed”. (Oral Statement page 2)*

¹⁰⁵ Special Rapporteur, Report of the Special Rapporteur on the Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 119, U.N. Doc. E/CN.4/1986/15 (19 February 1986).

¹⁰⁶ Neuroleptics: antipsychotica

¹⁰⁷ Nowak (2008), paras 40 and 47.

¹⁰⁸ Nowak (2008), paras 39, 47, 48.

Some highlights presented in the thematic report A/HRC/22/53 and the Oral Statement on torture in health care settings, as presented by the UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E. Méndez (March 2013)

- (61). Numerous calls by the mandate to **review the anti-torture framework in relation to persons with disabilities**¹⁰⁹ remain to be addressed. It is therefore necessary to reaffirm that the Convention on the Rights of Persons with Disabilities offers the most comprehensive set of standards on the rights of persons with disabilities, inter alia, in the context of health care, where choices by people with disabilities are often overridden based on their supposed “best interests”, and where serious violations and discrimination against persons with disabilities may be masked as “good intentions” of health professionals (A/63/175, para. 49).
- **IV.D.2. Absolute ban on restraints and seclusion**
(63). The mandate has previously declared that there can be no therapeutic justification for the use of solitary confinement and prolonged restraint of persons with disabilities in psychiatric institutions; both prolonged seclusion and restraint may constitute torture and ill-treatment (A/63/175, paras. 55-56). The Special Rapporteur has addressed the issue of solitary confinement and stated that its imposition, of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment (A/66/268, paras. 67-68, 78). Moreover, **any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment.**¹¹⁰ **It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions.** The environment of patient powerlessness and abusive treatment of persons with disabilities in which restraint and seclusion is used can lead to other non-consensual treatment, such as forced medication and electroshock procedures.
- **IV.D.3. Domestic legislation allowing forced interventions**
(64). The mandate continues to receive reports of the systematic use of forced interventions worldwide. Both this mandate and United Nations treaty bodies have established that involuntary treatment and other psychiatric interventions in health-care facilities are forms of torture and ill-treatment.¹¹¹ Forced interventions, often wrongfully justified by theories of incapacity and therapeutic necessity inconsistent with the Convention on the Rights of Persons with Disabilities, are legitimized under national laws, and may enjoy wide public support as being in the alleged “best interest” of the person concerned. Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment (A/63/175, paras. 38, 40, 41). Concern for the autonomy and dignity of persons with disabilities leads the Special Rapporteur to urge **revision of domestic legislation allowing for forced interventions.**

¹⁰⁹ See A/58/120; A/63/175, para. 41.

¹¹⁰ See CAT/C/CAN/CO/6, para. 19 (d); ECHR, *Bures v. Czech Republic*, Appl. No. 37679/08 (2012), para. 132.

¹¹¹ A/63/175, paras. 44, 47, 61, 63; Human Rights Committee, communication No. 110/1981, *Viana Acosta v. Uruguay*, paras. 2.7, 14, 15.

A selection of themes, combined with articles of the UN CRPD and references of the Special Rapporteur on Torture relevant in the context of mental health care:

Legal Capacity

CRPD Article 12: the right to legal capacity.

Special Rapporteur on Torture: “Fully respecting each person’s legal capacity is a first step in the prevention of torture and ill-treatment” ¹¹²

Liberty

CRPD Article 14: the right to liberty

Special Rapporteur on Torture: “Deprivation of liberty on grounds of mental illness is unjustified.

Under the European Convention on Human Rights, mental disorder must be of a certain severity in order to justify detention. I believe that the severity of the mental illness cannot justify detention nor can it be justified by a motivation to protect the safety of the person or of others. Furthermore, **deprivation of liberty that is based on the grounds of a disability and that inflicts severe pain or suffering falls under the scope of the Convention against Torture.** In making such an assessment, factors such as fear and anxiety produced by indefinite detention, the infliction of forced medication or electroshock, the use of restraints and seclusion, the segregation from family and community, should be taken into account.” ¹¹³

Torture

CRPD Article 15: Freedom from Torture

Special Rapporteur on Torture: “Forced psychiatric interventions are torture and ill-treatment”

“any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment.”¹¹⁴ It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions.” ¹¹⁵

Also relevant regarding the above themes of legal capacity, liberty and freedom from torture are:

- CRPD Article 25.d : the right to free and informed consent in health care
- CRPD Article 19: the right to living independently in the community

¹¹² Mendez (2013) A/HRC/22/53, IV.D.4

¹¹³ Mendez (2013) A/HRC/22/53 / Oral Statement HRC, 4 March 2013, page 5

¹¹⁴ See CAT/C/CAN/CO/6, para. 19 (d); ECHR, *Bures v. Czech Republic*, Appl. No. 37679/08 (2012), para. 132.

