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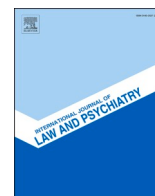
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Coercive interventions under the new Dutch mental health law: Towards a CRPD-compliant law?

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ABSTRACT

The Netherlands became State Party to the United Nation Convention on the Rights of Persons with Disabilities (CRPD) in 2016, a treaty that holds great promise for promoting and protecting human rights of persons with mental disorders. Yet, the Dutch government also made explicit reservations to the Convention. On 1 January 2020, the Netherlands introduced a new mental health law, the Compulsory Mental Health Care Act (CMHCA), which aims to strengthen the legal status of persons with psychiatric illnesses. To which extent does the new Dutch mental health law comply with the regulations as outlined in the CRPD? In this article, we examine how coercive interventions, specifically the elements of competence, involuntary treatment and involuntary admission are regulated in the domestic legislation and compare them to the CRPD approach. A normative analysis combined with literature review helps to understand the law, reveal the gaps and uncover the barriers that remain. Is there a need to reassess the domestic legal provisions allowing for coercive treatment, and if so, what advancements are required? After all, should the CRPD be strictly adhered to at all times?

1. Introduction

The United Nation Convention on the Rights of Persons with Disabilities (CRPD) was adopted in 2006 and presently has 181 States Parties. It has been described as the most swiftly ratified international human rights treaty (United Nations Committee on the Rights of Persons with Disabilities, 2018). The CRPD articulates existing civil, political, economic, social and cultural rights in a way that makes them more relevant for people with disabilities (Bartlett, 2012), without providing new regulations. However, with its embedment of the social model of disability, as opposed to the medical model (O'Mahony, 2012), and its respect for autonomous decision-making, the CRPD has been praised as representing a paradigm shift (Minkowitz, 2010). Persons with mental disorders represent a vulnerable group of persons who experience pervasive violations of their human rights (Drew et al., 2011). For them, the CRPD holds great promise.

Data from the World Health Organization's (WHO) Mental Health Atlas (2017) (World Health Organization, 2018) demonstrate that from 2014 to 2017, 94 countries updated their policies or plans for mental

health and 76 updated their mental health laws in accordance with international and regional human rights instruments. Article 33 CRPD implies that national policy and legislation are indicative of the degree of state commitment to implementation (Stavert, 2018) and studies of national mental health policies', plans' and laws' compliance with international human rights norms are therefore highly topical.

On 1 January 2020, the Netherlands introduced a new mental health law, the Compulsory Mental Health Care Act (CMHCA) (*Wet verplichte geestelijke gezondheidszorg*) which authorizes compulsory care for persons suffering from a mental disorder in certain exceptional situations. One of its aims is strengthening the legal status of persons with mental disorders (Tweede Kamer der Staten-Generaal, 2010). In 2016, the Netherlands ratified the CRPD. Pursuant to article 4 CRPD, States Parties must adopt appropriate legislation for the implementation of the rights contained in the CRPD and modify or abolish existing laws that discriminate against persons with disabilities. This article will examine to which extent the CMHCA complies with the CRPD in regulating coercive interventions, with a focus on treatment and the civil (rather than criminal) detention of adults (rather than children) with psychiatric

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illnesses.¹

Following the introduction in [Section 1](#), this article will proceed in four parts. [Section 2](#) will sketch the CRPD approach focusing on several key provisions in the context of psychiatric coercion. [Section 3](#) will introduce the CMHCA, outlining and exploring several relevant provisions. [Section 4](#) will apply the CRPD approach to the CMHCA to determine to which extent the Netherlands has embraced the CRPD approach. Further, we will place these findings in a broader context by not limiting ourselves to what 'is', but we will also discuss the merits and limits of the CRPD approach as applied to the national context to adumbrate how national mental health legislation 'ought' to be. We set out to critically assess the CRPD and show in which ways the CMHCA could serve as an example template for national mental health legislation in the CRPD-era. One question we will answer is to which extent it is possible and desirable to adapt national legislation for it to meet CRPD's standards, particularly with respect to coercive interventions in mental health care. We will argue that contrary to the views of the CRPD Committee, some forms of coercion are justified in limited circumstances and should not be abandoned. The new Dutch mental health law is the focus of our article to provide a national context, although the discussion pertaining to adapting and designing CRPD-compliant mental health laws could be equally relevant to other jurisdictions. Finally, [Section 5](#) will present some concluding thoughts.

2. The CRPD approach

The CRPD establishes a system for the promotion and protection of human rights of persons with disabilities, including persons suffering from mental disorders. Within the CRPD framework, persons with mental disorders are considered as rights holders, rather than recipients of treatment and protection ([United Nations General Assembly, 2018](#)). Instead of justifying the status quo with moral or legal arguments, the CRPD provides a framework to remove barriers that hinder the enjoyment of human rights and it further provides a pathway to eliminate the most common human rights infringements in mental healthcare practice.

2.1. Legal capacity and decision-making

In many countries, persons with mental disorders are deprived of their right to legal capacity,² formally or informally ([Series & Nilsson, 2018](#)), because of representation regimes or mental health laws that promote substituted decision-making ([Byrne, White, & McDonald, 2018](#)), the meaning of the latter will be explained in more detail below. The main problems induced by such representation regime are that persons are involuntarily admitted to mental health facilities and/or treated against their will. Article 12 CRPD, the right to equal recognition before the law ([United Nations General Assembly, 2006a](#)), lies at the core of the CRPD ([Keys, 2017](#)) and is considered a key right to provide protection against such interferences.

This article specifically recognizes that persons with mental disorders, equally to other members of the society, hold rights and duties (legal standing) and should be able to exercise these rights and duties (legal agency) ([United Nations Committee on the Rights of Persons with Disabilities, 2014a](#)). Legal standing can be described as a static status inherent to all human beings, and legal agency implies that one can create and extinguish legal relations based on the recognised rights and duties. The CRPD Committee clearly distinguishes between the concept of legal capacity and mental capacity; legal capacity being the legal

recognition that a decision made by a person is valid and binding, and mental capacity being a person's actual mental or psychological ability to make a decision which ought to be recognised by the law as valid and binding. The Committee declares that a mental disorder and thus, an alleged impaired decision-making capacity, can never justify a denial of legal capacity ([United Nations Committee on the Rights of Persons with Disabilities, 2014a](#)). There are various reasons why persons with mental disorders are considered to lack the capacity to make decisions, at least with regards to some aspects of their lives.³ This may lead to the partial or full removal of legal capacity, usually by way of court decision, often for an indefinite period of time. The most common reason according to the Committee is denying legal capacity because of supposedly deficient decision-making capacity ([United Nations Committee on the Rights of Persons with Disabilities, 2014a](#)). However, at this point it needs to be highlighted that many mental health laws, including the one at the heart of the discussion of the article, deprive persons with mental disorders of legal capacity because they are regarded as being at risk of harming themselves or others, a matter which is not addressed as such under the CRPD Committee's interpretation of Article 12, and which will therefore further be elaborated in [Section 4](#). Either way, declaring persons to lack the capacity to consent and hereby authorising a representative to make substituted decisions on their mental health intervention based on what they perceive would be for the best of the person concerned is a widely approved approach.

This is where the CRPD departs. In general, article 12 CRPD reaffirms that persons with mental disorders are recognised before the law with rights and responsibilities as anybody else, including that they can create, modify and end legal relationships. In situations where it is difficult or impossible to make decisions on one's own, individuals must enjoy the right to receive support for legal capacity. By that, article 12 proposes a supported decision-making regime which is based on the "will and preferences" of the person concerned ([United Nations Committee on the Rights of Persons with Disabilities, 2014a](#)). In supported decision-making, individuals can control who supports them and to what extent, and ultimately, they make the final decision themselves ([Series & Nilsson, 2018](#)). This is in clear contradiction to the substituted decision-making regime under which a third person makes a decision for the affected individual based on what they perceive to be in the "best interest" of the person concerned. According to the CRPD, even extreme situations (including cases of severe mental disorders) where the will and preferences cannot be determined, decisions must be based on the best interpretation of the will and preferences and still not on the person's best interest ([United Nations Committee on the Rights of Persons with Disabilities, 2014a](#)). Ultimately, supported decision-making is not only integral to the enjoyment of article 12, but also functions as a prerequisite to enjoy all other human rights as enlisted in the CRPD.

2.2. Freedom from involuntary admission

Depriving a person of their liberty and detaining them in mental health institutions raises concerns under article 14 CRPD, the right to liberty and security ([United Nations General Assembly, 2006a](#)). Similar to other human rights treaties,⁴ the CRPD provides for a right to liberty which protects against arbitrary deprivation of a person's liberty. The text of article 14 highlights that persons with (mental) disabilities enjoy this right equally to others ([United Nations General Assembly, 2006a](#)).

