

Self-binding directives under the new Dutch Law on Compulsory Mental Health Care: An analysis of the legal framework and a proposal for reform

Matthé Scholten^{a,*}, Laura van Melle^{a,b}, Guy Widdershoven^b

^a Institute for Medical Ethics and History of Medicine, Ruhr University Bochum, Bochum, Germany

^b Department of Ethics, Law and Humanities, Amsterdam University Medical Centers, VU University Amsterdam, Netherlands

ARTICLE INFO

Keywords:

Self-binding directive
Ulysses contract
Psychiatric advance directive
The Netherlands
Wvvgz
Coercion
Compulsory admission
Involuntary treatment
Psychiatry

ABSTRACT

Self-binding directives (SBDs) are a special type of psychiatric advance directive by means of which mental health service users can give advance consent to compulsory hospital admission or treatment during a future mental health crisis. SBDs are legally binding in the Netherlands since 2008. On the 1st of January 2020, the Dutch Law on Special Admissions to Psychiatric Hospitals (*Wet bijzondere opnemingen in psychiatrische ziekenhuizen*; Bopz) was replaced by the new Law on Compulsory Mental Health Care (*Wet verplichte geestelijke gezondheidszorg*; Wvvgz). This replacement brought with it various changes in the legal arrangement for SBDs. In this article, we expound the changes in the legal arrangement and assess the implications of these changes for the practical feasibility of SBDs. We argue that the procedures for arranging compulsory care based on an SBD in the new law are too complex and time-intensive for SBDs to yield their potential benefits. We close by proposing a workable mechanism of legal authorisation of compulsory care on the basis of an SBD.

1. Introduction

Self-binding directives (SBDs) are a special type of psychiatric advance directive by means of which mental health service users can give advance consent to compulsory hospital admission or treatment during a future mental health crisis (Berghmans & van der Zanden, 2012; Gergel & Owen, 2015; Gremmen, Widdershoven, Beekman, Zuijderhoudt, & Sevenhuijsen, 2008). SBDs are also commonly called “Ulysses contracts,” referring to the myth of the Sirens in Homer’s *Ulysses* (Dresser, 1984). On his journey home to Ithaca, Ulysses and his crew sailed past the island of the Sirens. Many a sailor reportedly fell in ruins being unable to resist the lure of their enchanting song. Following the advice of Circe, Ulysses had himself tied up to the mast of the ship and instructed his crew to plug their ears with wax and leave him tied to the mast no matter how much he might beg to be released. Protected against the lures of the Sirens in this way, Ulysses was able to enjoy their beguiling song and return home safely.

The myth of the Sirens highlights two features that distinguish SBDs from ordinary psychiatric advance directives (Atkinson, 2007; Hender-son, Swanson, Szmukler, Thornicroft, & Zinkler, 2008). The first is that whereas general psychiatric advance directives can typically be used only to state treatment preferences or refusals, SBDs are opt-in directives

that can be used to consent in advance to particular kinds of compulsory treatment. The second is that SBDs cannot be revoked in the circumstances for which they are written. By combining these features, SBDs can enable persons with mental disorders involving recurrent mental health crises to remain in control over their life and treatment.

There is an ongoing philosophical debate over the ethical and practical opportunities and challenges of SBDs (Bell, 2015; Berghmans & van der Zanden, 2012; Bielby, 2014; Davis, 2008; Del Villar & Ryan, 2020; Dresser, 1981; Dresser, 1984; Gergel & Owen, 2015; Gremmen et al., 2008; Kane, 2017; Quante, 1999; Raphael, 2020; Sarin, 2012; Spellecy, 2003; Standing & Lawlor, 2019; Walker, 2012; Widdershoven & Berghmans, 2001; Widdershoven & Berghmans, 2007). Philosophers often fail to appreciate, however, that the ethical justifiability and practical feasibility of SBDs depend to a large extent on the details of the accompanying legal arrangement. This dependency implies that one cannot make a conclusive assessment of the ethical and practical opportunities and challenges of SBDs in abstraction from the specific ways in which SBDs are legally regulated. With growing interest in SBDs internationally, it is thus important to look carefully into the legal arrangements for SBDs in jurisdictions where legal provisions for SBDs exist.