¹¹⁵ Mendez (2013) A/HRC/22/53, IV.D.2. 63

Annex 2: User experiences indicating human rights violations in mental health care in the Netherlands

Many persons in the Netherlands who face psychosocial problems and intellectual disabilities are helped in a satisfying way by voluntary ambulatory services. However at some levels of mental health care persistent complaints exist on human rights violations.

Lack of care in the community:

- *“It was Friday 18.00 when he came to ask for help. He was really desperate said he couldn’t take it anymore. He was afraid he was going to kill himself. An appointment was scheduled for Monday. At Sunday he committed suicide”. (R.I.P.)*
- *“She was 17 and was raped. The police had no active policy. She reached out to child care services. There was a waiting list for child-care-services and they said “she wasn’t so urgent, because she was able to speak for herself”, so she had to wait or several weeks before they would have any time for her. She committed suicide by jumping off a building, which she had said she would do”. (R.I.P.)*
- *“I can’t take it by myself anymore, so I reached out for help, but they can only help me in 3 months, what do I do now? How can I survive 3 months?”*

Over 1300 persons who face psychosocial problems commit suicide every year (80% of total suicides). Most of them have already been in contact with any form of mental health care.

- Facts on suicide – see 2.1.2

(Psychiatric) Institution:

- *“It’s a chain of empty Sundays. The people live from meal to meal, they may take a stroll, lay in bed in between, watch TV and are mainly all day drinking coffee and smoking, sometimes together with fellow patients, but also very often alone. (...) Buying tobacco can be the highlight of the day. (...) Personal contact with staff is often just about 5 minutes a day”¹¹⁶*
- *“The staff is often not available, they are in a lot of meetings, and when I knock on the door, they send me away”*
- *“It’s a life of meaninglessness and boredom, like you are outside of the real world”*
- *“My life was on a hold, or rather, wiped out. I lost everything when I was admitted, my house, my job, and most of my social contacts. I had to start all over again when I came out. It’s like I have been dead for 5 years”.*

Seclusion:

- *“ There are four walls, and the bed is placed in the middle. There is basically only a bed or just a mattress, and a pillow and 2 blankets (made of a strange uncomfortable and untearable fiber). I have to wear a kind of prison-like dress of the same material. Also there is a disposable card-board toilet-potty which looks like a hat. It smells bad when uncovered faeces are in it. I try not to look at it, and not to smell it. The room is not padded, but just 4 walls, one has a locked door, and one has a window, which is covered with plastic foil. On one wall there is a blackboard, but often no chalk to write on it. There is a ceiling with some weird things coming out: I guess one of these things must be a smoke detector, a camera, a microphone. There is a speaker in the wall, and an alarm bell, which you can press when you want anything, but when you press too often they stop coming and turn off the sound. And there is a floor, which is very cold. So cold that I don’t want to touch it with my bare feet”*

¹¹⁶ Een keten van lege zondagen, Trimbos-research on long stay psychiatric wards, <http://www.trouw.nl/tr/nl/5009/Archief/archief/article/detail/2497436/2001/11/12/Kantoortjesverpleging-en-eeen-keten-van-lege-zondagen.dhtml>

Experiences and testimonies on seclusion (continued):

- *“How can this be happening in the Netherlands? What is this? Where am I?”*
- *“I don’t understand why they use it. What good does it bring? That cell drives you crazy”.*
- *“It was a nightmare, I thought I had already died and I was in this strange confined space”.*
- *“When there is too much going on at the same time, I panic and I have to scream to make my head quiet, but they don’t understand that, and then I get secluded”.*
- *“It’s like they step onto your toes, and then give you a push, you cannot help falling down.”*
- *“Why can’t they just calm me down and comfort me at such moments?”*
- *“They hurt me when they dragged me to the seclusion cell, and they don’t have attention for what I go through”*
- *“It’s like teaching that the strongest person is always right”.*
- *“You wouldn’t treat a dog like that”.*
- *“I can’t bear to see him like that. I know he hasn’t showered for weeks probably. Sometimes you just don’t ask things, because you don’t want to know” (sister of Alex Oudman)*
- *“It’s just creating problems. There is nothing you can do. Four walls, a bed, a floor and a ceiling. That’s all there is to see. Try to keep yourself busy for half a day. And there is an alarm bell, but if you ring twice they stop coming”.*
- *“I thought: What am I doing here. I wanted to go away, away, away”.*

Forced medication:

- *“I was frightened when they came in with 4 persons and a needle. I cried and screamed”.*
- *“I got so angry afterwards, they had invaded me, I really felt like I wanted to kill them”.*
- *“I felt poisoned, like my identity got murdered, and I felt like I had lost everything I could cling on to. I didn’t trust myself anymore”.*
- *“I knew things were chaotic in my head, but I was figuring things out. Then after the injection I totally got confused. Maybe it was too much. The injection pushed me over the edge and then I really became psychotic”.*
- *“She had had a hard youth, and was forced to keep on taking neuroleptics. She gained weight and wasn’t happy with herself anymore. She kept on taking drugs from the street to get some relief. The trouble with her family continued, and eventually she killed herself”(R.I.P.)*

Fixation:

- *“My boy lives like a caged animal – he feels like a dog on a line” (Brandon’s mother).*
- *“I was in a kind of dazed state of mind, and I felt that something was holding me down. I didn’t know what it was, or where I was. I tried to free myself and I panicked. I struggled like it was a matter of life and death. To me it felt that way, I didn’t know what was happening or how long it actually lasted. But it was very frightening. It’s the worst experience I ever had” (fixation in general hospital)*
- *“I was tied at wrists and ankles, I couldn’t even chase away a mosquito, blow my nose, or wipe away the hair that was hanging in my eyes” (fixation in youth mental health institution)*
- *“It just hurts to see him like this” (Brandon’s mother - crying)*

Coercion in general:

- *“I feel lonely and misunderstood”*
- *“Doesn’t anybody get it? Don’t they see how life works? How can they be so short-sighted”*
- *“Am I different? Don’t they see things like I do? Maybe I should try to keep it inside, and find a way out of here. They don’t need to know I’m different. I can pretend to be like them, so they will release me. I guess I must deal with everything on my own, secretly...”*
- *“I don’t want to live like this...”*
- *“If my parents would treat me like that, they would be arrested”*

Annex 3 : Personal experiences of the author

I am Jolijn Santegoeds, founder of Stichting Mind Rights (www.mindrightrights.nl). I have personal experiences in mental health care in the Netherlands. I will share my personal story here. I spent almost 2 years in solitary confinement in mental health care in the Netherlands (1994-1996). I was 16 years old, and I had psychosocial problems. I didn't know how to get along and I tried to commit suicide. I was found and brought to the hospital. In the hospital I did another attempt. I was terrified of life. My parents were desperate when this all happened, and on advise of the doctors, they signed for forced admission in a specialized youth psychiatric institution.

There was a waiting list for placement in this youth institution, so the first 3 weeks I spent on a 'closed ward' for adults in Rosmalen, the Netherlands. There were about 2 or 3 staff and 10 other persons, all numbed and above age 35. It felt really strange to me. There were strict house-rules, which I didn't understand (why couldn't I drink milk at 3 pm. I didn't like tea..). There was a daily scheduled life, but I couldn't participate, because I was new and there was no plan for me. And that was it. I couldn't go to school anymore, no music-lessons or seeing any friends. I was forced to stay there, away from everything. I tried to run away during a stroll, but they brought me back. Then they locked me in my room, and when I totally freaked out, they put me in a seclusion cell for the first time. I was scared, I had never been put in a cell, and I wondered if I would be treated like a criminal now. I felt misunderstood, and like I was on a dead end, at this strange place. I had lost my life, without dying. I was stuck at this numb ward. I felt miserable. I didn't know what to do. All I could think of was dying. They told me it would be better at the youth institution, because they would be specialized in dealing with me. I had a tiny bit of hope.

Then I was transferred to the youth psychiatric institution, Herlaarhof in Vught, the Netherlands. It was not better there. They had other activities and other house-rules, but also this was a strange rather 'cold' place. I tried to commit suicide again. They said I was a "danger to myself". I was put in the seclusion cell. I screamed and cried. I banged the door, I was very upset and I wanted to die, I was a kind of exploding. The nurses then came in and overpowered me to give me a forced injection to calm me down. I didn't want that, and I felt poisoned and intruded. I didn't want to calm down or go to sleep. I wanted away from there, and not live like that. I started making plans for a new suicide attempt, and as soon as they let me out I did another attempt. I was secluded again. They then said I was "very dangerous to myself" and decided to keep me in the seclusion cell "for safety reasons, because they had no time to watch me 24/7". Of course this wasn't helping me, and I was still very suicidal. I tried to smuggle things into the isolation cell, and I used any available material trying to harm or kill myself. This led to a policy of continuous seclusion, sometimes naked, and forced body cavity checks performed by the staff or a general doctor (while nurses were holding me down and spreading me open..), I was forcefully drugged with several types of medication (even so much that I couldn't write, see, walk or speak properly, because of dizziness and numbness). And, at moments of most despair, I was tied up to a bed (without underwear, "for safety reasons"). I was supervised with showering, and I had to do my needs in a cardboard potty in the seclusion cell, which is smelly and stood there for hours. I wasn't allowed to wear my glasses (I had minus 10). I felt like an animal, with uncut hair and uncut nails, locked up and repressed. I saw no way out. And in fact, I guess nobody saw a way out. To everyone, including me, it was quite likely that I would die there, since it only got worse, and nothing changed... I was secluded 24/7 for many months in a row, and I kept on harming myself. My life felt like a complete failure.