³ The CRPD Committee accumulates these various reasons under the three common approaches which base the lack of capacity on (i) a person's status, (ii) an alleged unreasonable or negative outcome of a person's decision, or (iii) alleged deficient decision-making skills.

⁴ See for instance, Article 3 Universal Declaration of Human Rights, Article 9 International Covenant on Civil and Political Rights, Article 7 American Convention on Human Rights, Article 6 African Charter on Human and Peoples' Rights, and Article 5 European Convention on Human Rights.

¹ At this point it is important to note that the CMHCA allows for involuntary treatment (in the CMHCA referred to as "compulsory care") under specific circumstances, and one form of compulsory care is detention or the deprivation of liberty.

² We note here that we use "capacity" and "competence" synonymously.

The novel approach of the CRPD, however, interprets the right as prohibiting deprivation of liberty on the basis of actual or perceived mental impairment, even if additional factors, such as being dangerous to oneself and others or need for care, are used to justify the deprivation (United Nations Committee on the Rights of Persons with Disabilities, 2014b). Therefore, basing any deprivation of liberty on the presence of a mental disorder, even if in conjunction with other factors, is categorically unlawful under the CRPD. Some scholars argue that article 14, read in conjunction with articles 5 and 12, would be arbitrarily breached if persons with mental disorders are detained in institutions against their will or with the consent of a substituted decision-maker (Flynn, Pinilla-Rocancio, & Gómez-Carrillo de Castro, 2019). Detention for treatment and care or preventive detention can only be lawful if ‘de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis’ (United Nations High Commissioner for Human Rights, 2009). The European Convention on Human Rights (ECHR), on the other hand, allows for the detention of persons with “unsound mind” (Council of Europe, 1950).⁵ Based on this provision, the European Court of Human Rights (ECtHR) even set up a procedural test to assess the lawfulness of detaining a person with mental disorders in a psychiatric facility, using the Winterwerp criteria.⁶ The three minimum conditions that must be satisfied for a lawful detention are (i) a competent national authority must demonstrate the existence of a true mental disorder according to objective medical expertise, (ii) the degree of the mental disorder must warrant compulsory confinement, and (iii) a continued confinement must be validated by the persistence of the disorder.⁷ Consequently, the ECtHR approach justifies a deprivation of liberty based on a certain severity of mental disorder. The CRPD, on the other hand, does not distinguish between degrees of mental disorders and can therefore be understood as prohibiting the deprivation of liberty based on the existence of any actual or perceived mental disorder (emphasis added). Interesting to consider is therefore the implication of the CRPD in a country which is also bound by the ECHR, such as the Netherlands, which is the focus of this article. On that note, it needs to be taken into account that firstly, the CRPD came into force after the ECHR and after the ruling of the Winterwerp case and secondly, that even the European Union became party to the CRPD which highlights the treaty’s significance within the European region. Both facts point towards the assumption that a country like the Netherlands, which is party to both treaties, would have to ensure the compliance of its domestic legislation with the CRPD.

2.3. Freedom from involuntary treatment

In mental healthcare services, patients are particularly vulnerable of being subject to involuntary treatment, including forced medication, solitary confinement or chemical, physical or mechanical restraints (World Health Organization, 2019). In prioritising the importance of autonomy and dignity, the CRPD provides with article 17 the right to respect one’s physical and mental integrity on an equal basis with others (United Nations General Assembly, 2006a). Instead of legitimising restrictions to one’s personal integrity and clarifying to what extent persons with disabilities can be deprived of their rights, the CRPD solely reaffirms that persons with mental disorders possess personal integrity (Minkowitz, 2007). Delineated from its concluding observations, the CRPD Committee expressed its concerns with mental health treatment that is not based on individual, prior, free and informed consent of the

person concerned.⁸ The latter can be understood as the gatekeeper to personal integrity. While mental health treatment that is based on valid consent might not raise any issues under article 17, neither the text of the article nor the interpretations by the CRPD Committee reveal whether and under what circumstances the right to personal integrity might be limited.

Whereas article 17 encompasses even minor interventions, including forced medication, involuntary treatment can also amount to a violation of the right to be free from torture and ill-treatment prescribed in article 15, if a certain level of severity is attained (Seatzu, 2018). When treatment falls short of one or more of the four torture elements,⁹ it can still amount to ill-treatment (United Nations General Assembly, 2008). The CRPD Committee has defined psychosurgery, electroconvulsive therapy, extended isolation in cells without basic services, physical and chemical restraints, including emergency sedation, shackling, and physical abuse, among others, with the purpose to discipline or to correct or alleviate deviant behavior, as forms of ill-treatment and punishment.¹⁰ Regional human rights bodies also found that physical restraints or solitary confinement without a therapeutic justification amount to ill-treatment and torture.¹¹ However, some human rights bodies have declared that restrictive interventions cannot amount to ill-treatment and torture if persons with mental disorders are at risk of harming themselves or others, and a failure to intervene in such circumstances could be a form of discrimination and inhumane treatment and punishment in itself.¹² Similarly, the ECtHR established the “doctrine of medical necessity”, under which continuous forced medication, for instance, does not amount to torture or ill-treatment if it is believed to be of benefit to the person with mental disorder and thus, well intended.¹³ Yet, the concepts of medical necessity or dangerousness are perceived to be discriminatory and contrary to the CRPD.¹⁴

While arbitrary non-consensual interventions are widely seen as unlawful, opinions of human rights bodies and scholars differ in respect of what is perceived as crisis or emergency situations. Could it be that the respective CRPD articles must best be interpreted as protecting ‘the competent patient from unwanted treatment and the incompetent patient from unbeneficial treatment’, so as to limiting ‘overly intrusive treatment’ (McSherry, 2008)? The new paradigm poses a challenge in so far as it does not clarify possible limitations, for instance the treatment of agitated or violent persons with mental disorders. And the question remains how this uncompromising approach of the CRPD can be matched with actual crisis or emergency situations in the mental

⁸ See for instance, United Nations Committee on the Rights of Persons with Disabilities (2017a); and United Nations Committee on the Rights of Persons with Disabilities (2017b).

⁹ These include (i) severe physical or mental pain or suffering, (ii) an element of intent, (iii) a specific purpose, and (iv) state involvement or the acquiescence of a public official; see UNGA, Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (adopted 10 December 1984, entered into force 26 June 1987) 1465 UNTS 85, art 1(1).

¹⁰ See e.g. United Nations Committee on the Rights of Persons with Disabilities (2016a). United Nations Committee on the Rights of Persons with Disabilities (2016b); or United Nations Committee on the Rights of Persons with Disabilities (2019a).

¹¹ With regards to restraints, see e.g. *Ximenes-Lopes v. Brazil* (Merits, Reparations, and Costs) (2006) Inter-American Court of Human Rights, Series C no 149; and *MS v. Croatia* (No 2) (App no 75450/12) (2015) ECtHR; with regards to seclusion, see e.g. *Rosario Congo v. Ecuador* (1999) Inter-American Commission on Human Rights Report No 63/99; *Bures v. The Czech Republic* (App no 37679/08) (2013) ECtHR; and *Aggerholm v. Denmark* (App no 45439/18) (2020) ECtHR.

¹² See for instance *Bures v. The Czech Republic* (App no 37679/08) (2013) ECtHR; Center for Human Rights and Humanitarian Law (2014); or United Nations Human Rights Committee (2014).

¹³ See *Herczegfalvy v. Austria* (App no 10533/83) (1992) ECtHR.

¹⁴ See e.g. United Nations General Assembly (2013); United Nations General Assembly (2020); United Nations General Assembly (2018).

⁵ Council of Europe (1950), art. 5(1)(e).

⁶ *Winterwerp v The Netherlands* (App no 6301/73) (1979) European Court of Human Rights (ECtHR).

⁷ *Winterwerp v The Netherlands*, para 39.

healthcare practice.

3. Compulsory mental health care act

The CMHCA entered into force in 2020, replacing the previous Dutch mental health law, the 1994 Special Admissions to Psychiatric Hospitals Act (SAPHA) (*Wet bijzondere opnemingen in psychiatrische ziekenhuizen* (*Wet Bopz*)). Between 1996 and 2007, the SAPHA was evaluated three times by state-appointed committees consisting of experts from the field.¹⁵ The findings were partly incorporated into the CMHCA. One of the main criticisms of the SAPHA was its near exclusive focus on involuntary admission to a psychiatric hospital, allowing little room for involuntary care in the outpatient setting. However, with ensuing changes in society and mental health care, an increased need for involuntary outpatient care arose (Keurentjes, 2019). Further, the SAPHA covered patients with psychiatric, psychogeriatric, and intellectually disabilities. However, it became apparent that care requests of patients with psychiatric disorders were different from those with psychogeriatric and intellectual disabilities, with the latter requiring different care in a different setting than the former group (Hendriks & Frederiks, 2019). This created the need for two separate acts: the CMHCA and the Care and Compulsion Act (*Wet zorg en dwang* (*Wzd*)), the first act covering patients with psychiatric disorders and the latter act covering patients with psychogeriatric and intellectually disabilities. The Care and Compulsion Act will not be discussed in this article.