Explicit provisions for SBDs were included in the Dutch Law on

* Corresponding author at: Institute for Medical Ethics and History of Medicine, Ruhr University Bochum, Markstr. 258a, 44799 Bochum, Germany.

E-mail address: matthe.scholten@rub.de (M. Scholten).

Special Admissions to Psychiatric Hospitals (*Wet bijzondere opnemingen in psychiatrische ziekenhuizen*; Bopz) in 2008. This made The Netherlands one of the few countries worldwide in which SBDs are legally binding (Berghmans & van der Zanden, 2012). The completion rates for SBDs in The Netherlands remained very low until 2011 (Berghmans & van der Zanden, 2012) and it is unlikely that the uptake increased much in the past decade. One part of the explanation for the low uptake of SBDs lies in well-known barriers to the completion of advance directives in mental health care, such as a lack of familiarity with advance directives and a lack of support (Shields, Pathare, van der Ham, & Bunders, 2014). The other part lies in the high complexity of the legal arrangement for SBDs in the Bopz (Berghmans & van der Zanden, 2012).

On the 1st of January 2020, the Bopz was replaced by the new Law on Compulsory Mental Health Care (*Wet verplichte geestelijke gezondheidszorg*; Wvvggz). This replacement brought with it various changes in the legal arrangement for SBDs. Notwithstanding strong stakeholder involvement during a legislative process of more than a decade, the Wvvggz immediately met with widespread criticism (Meurs, 2019; Effting, 2019; Belt, 2018; Scholten, 2020; Koopman & Spijkerman, 2020). At the centre of this criticism are the complex and time-intensive procedures and extensive paperwork required to arrange compulsory care. Although SBDs were not in the focus of this criticism, concerns about overly complex bureaucratic procedures also apply to the new legal arrangement for SBDs.

Two reparation law proposals for the Wvvggz were prepared in response to this criticism (EKDS, 2020; *Reparatiewet Wvvggz en WZD*, 2020), but neither of these contains fundamental changes in the procedures around SBDs. Such changes can still be made in the near future, because the Wvvggz will be evaluated before the end of 2021 and amended, if necessary, based on the results of the evaluation (Ministerie van Volksgezondheid WeS, 2020).

In this article, we argue that the new procedures for compulsory care based on an SBD are too complex and time-intensive for SBDs to yield their potential benefits. We describe the differences between the legal arrangements for SBDs in the Bopz and the Wvvggz, outline the potential benefits of SBDs, identify problems with the current legal arrangement and suggest ways in which it can be improved.

2. The criteria for SBDs

The differences between the legal arrangements for SBDs in the Bopz and the Wvvggz are summarised in Tables 1 and 2. In this section, we will focus on the differences between the two laws in relation to the validity criteria for SBDs, deferring a discussion of the legal procedures for obtaining legal authorisation of compulsory care on the basis of an SBD to the following section. References to the relevant law articles can be found in the tables. To improve readability, we will provide the references to the law text only where these are not already contained in the tables.

We will elaborate on the most salient differences summarised in Table 1. Two differences immediately catch the eye. The first concerns the location of the article on SBDs in the law text: while in the Bopz the provisions for SBDs are listed subsequent to the other legal bases for compulsory care, in the new law they are listed before any other legal basis for compulsory care is mentioned. One cannot draw legal conclusions from this, of course, at least not without further argument. Still, it is a basic principle of the Wvvggz that the wishes and preferences of service users should be respected as far as possible (Art. 2:1 par. 6), and SBDs enable service users to document their wishes and preferences regarding compulsory care. For this reason, we suggest that SBDs should play a far more prominent role in the arrangement of compulsory care than they have played thus far.

The second difference is that the article on SBDs in the new law is much shorter and less complex than the article in the old law. The reduced length of the new article is largely due to the new mechanism for the legal authorisation of compulsory care on the basis of an SBD. In

Table 1
The criteria for SBDs.

