Summary

1. Introduction

The Psychiatric Hospitals (Compulsory Admissions) Act, or BOPZ Act, took effect in the Netherlands in 1994. It regulates the compulsory psychiatric hospitalisation and treatment of people with severe mental illness. Involuntary psychiatric admissions are subject to the following criteria:

- The individual has a mental disturbance (or insufficiently developed mental faculties);
- The mental disturbance causes danger to that individual, to other people or to the safety of persons or property in general;
- The danger cannot be averted by the intervention of persons or agencies in the community;
- The individual does not show the necessary willingness to seek treatment.

From 1 January 2004, the BOPZ Act was expanded to allow for *conditional hospital orders* (article 14), under which patients can avoid compulsoryhospitalisation by complying with specified conditions pertaining to theirtreatment in the community. A key element of conditional hospital orders asthey presently exist is that patients must *explicitly consent* to their treatmentplan and must state their willingness to *comply with the specified conditions.* The reason why the Dutch parliament introduced the conditional hospital orders was to put an end to the so-called 'umbrella order' – a measure developed in judicial practice. Under an 'umbrella order', a patient was admitted to an institution *on paper* and then *discharged under specified conditions* immediately thereafter.

In practice, conditional hospital orders have never proven a sufficient alternative to the umbrella order. Many patients are unwilling to *state their explicit consent* to the specified conditions and the treatment plan, and a ruling by the Dutch Supreme Court (29 April 2005, no. 15) has declared that granting a conditional order without a patient's explicit consent was not correct. Umbrella order also still continued to be employed after the conditional hospital orders were introduced, but the Supreme Court has recently declared that this practice is not correct (11 November 2005/065HR). The latter ruling, however, was not yet available when the present study was carried out. In an attempt to keep practitioners and courts from resorting to surrogate instruments, the Dutch government is now proposing fresh changes to the BOPZ Act to widen the applicability of the conditional hospital orders. These are the most important changes:

- *Patients in future would no longer be required to expressly consent to the conditions set. It will suffice if a court is sufficiently convinced that a 35 patient will duly comply with those conditions (amendment to article 14a, section 8, BOPZ Act).*
- *Patients in future would no longer have to expressly consent to the treatment plan. It will suffice if the treating doctor ascertains that the patient can reasonably be presumed to adhere to the treatment plan (article 14a, section 5, BOPZ Act).*

- *Patients could be hospitalised more swiftly in future if they fail to comply with the conditions set. Consultation with an independent psychiatrist would no longer be required. The hospital's medical director would determine whether hospitalisation is necessary after non-compliance (article 14d, section 1, BOPZ Act).*

The Netherlands Institute of Mental Health and Addiction (Trimbosinstituut) was commissioned by the Research and Documentation Centre (WODC) of the national Ministry of Justice to conduct a limited prospective study to assess whether the proposed legal changes will achieve the intended results. The intention is to ensure that conditional hospital orders will indeed be issued for those patients who cannot or will not state their willingness to comply with the specified conditions, but who can still reasonably be presumed to comply in practice after the order is granted. A further purpose of the study was to assess whether the broader conditional orders now being proposed could put an end to the 'umbrella orders' as have developed in practice.

Research aims and questions

Research questions

- How do interested parties (judges, public prosecutors, psychiatrists) gauge the viability of the proposed statutory changes?
- To what extent do they believe the proposed statutory changes will achieve the intended results?

Research aim

- To assess whether the proposed statutory revision will be viable and whether current practice would have been different had the changes been made earlier.

We pursued the following activities to address the research questions:

- Study of written documents (including those on the proposed changes to the BOPZ Act where they relate to conditional hospital orders);
- Nine face-to-face interviews with psychiatrists, public prosecutors and judges.

2. Viability and effectiveness

2.1 Swifter hospitalisation

The amendment designed to enable swifter hospital admission had been positively received by the respondents. They expected the measure to be workable and to achieve the intended purpose because:

- an independent psychiatrist no longer has to be consulted and the medical director of the hospital can rule on admitting patients who have been unable to cope with community living. The expectation is that higher numbers of conditional hospital orders would be granted. Whether the proposed change would enable rapid enough hospital admission will have to be seen in practice.

2.2 Patient consent

Opinions were divided about the proposed amendment to abolish the requirement for explicit patient consent to the conditions and the treatment plan.

Positive responses

Respondents who assented to the measure (in one interview with a psychiatrist, one with a judge and two with prosecutors) believed the changes would deliver the desired results:

- Applications for conditional hospital orders would be made more readily for patients who, despite their poor illness insight, can be treated outside the hospital to avoid admission.
- Umbrella order would no longer be needed, because the broader conditional hospital orders would contain options equivalent to those now provided by the umbrella order.