The CMHCA was first presented to the House of Representatives in 2010. After several amendments, the House of Representatives adopted it in 2017 and in 2018 it was adopted by the Senate. The CMCHA's compliance with the CRPD was discussed, among other, in the House of Representatives and Senate (see also below).¹⁶ The government repeatedly denied any violation with the CRPD. In fact, according to the government, the CMHCA was not only in accordance with the CRPD, but also supported the aims of the CRPD by aiming to prevent compulsion whenever possible, involving the patient in their treatment as much as possible, honoring the wishes and preferences¹⁷ of the patient whenever possible, and also by having a legal requirement for promoting the preconditions necessary for the patient to take part in society (Eerste Kamer der Staten-Generaal, 2013).

The CMHCA authorizes compulsory care for persons with mental disorders under strict conditions, inside and outside institutions.¹⁸ It does not apply to those placed under voluntary psychiatric care. The CMHCA's central tenet is "compulsory care", of which admission is only a subset. Consequently, patients under the CMHCA may be provided with compulsory care in their homes. One proposed advantage of compulsory care in the outpatient setting is that patients need not be removed from their environment, family members and loved ones may be able to actively support the patient in their home, and return to civil life will be facilitated (Leenen et al., 2020). Further, it was expected that by allowing for less far-reaching measures at an earlier stage, such as requiring the patient to take their medication in their home, more far-

reaching measures, such as admitting the patient to a psychiatric hospital, could be prevented (Tweede Kamer der Staten-Generaal, 2010). Whether this bears out in practice remains to be seen.

All coercive interventions (admission, treatment etc.), be it in the inpatient or outpatient setting, are referred to in the CMHCA by the umbrella term "compulsory care" (see article 3:2 in the Appendix for the types of compulsory care). This section will highlight several key provisions.

3.1. General principles

The CMHCA aims to balance the fundamental right to bodily integrity of each individual and the government's duty to protect its citizens and provide the necessary care (Tweede Kamer der Staten-Generaal, 2010). Chapter 2 CMHCA affirms several general principles. These principles, which were notably lacking in the SAPHA and were added based upon the recommendations of the abovementioned committee (Keurentjes, 2019), must be observed when applying the law and they are not merely aspirational in nature. Article 2:1(1) provides the *ultimum remedium* principle, which holds that that care providers must provide ample opportunity for voluntary care so as to avoid compulsory care. In other words, voluntary care should be the rule and involuntary care should be the exception. This is a key principle that aims to prevent the unnecessary application of involuntary care. The second paragraph expands the *ultimum remedium* principle by stating that compulsory care must be considered only as a last resort when there is no possibility for voluntary care. The third paragraph emphasizes several general principles of law by ensuring that each time compulsory care is considered, the proportionality, subsidiarity, effectiveness and safety thereof are taken into consideration as well. Subsidiarity also entails that ambulatory compulsory care, in principle, is given preference over compulsory admission (Leenen et al., 2020). The fourth paragraph encapsulates the principle of reciprocity which entails that placing a patient under compulsory care also implies a duty to create a precondition for this person to successfully participate in society. This entails not only providing good care, but also enabling the patient to transition from involuntary to voluntary care and offering adequate 'aftercare' by the care providers and government, i.e. providing assistance with organizing the patient's housing, finances, etc. (Tweede Kamer der Staten-Generaal, 2010). Finally, the fifth paragraph ensures that the wishes and preferences of the patient with respect to the compulsory care are recorded. The latter underscores the notion that although a patient could be placed under compulsory care, the patient can still indicate their wishes and preferences pertaining to the compulsory care (e.g. their wish for medication over placement in a segregation cell (Leenen et al., 2020)).

3.2. Conditions, goals and types of compulsory care

Under what circumstances can compulsory care be initiated? The key criterion in the CMHCA is a "serious disadvantage". A "serious disadvantage" is defined in article 1:1(2)) as a considerable risk for:

- danger to life, serious bodily harm, serious mental, material, immaterial or financial damage, serious neglect, societal collapse, seriously disturbed development for or of the individual concerned or others;
- threat to the security of the individual concerned whether or not he becomes under the influence of others;
- the situation in which the individual concerned elicits the aggression of others with bothersome behavior or
- the situation which endangers the overall safety of persons or goods

The "serious disadvantage" criterion appears rather far-reaching. In the SAPHA the equivalent criterion was "danger", which is the more common criterion in mental health legislation. *Prima facie* "serious

¹⁵ See for the most recent report from the third committee, Tweede Kamer der Staten-Generaal (2008). *Derde evaluatierapport Wet Bopz*.

¹⁶ See for instance, Eerste Kamer der Staten-Generaal (2013) *Kamerstuk 32,399 Regels voor het kunnen verlenen van verplichte zorg aan een persoon met een psychische stoornis (Wet verplichte geestelijke gezondheidszorg) Nr. 9*, pp. 38–40.

¹⁷ We note here that "wishes and preferences" is the way this phrase appears in the CMHCA (*wensen en voorkeuren*) as translated by us (as there is no official English translation of the CMHCA). The Dutch *wensen* is more accurately translated as "wishes" than as "will" in our view. We are aware that the equivalent phrase in the CRPD is "will and preferences". We shall use "wishes and preferences" when referring to the CMHCA and "will and preferences" when referring to the CRPD.

¹⁸ Persons with psychogeriatric and intellectual disabilities are covered by a different act, namely the Care and Compulsion Act (*Wet Zorg en Dwang*) which also entered into force on 1 January 2020.

disadvantage” appears to have a wider scope than “danger”, but the legislator denied any material expansion of this criterion compared to the “danger” criterion that was used in the SAPHA ([Eerste Kamer der Staten-Generaal, 2013](#); [Ministerie van Volksgezondheid, Welzijn en Sport, 2020](#)).¹⁹

Article 3:3 provides that if the person’s behavior as a result of their mental disorder, not being a psychogeriatric condition or an intellectual disability, results in a serious disadvantage, then as a last resort compulsory care can be provided, if:

- a) there are no options for voluntary care;
- b) for the individual concerned there are no less onerous alternatives with the intended effect;
- c) the provision of compulsory care, considering the intended goal of the compulsory care, is proportionate; and
- d) it is reasonable to expect that providing the compulsory care is effective.

The CMHCA also exhaustively lists the goals of compulsory care in article 3:4, which include averting a crisis situation, averting a serious disadvantage, and stabilizing the patient’s mental health.

What constitutes compulsory care then? Article 3:2 provides an extensive list and includes providing fluids, nutrition, and medication, limiting the patient’s freedom of movement, examining the patient’s body or clothing, limiting the patient’s right to receive visitors, and admitting the patient to a psychiatric institution. Depending on the circumstances and the wishes and preferences of the patient, the compulsory care may be provided in the outpatient setting as opposed to the inpatient setting ([Tweede Kamer der Staten-Generaal, 2010](#)).

3.3. Competence

Competence (or capacity) is related to the decision-making process and concerns the competency to make a decision, not the content thereof ([Blankman & Willems, 2016](#)). In ethical and legal literature, four components of competence are distinguished: first, being able to express a decision; second, being able to understand the information; third, being able to apply the information to one’s situation, and fourth, being able to reason ([Blankman & Willems, 2016](#)). Dutch health law defines competence as being capable of a reasonable appreciation of one’s interests in the matter. One important generally accepted view is that psychiatric patients are not always incompetent. Indeed, many always retain competency. Neither is incompetency exclusively related to psychiatric illness; some somatic conditions may also affect a patient’s competency.

It should be emphasized, once again, that incompetency is not one of the conditions for placing the patient under psychiatric compulsory care (see [Section 3.2](#) and article 3:3 CMHCA), and neither does a patient become incompetent once they meet the conditions for compulsory care. That competency is not one of the conditions for compulsory care was flagged by commentators as a missed opportunity in drafting the CMHCA ([Widdershoven & Dörenberg, 2014](#)). Under Dutch law (and most other jurisdictions), non-psychiatric (i.e. somatic) patients can only be provided with compulsory treatment if they are incompetent, if consent cannot be asked or when care is essential to prevent serious harm to the patient. Whether it is justified to distinguish between psychiatric and somatic patients, particularly in light of the CRPD, in this way is a highly contentious issue which will be addressed in the next section.