At age 17,5 I was transferred to a closed psychiatric ward for adults. It was said that there were more "treatment options" there, but there was no difference. I was locked up with the same solitary confinement policy, basically for another 11 months. At some moments they let me out (often only supervised 1 on 1, or even 2 on 1), but very often I managed to do another suicide attempt. I was very 'clever' in those things. I didn't see much reason to live anymore. I had no life. It was just a struggle (I was young, I couldn't see beyond that..).

In the psychiatric institution, all of my problematic behaviour was seen as “drawing attention”, and even physical injuries were neglected under this pretext. Finally this ward was closed due to severe disagreements between the staff and the general management (about the staff’s practices).

After closure of the ward (age 18) I was transferred to an “Intensive Care Unit”(KIB) of the psychiatric institution GGzE in Eindhoven, the Netherlands. Eventually this meant a change in my life. The negative spiral of repression was broken here, and I got new social chances. I did no longer feel like I was surrounded by enemies, who were rigidly making my life miserable, but I felt surrounded by people who were people. I was allowed to go outside, and I met even more people who were friendly and nice. I could even have fun. It was quite amazing to me. This gave me hope again. I didn’t feel so excluded or weird anymore, and I actually forgot that I was “depressed and suicidal”. I went out to have fun more and more often. The staff at the ward complained that I should be present at therapies, but I declined by saying that my depression had already been cured, and I didn’t want to be there anymore. Then I sent a letter to the Court myself (a clever move) saying I was cured and wanted to leave, and I got a response from the Court saying I was free to leave, because the suicide risk wasn’t there anymore.

The institution wasn’t supporting my leave, because they thought I still needed treatment. I left anyway. Then I have been homeless for over 2 years in Eindhoven, the Netherlands (at age 19-21), at first I was very scared. In the beginning I lived in the bushes of the institution, the only “safe” place (known place) to me, where I was often chased away by the security. I was forced to move towards the “outside world”. I never dared to go to a squad, because I was afraid to be thrown in jail for anything, and I was basically scared of everyone... I looked like a young boy (I was very convincing). That made me feel safer. Often I smelled bad too, which was also making me feel safer. After a while I found some friends to hang around with, enjoying life. I was still sleeping outside, and sometimes in night shelters (for 7,50 a night, max. 5 nights a month): which means a shower and a hot meal + lunch package about once a week. I still had my welfare-income, so I could survive. I felt free, there was nobody who told me what I had to do, and I was trying to make the best of it every day. I was good to myself and to others, and I felt like I was growing every day. It made me strong and proud. It made me even more convinced to always stand up for my own beliefs, and define my own path.

Around the year 2000 (age 22) I found a safe place to stay, and I started studying to become a Bachelor on Sustainable Engineering. I liked that study, and I succeeded. In 2006 I even won the first prize on Sustainability in graduation reports (Cirrusprijs).

During my study, around 2003 I heard that seclusion cells were still in use in the youth psychiatric institution Herlaarhof in Vught, the Netherlands, and I decided that I needed to do something against the injustices in mental health care. I started a protest group against the use of isolation cells and coercion in child-mental health care, with the name: **“Actiegroep Tekeer tegen de isoleer!” (Action group Rage against isolation, 2003)** spreading posters and leaflets, and doing protest marches. In 2006 I raised an official foundation, called **“Stichting Mind Rights”** (www.mindrighs.nl) And now I am a full time volunteer chairing this organization against coercion in mental health care.

In 2009 I became a **Board member and Treasurer of the World Network of Users and Survivors of Psychiatry** (www.wnusp.net) , and in 2010 the mayor of Eindhoven gave me an honourable reward of 2500 euro for my ‘ground-breaking resistance against isolation cells in mental health care’.

It’s the personal feeling of knowing what it’s like to be subjected to forced treatments, that gives me an endless drive to push for a change. Nobody should have to suffer like that.

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