They cited some key benefits of the changes:

- A legal alternative would now exist for the umbrella order that has emerged in practice;
- Patients would enjoy better legal protection;
- Patient consent would no longer form a stumbling block;
- Patient turnover in hospitals would improve, making more beds available for people who need them;
- Fewer patients would be hospitalised on the basis of unusual legal constructs;
- Clarity would improve, because only one type of order would be used instead of two.

Critical responses

Among those who were reluctant to endorse the changes involving patient consent (in two interviews with judges, two with psychiatrists and one with prosecuting service staff), psychiatrists and judiciary respondents tended to view the matter from different perspectives and highlighted different issues:

- Psychiatrists expressed misgivings about whether the conditional hospital orders would provide the best *protection* to the group of patients with little or no illness insight. Conditional hospital orders would possibly be less suitable for them, as such patients need and benefit from structure, and sufficient structure may be harder to provide in community living. For that group, respondents assumed that the intended results might be better achieved by further perfecting the use of crisis cards and joint crisis plans.
- Judges focused mainly on the *legal basis* for the proposed changes and on the patients' *legal protection* and *rights of self-determination.* They regretted that the currently existing conditional hospital orders would no longer available for the (relatively small) group of BOPZ patients for whom the instrument now functions well and stimulates their sense of responsibility. They also felt the proposed changes were at odds with the basic premise of conditional hospital orders; they argued that conditional orders are intended mainly for patients who are *compos mentis,* who understand what the specified conditions entail and who expressly

commit themselves to following them. If patient consent were no longer required, then the label would no longer fit the content from a legal point of view. Certain respondents also feared that the so-called 'best interests principle' was now being reintroduced into the BOPZ Act through the back door. To them it was not immediately clear what impact the proposed legal changes might have. They pointed out that the BOPZ Act has been amended frequently in the past and that the changes have often had undesirable ramifications in practice. Nevertheless, several public prosecutors still believed that if the changes do actually become law and the use of the umbrella order is no longer feasible, then the BOPZ Act will become the governing statute.

2.1 Targeted group

Not every patient who is subject to the BOPZ Act is suited to receive a conditional hospital order. The majority of respondents argued that even if explicit patient consent is no longer required, a patient must, at the very least, have a *certain realisation* of what the treatment will entail and what conditions are attached to it. It seemed to them inadvisable to issue conditional hospital orders for mentally incompetent persons. In the case of patients with little or no illness insight, several judges and prosecutors urged that clear criteria be set out for granting conditional orders:

- The case history should show that the patient is treatment-adherent;
- A treatment provider should be available with whom the patient maintains close contact and who can monitor whether the patient takes the prescribed medication;
- The patient should have a broad social safety net (friends, relatives) that can exercise supervision.

2.2 Role of the courts

Under the proposed legislation, a court would have to assess whether a patient is likely to comply with the conditions of the order. Respondents in our study urged the creation of step-by-step guidelines for judges, to avoid them getting into discussions with patients about the content of the treatment. The guidelines would be as follow:

- Ascertain first whether a serious treatment plan exists;
- After consulting with the treating doctor, assess whether the patient is likely to comply with the conditions set;
- In case of serious doubt, obtain a second expert opinion.

3. Umbrella order obsolete?

Whether the current umbrella order would no longer serve a purpose after the changes would depend on several factors, and here again the judges and prosecutors took a different perspective to that of the psychiatrists:

- Judges and public prosecutors believed it would depend on how clearly the follow-up pathways are defined in case patients are later subject to compulsory admission. An additional constraint could be the number of periodic checks required under a conditional hospital order.

- Psychiatrists mainly emphasised that patients perceive umbrella orders differently than conditional hospital orders. The message of a conditional order is: 'No, you don't need to go to hospital as long as you stick to the rules.' In an umbrella order it is: 'Yes, we're putting you in hospital, but you're allowed to leave if you take your pills on time.' If compulsory admission is later ordered, there may be a greater risk under conditional hospital orders that patients will put up resistance than under umbrella orders. This could form a barrier to applying for a conditional hospital order in the first place. In addition, unstable patients may find it threatening if one type of order needs to be converted into another (such as a conditional into a temporary order).

4. Conclusion

Though all respondents agreed that the BOPZ Act provides good legal protection to patients with severe mental illness, most of them pointed to the need to draft completely new legislation to replace it. They argued that the present law grafts too heavily on an antithesis that does not exist in reality – hospitalisation versus non-hospitalisation. Most argued that a new law should concentrate on the treatment that is needed to protect each patient. The bottom line then would not be whether a patient can survive outside a hospital, but whether community living can provide the best protection to that particular patient.