Unlike the SAPHA which did not distinguish between competent and incompetent patients ([Keurentjes, 2016](#); [Leenen et al., 2020](#)), the

CMHCA does address the issue of competent refusal in its general principles. Article 2:1(6) stipulates that the wishes and preferences of the patient will be honored unless the patient is considered incapable of a reasonable appreciation of one’s interests in the matter (i.e. incompetent)²⁰ or there is an emergency situation involving the patient or others. This provision is ambiguous. What does it mean to honor the wishes and preferences of the patient? Can competent patients not in acute danger or posing any danger to others entirely refuse treatment? Or can a competent patient merely indicate a preference for a particular treatment modality, but not entirely refuse treatment? A literal interpretation would imply the latter. This question was raised in the Senate, particularly in light of the CRPD. The government explained the meaning as allowing for a competent patient to be placed under compulsory care only if there is acute danger to the life of the patient or there is a considerable risk for a serious disadvantage for others. In the case of acute danger to the life of the patient (i.e. suicide), according to the legislator, providing care outweighs the right to self-determination ([Eerste Kamer der Staten-Generaal, 2013](#)). So, it seems that a competent patient may only be placed under compulsory care on narrower grounds. It remains to be seen how this plays out in practice and in jurisprudence.

Further questions were raised with respect to whether offering compulsory care violates articles 14 and 15 of the CRPD. The government asserted that the CRPD does not exclude compulsory care as such and that the CRPD Committee recommendations that do are very strictly stated and are not binding. Further, the government noted that the interpretation of the CRPD Committee is also not in line with judgments from the ECtHR and recommendations from the Council of Europe. In any case, the Netherlands issued an interpretative declaration which states that the Netherlands interprets the CRPD as allowing for compulsory care under strict conditions ([Eerste Kamer der Staten-Generaal, 2013](#)).

At this point, it should be noted that in the Netherlands, competence is determined employing a functional approach (“where a person’s decision-making skills are considered to be deficient”)([United Nations Committee on the Rights of Persons with Disabilities, 2014a](#)), as opposed to the status (“on the basis of the diagnosis of an impairment”)([United Nations Committee on the Rights of Persons with Disabilities, 2014a](#)) and outcome (“where a person makes a decision that is considered to have negative consequences”)([United Nations Committee on the Rights of Persons with Disabilities, 2014a](#)) approach. This is supported by the description of incompetency in Dutch law (i.e. incapable of a reasonable appreciation of one’s interests in the matter) where “in the matter” indicates that competency is context-dependent ([Van Meersbergen & Biesart, 2016](#)). Stated differently, a patient may be considered competent with respect to some decisions, (e.g. whether to go for a walk), but incompetent with respect to other decisions (e.g. which treatment to initiate). Therefore, assessment of competence is decision specific. Because the competence of persons with mental disorders can fluctuate in time, competence must be determined on a case-by-case basis.

If a patient is deprived of their competence, a representative substitutes the patient with respect to deciding on a particular matter. The competence of a representative is limited to the specific matter for which the doctor deemed the patient incompetent. A patient is thus never deemed incompetent indefinitely and for all decisions. Article 1:3(3) lists who can represent the patient in order of preference, and includes a guardian or mentor, an authorized representative, a spouse, registered partner or other life partner and several family members. Article 1:3(6) excludes the care provider and medical director (*geneesheer-directeur*) as

¹⁹ The terminology changed, most likely, for harmonization purposes with a different Dutch health law (*Wet op de geneeskundige behandelingsovereenkomst*) regulating compulsory care in somatic medicine. This law uses “serious disadvantage” as the key criterion.

²⁰ The Dutch term for incompetent or incapacitated does feature as such in the CMHCA (and neither in Dutch health law in general). Incompetence features in the CMHCA by way of a description (i.e. incapable of a reasonable appreciation of one’s interests in the matter). See [Keurentjes \(2019\)](#).

potential representatives to avoid a potential conflict of interest issues. A deprivation of competence can be contested by the patient. If the patient disagrees with their deprivation of competence, they can file a complaint with the complaints committee (article 10:3(a)). If a patient is represented by a guardian or mentor, they can still access the courts if, for instance, they disagree with a particular decision with respect to the compulsory care (article 1:3(8)).

With respect to how a representative must represent the patient, article 1:3(7) merely provides that the representative must exercise the care of a good representative and must include the patient as much as possible in the execution of their task. This implies that the representative must act in the interests of the patient and it is assumed that the representative knows and is guided by the patient's wishes and preferences (Keurentjes, 2019). Nevertheless, it has been observed, more generally, for the Dutch representation regime that a general guiding principle for the representative is absent (Blankman & Vermariën, 2016). Therefore, it is not entirely clear which standard the representative should apply: what the patient (likely) would have wanted, what the representative considers worth pursuing, or what is considered reasonable and desirable in society? (Engberts, 2017) Although from the perspective of the CRPD this is an important distinction, the Dutch law is silent. Scholarly literature does provide guidance on this matter, however (Engberts, 2017). If the patient used to be competent, but became incompetent at an adult age, the representative must consider whether the patient previously expressed a substantive opinion on the situation the patient is currently in. If the patient did, then this expression of their will should be the point of departure for the representative. If the patient did not express a substantive opinion and their biography does not help to formulate a reference point, the representative can only take note of their own values, taking into consideration the consensus in society.

How are the patient's wishes and preferences considered in the CMHCA? This is where the CMHCA introduces, compared to the SAPHA, two new features. First, in the care map, the patient can indicate their wishes and preferences when compulsory care is required, such as their wish for medication in favor of detention in a segregation cell (Leenen et al., 2020). Second, the patient can complete a plan of action, alone or with the help of their family members, which details a plan for avoiding compulsory care. In addition, as mentioned previously, article 2:1(5) also requires as a general principle the recording of the patient's wishes and preferences related to the compulsory care.

3.4. *The role of the health care providers with respect to compulsory care*

The responsible clinician must ensure that an independent psychiatrist completes a medical certificate, based on a recent assessment of the patient. The medical certificates must specify the patient's symptoms, (preliminary) diagnosis, the relationship between the mental disorder and the resulting serious disadvantage, and the required compulsory care. In addition, the responsible clinician must complete a care plan which details the (preliminary) diagnosis, the goal and type of compulsory care that is required, and how the patient's preferences will be considered (see article 5:14(1)). The care plan is passed on to the public prosecutor, who in turn, passes the care plan, together with several other documents, to the judge, if the public prosecutor deems that the conditions for compulsory care are met.

Based on the request of the patient, their representative, the lawyer, the responsible clinician, or of their own accord, the medical director will decide whether to terminate compulsory care if the goals have been achieved or the conditions are no longer met. The decision may be appealed against through the courts.

3.5. *The role of the judge in regard to compulsory care*

Whether the patient is placed under compulsory care is ultimately decided by the judge. The judge must assign counsel to the patient if the patient lacks legal representation and hear the patient in a court session.

Under the SAPHA, the judge only issued authorization on admission and subsequently the responsible clinician took decisions with respect to compulsory treatment (against which the patient could appeal) (Leenen et al., 2020). Under the CMHCA, the judge decides on all types of compulsory care. To place the patient under compulsory care, the judge issues a care authorization. It has been argued that the judge is authorized to exercise a great deal of discretion (Dijkers, 2018). The judge may decide to deviate from the care plan, include different types of compulsory care or specify other goals of compulsory care, although it is likely that the judge will usually defer to expert opinion, given that the judge is (usually) not a medical expert.

Based on article 6:5, the judge issues a care authorization for the duration necessary to accomplish the goal of the compulsory care, but depending on the particular goal, different duration limits apply (12 months for article 3:4(a) and six months for article 3:4 (b-e)).

If the judge decides to place the patient under compulsory care, the patient cannot appeal this decision, but the patient could lodge an appeal in cassation to the Dutch Supreme Court (Leenen et al., 2020). The Supreme Court can annul the court's judgement if it infringes upon the law.

3.6. *The role of the mayor in regard to compulsory care*

In emergency situations, the mayor instead of the judge, may decide to place the patient under compulsory care for up to three days. The abovementioned criteria and procedures still apply, however. A patient must still meet the conditions stipulated by article 3:1, be assessed by an independent psychiatrist, etc. If continuation beyond three days is necessary, the above-described judicial procedure must be initiated.

4. Discussion

It is apparent that the CRPD facilitated a paradigm shift that strongly emphasizes the patient's autonomy. With equal recognition before the law (article 12) as its central tenet, the CRPD recognizes legal capacity of persons with disabilities at all times, from which other rights flow such as the right to liberty and security of the person (article 14), the right to be free from torture and other forms of ill-treatment (article 15), and the protection of the integrity of the person (article 17). The CMHCA, by contrast, authorizes the provision of coercive interventions under certain circumstances and has a representation regime in place. These two aspects deserve further elaboration in determining to which extent the CMHCA complies with the norms set out in the CRPD (Sections 4.1 and 4.2). We will not limit ourselves to the CMHCA's compliance with the CRPD. The merits and limits of the CRPD approach can and should also be discussed. Is the CRPD approach requiring States Parties to abolish all substitute decision-making regimes perhaps too strict, is it too much of an ideal that cannot be realized in the national context and is it even realistic and desirable to do so (Section 4.3.)? Considering all this, in which direction should mental health legislation proceed (Section 4.4.)?

4.1. *Competence: supported vs. substituted decision-making*

As noted previously, the CRPD Committee opines that deficient mental capacity must not lead to a denial of legal capacity; mental capacity and legal capacity being distinct concepts, according to the Committee (United Nations Committee on the Rights of Persons with Disabilities, 2014a). The CMHCA authorizes substitute decision-making and conflates mental capacity and legal capacity. Although there are elements of supported decision-making in the CMHCA, such as the care map, plan of action, and that the representative is obliged to include the patient as much as possible in the execution of their task, ultimately, the authors see the regime under the CMHCA still as substituted decision-making. Further substantiation of the concept of a good representative is absent in the CMHCA (and elsewhere in Dutch health law). This we see

as a notable omission.

It should be noted that with respect to article 12, several countries expressed declarations and reservations, including the Netherlands, which stated that it “[i]nterprets Article 12 as restricting substituted decision-making arrangements to cases where such measures are necessary, as a last resort and subject to safeguards.”²¹ The Dutch government observed that since the CRPD Committee’s recommendations are non-binding, they cannot limit the obligations undertaken by States Parties upon ratification of the CRPD, but the government nevertheless wants to ensure its compliance with the Convention (*Tweede Kamer der Staten-Generaal, 2010*). This refers to the notion that General Comments issued by UN bodies are indeed non-binding soft law. Further, the Netherlands stated in its Initial Report to the CRPD Committee that “[i]n some cases, replacing decision-making actually provides protection for people from a violation of their human rights.” (*United Nations Committee on the Rights of Persons with Disabilities, 2019b*) This is an interesting argument, but it is not elaborated upon further. All of this raises the question: Is it possible to comply with the CRPD whilst disregarding this central tenet? Although the Dutch government’s declaration appears to be a sound solution, it is difficult to see how the Convention can be fully complied with given that the declaration cuts at the core of the CRPD, namely article 12. Since the CRPD Committee is also in charge of monitoring State Parties’ compliance with the CRPD and the CRPD Committee considers individual complaints under the Optional Protocol to the CRPD, the views may be non-binding, but should be considered authoritative to say the least. Canada expressed a similar interpretative declaration and the CRPD Committee in its concluding observations recommended that Canada withdraw its declaration. Dutch commentators have rightly observed that although the CMHCA, compared to the preceding mental health act, to a greater extent complies with the obligations flowing from the CRPD (*Blankman, 2016*), the representation regimes still need to be altered to be fully brought in line with the CRPD (*Blankman & Vermariën, 2016*). The CMHCA should more strongly stress the will and preferences of the patient and not merely include the provision which requires the representative ‘to include the individual concerned as much as possible in the execution of his task’ (article 1:3(7)).

4.2. Conditions for compulsory care: the presence of a mental disorder as justification for coercive interventions

The presence of a mental disorder is one of the conditions which is used to justify coercive interventions. The provision of compulsory care could involve deprivation of liberty (in the case of admission to a psychiatric institution) or involve an interference upon the integrity of the person or even amount to ill-treatment (if non-consensual treatment is provided, be it in the inpatient or outpatient setting) or both if a patient is placed in a psychiatric institution and is treated involuntarily. Article 14 CRPD states that the existence of a disability shall in no case justify a deprivation of liberty, even when based on dangerousness or an alleged need to care. Although it does not explicitly refer to involuntary admission, it could be argued that involuntary admission of a person with a mental disorder on these grounds is prohibited (*Seatzu, 2017*). Furthermore, Article 17 CRPD prescribes that irrespective of the severity of the mental disorder, persons must express their prior, free and informed consent to treatment, if needed with support. In the CMHCA, the existence of a mental disorder is certainly not the sole reason for initiating compulsory care, but it is a *conditio sine qua non*. However, even if the presence of a mental disorder is combined with other conditions, such as a serious disadvantage, this is still in breach of article 14 CRPD, as interpreted by the CRPD Committee which states that “[t]he

involuntary detention of persons with disabilities based on risk or danger, alleged need for care or treatment or other reasons relating to impairment or health diagnosis, such as severity of impairment, or for the purpose of observation, is contrary to the right to liberty, and amounts to arbitrary deprivation of liberty” (*United Nations General Assembly, 2017*). To mitigate this problem, the Netherlands submitted an interpretive declaration upon ratifying the CRPD which stated that it “[d]eclares its understanding that the Convention allows for compulsory care or treatment of persons, including measures to treat mental illnesses, when circumstances render treatment of this kind necessary as a last resort, and the treatment is subject to legal safeguards”.²² Complementing this assertion, the Netherlands observed in its initial report to the CRPD Committee that “[a] mental disorder as such is therefore no ground for involuntary care” (*United Nations Committee on the Rights of Persons with Disabilities, 2019b*). This is a curious argument and not a convincing one. Certainly, the presence of a mental disorder is not a *sufficient* condition for compulsory care, but it is a *necessary* condition (other additional criteria than the presence of a mental disorder must be fulfilled). The United Nations High Commissioner for Human Rights has stated that legislation linking coercive interventions with the presence of an apparent or diagnosed mental disorder must be abolished (*United Nations High Commissioner for Human Rights, 2009*). The Dutch government appears to be trying to reconcile its legislation with the CRPD, but the way in which it does so fails to convince. Welie and Widdershoven have rightly observed that this line of reasoning is limited and lacking, representing a form of reality denial (*Welie & Widdershoven, 2019*). It appears that these declarative interpretations are serving the function of demonstrating a commitment to upholding the CRPD standards, whilst simultaneously reserving the option to limit them.

Having addressed the issue to which extent the CMHCA embraces the CRPD approach, quite another dimension is to which extent national mental health legislation should (fully) comply with the CRPD. As we shall argue below, although the arguments of the Dutch government could have been stronger, we are not unsympathetic towards the declarative interpretations issued by the Netherlands in principle for we do not believe that coercive interventions should be entirely abolished.

4.3. The merits and limits of the CRPD approach to autonomy

4.3.1. Different conceptions of autonomy

The emphasis for the respect for the autonomy of the patient, which is at the heart of the CRPD, is one which emerged in the 1960s, although its origins can be traced back to the Enlightenment (*Ten Have, Ter Meulen, & Van Leeuwen, 2013*). Autonomy is commonly conceptualized as the right to self-determination, which emphasizes non-interference (i.e. negative liberty), but autonomy also encompasses which choices a person makes and whether these fit the person, and what the person deems important in life, all of which encompasses the person’s ability of self-realization (i.e. positive liberty) (*Frederiks & Landeweer, 2016*). Stated differently, negative liberty could be construed as freedom *from* and positive liberty *to* (*Ten Have et al., 2013*).

Yet in practice, if a patient refuses to accept treatment or be admitted, and care providers see either option as the only way to mitigate a particular danger that results from the patient’s mental disorder, the principle of respect for autonomy clashes with another principle of medical ethics, namely that of beneficence, thereby creating a moral dilemma which requires a careful balancing of principles (*Frederiks & Landeweer, 2016*). (This balancing of principles is referred to as the ‘principles approach’, the principles referring to the four principles of medical ethics (beneficence, non-maleficence, autonomy, and justice) as codified by Beauchamp and Childress (*Beauchamp & Childress, 2012*).

²¹ See United Nations, ‘Declarations and Reservations’ <https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtmsg_no=IV-15&chapter=4> Accessed 8 March 2021.

²² See United Nations, ‘Declarations and Reservations’ <https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtmsg_no=IV-15&chapter=4> Accessed 8 March 2021.

The principles approach is not the sole, but is the dominant approach dealing with ethical issues in healthcare (Widdershoven, 2000.) The CRPD Committee privileges autonomy almost exclusively by stating that “[a]t all times, including in crisis situations, the individual autonomy and capacity of persons with disabilities to make decisions must be respected.” (United Nations Committee on the Rights of Persons with Disabilities, 2014a). Conversely, most national mental health laws, including the CMHCA, have, to varying degrees, elements of beneficence to counteract autonomy. How should these principles be balanced? And which specific concept of autonomy does the CRPD Committee have in mind here?

As coercive interventions are commonly used in psychiatry throughout the world, the views of the CRPD Committee were, quite understandably, heavily criticized, particularly by the medical community (Freeman et al., 2015). An analysis and comparison of the views of the CRPD Committee and the medical community reveals that they have different conceptions of autonomy in mind. Whereas the CRPD Committee defends negative liberty, the medical community, generally, is willing to (temporarily) limit negative liberty to achieve positive liberty down the line, and, as we shall argue, for good reasons. For instance, Burns, Professor of Social Psychiatry, argues that mental illness, unlike physical illness, has at its core an impaired appraisal of the self and the world, with mentally ill patients alienated from themselves (Burns, 2014). According to Burns, it is the nature of mental illness and their treatment that shape mental health legislation, not the other way around, and because mental illness and physical illness are different, the case for treating them equally in law is not convincing. Paternalistic decisions are based upon the clinician’s judgement of what the normal self of the patient would want (Burns, 2011). In his article, Burns appeals to Gerald Dworkin conception of autonomy, a much different one than the one the CRPD Committee defends, which conceives autonomy “as a second-order capacity of persons to reflect critically upon their first-order preferences, desires, wishes, and so forth and the capacity to accept or attempt to change these in light of higher-order preferences and values” (Dworkin, 1988). It could rightly be believed that mental illness clouds the patient’s fundamental (or second-order) desires and coercive interventions counter first-order desires to protect the patient’s second order desires (Burns, 2011).

Considering that, for instance, delusions, hallucinations and cognitive deficits are the core clinical features of a psychotic disorder, it is quite plausible that second-order desires could be crowded out by a psychotic disorder, resulting in first-order desires that the patient would not normally want to pursue. Similarly, in the case of addiction, a person may not be acting freely, despite the fact that their actions accord with their desires (i.e. to engage in substance abuse). When the person’s desires are compelled by addiction (or more broadly, by a psychiatric disorder), we argue that we would be doing a disservice to patients by not intervening in certain circumstances (more on what these circumstances are below). There is more to autonomy than leaving patients to their own devices. One’s desires must be under one’s own control or stated differently, one’s desires about ones’ (second-order) desires must be in check. This self-reflection about one’s desires that is required for second-order desires distinguishes, as Frankfurt argues, humans from non-human animals, and it is this self-reflective capacity that is essential for free will (Frankfurt, 1971). Regardless of whether Frankfurt correctly identified humans as the exclusive holders of second-order desires, we do believe the capacity for self-reflection must be taken very seriously in the context of patients with mental disorders to ensure that their decisions are truly free. An action is thus only truly free, in the hierarchical account of free will, when it accords with one’s second order-desires, the desires that one desires. A person who is compelled by a severe psychiatric disorder to harm themselves or others would therefore not be truly free and their first-order desire to refuse treatment should not be regarded as the hallmark of autonomy. Coercive interventions, by limiting the patient’s negative liberty, serve the purpose of promoting the true self of the patient, thereby enhancing their positive liberty, as

Burns rightly argues (Burns, 2011). This point highlights a weakness of the ‘principles approach’, namely that autonomy is construed as non-interference or negative liberty, but the principles approach does not provide space for autonomy as positive liberty where active self-determination occurs with support from others (Widdershoven, 2000). As Berlin, who originally distinguished between negative and positive liberty, noted, “to offer political rights, or safeguards against intervention by the State, to men who are half naked, illiterate, underfed and diseased is to mock their condition” (Berlin & Hardy, 2002).

Likewise, would we not be mocking patients who, for instance, experience a severe psychotic disorder, by offering them the autonomy that the CRPD Committee demands? To promote true liberty, persons with mental disorders surely must be provided with the opportunity to become their true self. Without coercive interventions in some circumstances, it is difficult to see how persons with severe mental disorders can become their true selves. To be truly free one must need more than non-interference from the state, but rather the state should create conditions conducive to achieving positive liberty. By defending legal capacity as an absolute right, the CRPD Committee may be absolutely defending negative liberty, but not positive liberty, at the expense of the mental health of some of the most vulnerable patients. Defending negative liberty, may, as Freeman and colleagues rightly argued, result in “undermining the right to health to allow a person to stay in a psychotic state and never allow them to get to a point of refusing or accepting treatment in an informed manner” (Freeman et al., 2015). Similar ideas have also been voiced by proponents of care ethics (Verkerk, 2001).

4.3.2. Discrimination and equality

Yet interfering into the lives of persons with mental disorders, as sketched above, is certainly not without its critics. Emeritus Professor of Psychiatry and Society Szmukler argues that mental health legislation does discriminate against persons with mental disorders (Szmukler, 2016). He proposes that, firstly, deeply entrenched stereotypes of mental illness could explain why law treats physical and mental illness differently. By differentiating in law between the treatment of persons with physical disorders and persons with mental disorders, persons with mental disorders are implicitly presumed to be incompetent because of their mental illness (Holloway & Szmukler, 2003). Secondly, persons with mental disorders are stereotypically considered intrinsically dangerous, although dangerousness as a consequence of mental illness results in only a minority of patients (Szmukler, 2016). It becomes difficult to justify why persons with mental disorders can be preventively detained on the account of their risk to others, whilst everyone else without a mental disorder cannot. The principle of non-discrimination requires that either generic legislation applies to all or to none (Szmukler, 2016). Indeed, the argument raised by those who argue in favor of temporarily limiting negative liberty to enhance positive liberty could equally be applied to those without a mental disorder as to those with a mental disorder.

Although the latter appears sound from the perspective of lessening discrimination and raising equality, it does raise the question to which extent it is feasible and desirable to apply coercion in such a manner. One reason to argue against it is that coercion is applied in mental health law precisely because of extreme cases in which psychiatric disorders could respond well to treatment. It is less clear whether applying coercion in other cases would be a good use of limited resources. Further, although a generic law, as proposed by Szmukler and others is an innovative solution, it is not without its problems (more on this below).

4.4. Future directions for the CMHCA and national mental health legislation

4.4.1. Amending existing national mental health legislation

To bring the discussion back to the CMHCA and national mental health legislation in general, several issues become clear.

First, we believe that competence should have a more central and decisive role in the CMHCA. As stated above, competence is not a condition for or against compulsory care. When the SAPHA was evaluated in 2011, it was recommended to guarantee competent refusal in future mental health law, but the CMHCA does not quite live up to this recommendation (Leenen et al., 2020). As Szmukler and Holloway argued, “[t]here is an unstated assumption within existing law, which is empirically wrong, that by definition people with mental illness necessarily lack capacity” (Holloway & Szmukler, 2003). Although competence does come into play in the CMHCA, it does so by way of resorting to the general principle of honoring the wishes and preferences of the patient (article 2:1(6)). This is both instrumentally and intrinsically inadequate to address the discriminatory issue. Instrumentally, competent refusal is respected, namely with respect to the competent patient’s wishes and preferences regarding their coercive interventions. Although parliamentary history (Eerste Kamer der Staten-Generaal, 2013) does suggest that competent patients can only be placed under compulsory care in cases of acute life danger or danger to others, the relevant provision is formulated ambiguously, and a literal reading does not indicate an absolute right to self-determination. This ambiguous provision seems to perpetuate the underlying assumption outlined above that having a mental disorder, more often than not, entails being incompetent. Indeed, respecting the wishes and preferences of competent patients does not send the same strong message as stating that competent patients cannot be subjected to coercive interventions. If the intention of the law was to place competent patients under compulsory care on narrower grounds, it is unclear why this had to be stated in such a roundabout way. By making competence as one of the conditions for compulsory care, the mental health law would be brought in line with the laws governing persons with physical illness, for which being incompetent is the key condition for involuntary treatment and thus it would be less discriminatory. Another concern is that the CMHCA is silent on how and to which extent the wishes and preferences of incompetent patients are taken into consideration. Article 2:1(6), *a contrario*, suggests that the wishes and preferences of incompetent patients should not be honored. It is unclear why this should be so, particularly in light of the CRPD. The Explanatory Memorandum (Ministerie van Volksgezondheid, Welzijn en Sport, 2020) does indicate that the wishes and preferences of incompetent patients should also be considered on a case-by-case basis, but once again, it is unclear why this was not enshrined in law.

This is not to say that the determination of competence is without its problems. Indeed, despite all attempts to make the determination as objective as possible, there is still some subjectivity involved. For instance, doctors are more likely to question the patient’s competence if the patient refuses useful treatment than when the patient refuses less useful treatment (Ten Have et al., 2013). Further, it appears that the competence of patients with mental disorders as opposed to those without mental disorders is unjustifiably held to a higher standard (Leenen et al., 2020). In addition, we do realize that the CRPD Committee has been critical of competence assessment and attaching greater weight to competence assessment is not, *prima facie*, in line with the CRPD for the CRPD Committee advocates for persons with mental disorders to be equal to persons without disability and not for equality between persons with mental disorders and physical disorders.²³ Nonetheless, if competence is used in health law in general (and it certainly is used widely throughout the world), it is reasonable to use it similarly for all patients, and treat those with mental illness and those with physical illness alike. This, to a greater extent, eliminates discrimination between persons with mental and physical disorders and thereby could potentially lessen the stigma that is attached to having a mental disorder. Although putting impaired decision-making competence at the heart of all compulsory care is not in the spirit of the CRPD, it will likely achieve one of the aims of the CRPD, namely to reduce the

discrimination.

However, the CRPD’s requirement of recognizing legal competence at all times exceeds what is considered reasonable. It has been rightly argued that if there is considerable risk for the patient only, in principle, there should not be ground to apply psychiatric coercion in case of competent refusal (Widdershoven, 2006). Persons with mental disorders, provided they are competent, should be allowed to make decisions which may be detrimental to their health. But should this then be extended to an absolute right to self-determination? For instance, should competent suicidal patients then be allowed to commit suicide? This is where, the previously mentioned first and second-order desires may clash, and difficult balancing decisions need to be made. One difficulty with distinguishing between first and second-order desires and attaching greater weight to one’s second-order desires is at which point do first-order desires become second-order desires? Could it be that the competent suicidal patient comes to desire the desire to commit suicide? It is certainly not inconceivable. In the metaphysical sense, the problem of personal identity, under which conditions there is continuity of the same person over a period of time, is one that still puzzles us today. But it is at this point, in the absence of clear answers, that common sense, our intuitions and experiences with other persons in similar situations are our main guides. Leaving aside the issue that States Parties under some regional human rights regimes have the duty to protect the right to life (and under the CRPD as well), most will feel a sense of unease in leaving suicidal patients to their own devices, knowing that suicidal patients can and do resume meaningful lives after being prevented from committing suicide. Naturally, we cannot know for certain, that a specific individual is simply misguided by their first-order desires which are clouded out by a psychiatric disorder to commit suicide. Empirical evidence will not come to the rescue, for empirical evidence can only inform us about generalizations (which, nonetheless, can be instructive about general tendencies). With respect to decision on an individual level, we must resort to intuitions and we believe the general intuition to prevent persons from suicidal behavior is justified simply because we do have good reasons to believe that psychiatric disorders may induce behaviors that the person would not, in the absence of the psychiatric disorder, would want to pursue.

At this point, it should be noted that “coercion” is really a spectrum of treatment pressures, ranging from persuasion, interpersonal leverage, inducements or offers, threats and finally, compulsion (Szmukler, 2016). Considering the CRPD’s drafting history and the CRPD Committee’s case law, some scholars interpret that the CRPD Committee rejects any mental health treatment without consent given.²⁴ Others, such as Szmukler, argue that the CRPD approach is most likely not excluding involuntary treatment in all cases, referring to emergency situations (Szmukler, Daw, & Callard, 2014). Or as McSherry proposes, as written above, that Article 17 must be understood as protecting competent patients from unwanted treatment and incompetent patients from unbeneficial treatment (McSherry, 2008). It is reasonable to assume that suicide prevention could be beneficial, and some degree of coercion is therefore justified. It could be argued that potentially in a case of a suicidal competent patients, coercion need not be exercised straight away at the level of compulsion, but first at a lower level, gradually building up from the lower end of the spectrum to the higher end.

There are equally good (and maybe even better) reasons to apply coercion when the risk involves not (only) the patient themselves, but others (as well). Therefore, we believe that competent refusal in this case should not be respected. Indeed, even the staunch defender of liberty, John Stuart Mill, defended the ‘Harm Principle’ in *On Liberty*, which states that it is justified to limit one’s freedom if the person threatens to harm another (Mill, Philp, & Rosen, 2015). Leaving aside the issue that is likely impossible to discover a single compelling interpretation of the Harm Principle (Shapiro, 2003), it is more reasonable to apply coercive

²³ We thank two anonymous reviewers for pointing this out.

²⁴ See United Nations General Assembly (2006b) and Seatzu (2018).

interventions in the case of harm to others than when the harm involves only the patient. This aligns with our intuition that the criminal justice system as is in place in most of the world, serves the justified purpose of protecting others from the harm that an individual could pose. Naturally, the distinction between harm to oneself and harm to others is not always clear cut and one could indirectly lead to the other. One need only consider, for instance, the suicidal patient that serves as the ‘role model’ for others to commit suicide or the suicidal parent that harms their children by rescinding their caretaking duties. Numerous other situations are conceivable.

Second, the representation regimes should be amended to comply with the CRPD. Firstly, we would not like to advocate for complete abolishment of substitute decision-making as a measure of last resort. Even the CRPD Committee acknowledges that “after significant efforts have been made, it is not practicable to determine the will and preferences of an individual, the “best interpretation of will and preferences” must replace the “best interests” determinations” (United Nations Committee on the Rights of Persons with Disabilities, 2014a). Whether “best interpretation of will and preferences” qualifies as a form of substitute decision-making is dubious, but as was noted above, neither the CMCHA, nor the Dutch law in general provides guidance on how representatives must represent the patient. The standard of a “good representative” insufficiently encompasses the requirement to determine the (best interpretation of) will and preferences of the person. Although, as noted, literature does provide guidance, the provisions themselves are entirely silent on the matter.

With all these amendments, having a mental disorder would still be one of the legitimate conditions for compulsory care. If this is discriminatory, what could be a potential alternative?

4.4.2. Alternatives to conventional mental health laws

In keeping with the CRPD’s emphasis on the social model of disability, which suggests that the way to address the problems of the disabled is through social change (Wolff, 2019), law has not only instrumental, but also intrinsic value and arguably a certain moral force (e.g. ‘an unjust law is no law at all’, as is the standard legal maxim) which could potentially bring about social change. The existence of mental health laws, particularly ones that set different standards for psychiatric patients as compared to the standards set by general health legislation for somatic patients, can be argued to be discriminatory. Therefore, a good case could be made for a generic law.

Even if the CMCHA or similar mental health laws were amended as described above, the question arises whether having a separate law governing persons with mental disorders is not inherently discriminating. To address this concern, Szmukler and colleagues proposed an innovative solution, the “Fusion Law” which fuses mental health legislation and mental capacity legislation on how to reform existing mental health laws in compliance with the CRPD (Dawson & Szmukler, 2006). The Fusion Law has been analyzed and critiqued extensively elsewhere (Szmukler, 2016; Szmukler, Daw, & Dawson, 2010; Szmukler & Kelly, 2016), but in essence it comes down to a generic law, applicable to all patients (those with physical and mental disorders), whereby involuntary interventions are based upon impaired decision-making capacity and their being in the patient’s best interests. In a similar vein, Welie and Widdershoven proposed a solution whereby, on the one hand, decision-making capacity is the key condition in case a patient poses danger for themselves, and on the other, danger is the key condition in case a patient poses danger to others, or a combination of both requirements (Welie & Widdershoven, 2019). In neither situation is the presence of a mental disorder a consideration for providing a patient with coercive interventions, as required by the CRPD. One law governing all patients could potentially reduce the stigma that is attached to having a mental disorder. A law such as the CMHCA does single out persons with mental disorders as a special category of persons requiring special treatment in law, a special treatment that could be seen as discriminatory, as was highlighted above. Not only may it lessen stigma, a fusion law seems

more compliant with the CRPD for it delinks coercive interventions with the presence of a mental disorder. Szmukler argues that the Fusion Law is “as close as we are likely to get to the CRPD ideal in practice”, and although a promising concept, it is not without its problems (Szmukler & Kelly, 2016; Campbell & Rix, 2018).

Kelly argues that, by contrast, the Fusion Law is not in accordance with the CRPD (and specifically article 14) and with the critical position that the CRPD Committee takes on mental capacity by rejecting it altogether (let alone as the paradigm of a new system) (Szmukler & Kelly, 2016). However, it is conceivable that the CRPD Committee would reject mental capacity within the conventional mental health law framework, but not necessarily within the fusion framework, a framework that does not discriminate against persons with mental disorders because it applies to everyone. Previously rejected concepts may take on a new meaning in a new paradigm. More worryingly is, perhaps, to which extent will mitigating the de jure discriminatory nature of mental health legislation have a tangible de facto effect. For it could be that those who will be placed under coercive interventions under the generic law will still be mostly patients suffering from mental disorders (Welie & Widdershoven, 2019), in which case the generic law will be but a cosmetic solution. This is an empirical matter, however, which should be studied when the occasion arises. And the occasion has arisen.

Although no state so far has abolished mental health law, Northern Ireland has taken the groundbreaking step as the first jurisdiction of replacing its conventional mental health law with the Mental Capacity Act (Northern Ireland) in 2016, a fusion law as sketched above (Lynch, Taggart, & Campbell, 2017). As more states adopt new (CRPD-compliant) legislation, presumably if they are party to the CRPD, we believe that studies comparing different outcomes could be instrumental in determining which direction the law should go. As we demonstrated above, neither solution is unproblematic. By comparing outcomes from different legal frameworks, best practices could be derived and applied to the specific local context. We believe that empirical outcomes, at this point, are of critical importance. At this point it is far from clear how the radical paradigm shift of the CRPD should be brought into workable practice. Should existing mental health legislation be adapted or should entirely new legislation, such as the fusion law, be adopted? The CRPD provides several admirable ideals but leaves lawmakers with the great challenge of putting them into a workable legal framework. How can we work towards lessening the stigma that is attached to having a mental disorder, whilst at the same time supporting patients with mental disorders towards becoming their true selves? This is why ambitious and innovative steps such as those taken by Northern Ireland are so valuable in potentially advancing this area of human rights.

5. Conclusion

The CRPD with its emphasis on respecting the decision-making of persons with mental disorders introduced an important paradigm shift. The swift ratification of the CRPD demonstrates a commitment among almost all States of the world to improve the rights of persons with disabilities. Nevertheless, States are also struggling with reconciling the CRPD approach with their national mental health legislation. It is here where we reach an impasse: the CRPD presents a paradigm shift for States Parties to incorporate, but leaves it in the middle how States Parties should go about creating a workable legal framework. Should States Parties adapt existing legislation or abolish it and adopt entirely new legislation? How must states balance the right to self-determination with the duty to support patients to become their true selves? The discussion of the recently introduced Dutch mental health law demonstrates how these issues arise for a State Party to the CRPD. The CHMHCA, compared to its predecessor, has moved into the direction of the CRPD by, inter alia, affirming several general principles that must be considered when placing patients under compulsory care and attaching greater weight to competent refusal. However, the CMHCA still has a long way to go towards embracing the CRPD approach. Although under

the CMHCA, compulsory care is a measure of last resort, it arguable exceeds what the CRPD Committee would consider justified. At the time of writing, the CRPD Committee had not issued its concluding observations on the Netherlands, but we predict a critical stance of the CRPD Committee towards the CMHCA. Several issues could be improved to move towards lessening the stigma that is attached to having a mental disorders, namely to a greater extent recognizing competence as a condition for compulsory care (although we are aware that the CRPD Committee is critical of competence assessment) and adequately recognizing supported decision-making and distinguishing it from substitute decision-making. Nevertheless, we think that completely abolishing coercive interventions, as demanded by the CRPD Committee is quixotic. The CRPD Committee has taken a stance, a stance that is necessary to address severe human rights violations of persons with mental disorders. But it would be unwise to abolish with one sweep decades of lawmaking without leaving parts that do increase the positive liberty of these very vulnerable patients. We would be doing a disservice to patients with mental disorders who are greatly suffering yet refuse care because their first-order desires cloud out their second-order desires, their "true selves". Therefore, we would advocate for a 'best of both worlds' approach: moving towards a CRPD-complaint legislation while retaining some aspects from conventional mental health laws. But we also realize that having separate mental health legislation may single out persons with mental disorders, creating unnecessary stigma. We therefore welcome new approaches to mental health legislation. The approach taken by Northern Ireland, fusing mental health legislation and capacity legislation, should be studied empirically for relevant outcomes and compared to existing mental health legislation. Such studies could be instrumental in determining a future direction for a legal framework that maximally facilitates human flourishing of persons with mental disorders.

Declaration of interest

None.

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Appendix A. (unofficial translations of selected articles of the CMHCA)

Article 1:1

2. For the application of this act and the provisions founded upon it, a «serious disadvantage» is considered the existence of a considerable risk for:

- a) danger to life, serious bodily harm, serious mental, material, immaterial or financial.
- b) damage, serious neglect, societal collapse, seriously disturbed development for or of the individual concerned or others;
- c) threat to the security of the individual concerned whether or not he becomes under the influence of others;
- d) the situation in which the individual concerned elicits the aggression of others with bothersome behavior or the situation which endangers the overall safety of persons or goods.

Article 1:3

3. As a representative to an adult individual, regarding the exercise of the rights and duties of this act, shall act:

- a. a representative as authorized as such by the individual concerned, or
- b. if the individual concerned is considered incapable of a reasonable appreciation of one's interests:
 - the guardian or mentor, or in the their absence,
 - the authorized representative, as meant by a, or in the their absence,
 - spouse, registered partner or other life partner; or, in case they do not wish to do so or in their absence,
 - a parent, child, brother, sister, grandparent or grandchild of the individual concerned, unless they do not wish to do so, or they are unavailable.

7. The representative shall exercise the care of a good representative and is obliged to include the individual concerned as much as possible in the execution of his task.

Article 2:1

1. The care provider and the medical director offer sufficient possibilities for voluntary care, so as to avoid compulsory care as much as possible.
2. Compulsory care can only be considered as a measure of last resort, in case there are no possibilities for voluntary care anymore.
3. In preparing, issuing, enforcing, carrying out, altering, and terminating a crisis measure, authorization for continuing the crisis measure or care authorization of the compulsory care, the proportionality, subsidiarity, which encompasses compulsory care in the outpatient setting, as well as the effectiveness and safety will be assessed.

6. The wishes and preferences of the individual concerned regarding compulsory care must be honored, unless:

- a. the individual concerned is considered incapable of a reasonable appreciation of one's interests, or
- b) acute danger to life threatens the individual concerned or there is considerable danger to the lives of others, serious bodily harm, serious mental, material, immaterial or financial damage, serious neglect, societal collapse, or that he will be seriously disturbed in his development or the situation which endangers the overall safety of persons or goods.

Article 3:2

2. Compulsory care consists of:

- a) providing fluids, nutrition and medication, as well as carrying out medical check-ups or other medical procedures and therapeutic measures, for the treatment of a mental disorder, or as result of that disorder, for the treatment of a somatic condition;
- b) limiting the freedom of movement;
- c) containment;
- d) carrying out supervision over the individual concerned;
- e) examining clothing or body;
- f) searching the housing or staying space for behavior-modifying substances and dangerous objects;
- g) checking for the presence of behavior-modifying substances;
- h) setting limits on the freedom to organize one's life, which results in the individual concerned having to do so or to omit something, such as the use of means of communication;
- i) limiting the right to receive visitors;
- j) admitting to an accommodation
- k) depriving the individual concerned of his freedom by moving him to a place suitable for temporary stay as meant by article 7:3 paragraph 3.

Article 3:3

If the person's behavior, as a result of their mental disorder, not being a psychogeriatric condition or an intellectual disability results in a serious disadvantage, then as a last resort compulsory care as meant by article 3:1 can be provided, if:

- a) there are no options for voluntary care;
- b) for the individual concerned there are no less onerous alternatives with the intended effect;
- c) the provision of compulsory care, considering the intended goal of the compulsory care, is proportionate; and
- d) it is reasonable to expect that providing the compulsory care is effective.

Article 3:4

Compulsory care can be provided to:

- a. avert a crisis situation,
- b. avert serious disadvantage,
- c. stabilize the mental health of the individual concerned,
- d. stabilize the mental health of the individual concerned to such an extent that he regains his autonomy as much as possible, or
- e. stabilize or recover the physical health of the individual concerned in the case when his behavior as a result of his mental disorder results in serious disadvantage for it.

Article 5:9

1. The medical director ensures that the psychiatrist in any case specifies his findings in the medical certificate with respect to:

- a. the symptoms that the individual concerned displays and a diagnosis or preliminary diagnosis of the mental disorder of the individual concerned;
- b. the relationship between the mental disorder and the behavior leading to the serious disadvantage;
- c. the care that is needed to avert the serious disadvantage.

Article 5:14

1. The care plan specifies in any event:

- a. diagnosis of the mental disorder of the individual concerned as established by the responsible clinician and the, from the mental disorder, resulting behavior which results in a serious disadvantage;
- b. the care that is needed to avert the serious disadvantage;
- c. the goal of compulsory care;
- d. the way in which the preferences of the individual concerned regarding the care will be taken into account, as established on the care map including the attachments;
- e. the views and contact details of persons, as meant by article 5:13 paragraph 4;
- f. the maximum duration of the separate forms of compulsory care;
- g. the way in which the care provider and the medical director protect the quality of the compulsory care and monitor the execution of the compulsory care in outpatient settings;
- h. the essential conditions for participation in society of the individual concerned, in case they are lacking;
- i. the frequency with which and circumstances under which the care plan and the subsidiarity, proportionality, effectiveness and safety of the compulsory care with the individual concerned, the representative, as well as the family member or relative and the patient's representative are evaluated and the care plan is updated
- j. the care provider that can be charged with the execution of the care authorization, and if need be, the accommodation.

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