Aspect	Article	Bopz	Article	Wvvggz
General differences				
Location in the law	34	after the other legal bases for compulsory care	4	before the other legal bases for compulsory care
Length of the article	34a-p	described extensively	4:1–3	described concisely
Differences based on the basic principles of the law				
Location of compulsory care	34a.1	inpatient	3:2	inpatient or outpatient
Validity criteria				
Age limit	34a.1	16 years or older	4:1.1 4:1.4 and 1:4.2a	16 years old or older 12–16 years old if the service user has mental capacity and the legal representative co-signs the SBD
Signatures	34d.1	The SBD must be signed by the service user, the treating psychiatrist and the independent psychiatrist who assessed mental capacity	4:2.1	The SBD must be signed by the service user, the treating mental health professional and the medical director (<i>geneesheer-directeur</i>)
Mental capacity for completion	34a.1	Service users can complete an SBD only if they have mental capacity	4:1.1	Service users can complete an SBD only if they have mental capacity
Mental capacity for revocation	34e.3	Service users can change or revoke an SBD only if they have mental capacity	4:3	Service users can change or revoke an SBD only if they have mental capacity
Capacity assessment	34c.a	independent psychiatrist	4:1.7	independent psychiatrist or clinical psychologist
Required content	34b	the conditions under which compulsory care should be provided; the kind of care; and the duration of compulsory care	4:1.2a-e	the conditions under which compulsory care should be provided; the kind of care; the duration of compulsory care; the period of validity of the SBD; and contact persons
Duration of validity of the SBD	34e.1	1 year	4:1.2d	specified in the SBD
Copies and registry				
Copy of the SBD	34d.2	The psychiatrist and hands out copies of the SBD to the service user, a person appointed by the service user, another treating mental health professional, if available, and the health care inspectorate	4:2.2	The medical director hands out copies of the SBD to the service user, the legal representative, the care coordinator, and the office of the public prosecutor
Registry	34d.3	at the health care inspectorate	N/A	no registry

both laws, compulsory care on the basis of an SBD is subject to legal authorisation by the judge. The Bopz contained a special mechanism of legal authorisation for SBDs, namely the “self-binding authorisation” (*zelfbindingsmachtiging*). The procedures for obtaining this authorisation

Table 2

The process for obtaining legal authorisation.

Aspect	Article	Bopz	Article	Wvggz
Process for obtaining legal authorisation				
Form of legal authorisation	34a.2	subject to legal authorisation in the form of a special “self-binding authorisation”	5:17.5 and 6:2.1d	subject to legal authorisation in the form of a general “care authorisation”
Initiation of the application for legal authorisation	34 g	The application can be initiated by the treating psychiatrist or a person who is appointed by the service user and has a copy of the SBD	5:3	The application can be initiated by the medical director or a treating mental health professional
Assessment of the application for legal authorisation	34i	The public prosecutor assesses whether the criteria for compulsory care are met and submits the application to the judge	5:16 and 5:17	The public prosecutor assesses whether the criteria for compulsory care are met and submits the application to the judge
Term for the assessment	N/A	No term specified	5:16.1 and 5:17.1	max. 4 weeks
Term for legal authorisation	34 k.1	max. 5 days	6:2.1d	max. 3 days
Criteria for compulsory care on the basis of an SBD				
Content criterion	34 f.2	Compulsory care can be provided on the basis of an SBD only if the circumstances described in the SBD obtain	4:1.2a	Compulsory care can be provided on the basis of an SBD only if the circumstances described in the SBD obtain
Risk criterion	34a.1	Compulsory care can be provided on the basis of an SBD even if there is no risk of harm to self or others	4:1.2a	Compulsory care on the basis of an SBD should be provided to prevent a risk of harm to self or others
Capacity criterion	N/A	Not mentioned	N/A	Not mentioned
Legal authorisation	34a.2	Compulsory care can be provided on the basis of an SBD only if a self-binding authorisation is granted	3:1 and 5:17.5 and 6:2.1d	Compulsory care can be provided on the basis of an SBD only if a care authorisation is granted
Maximum duration of compulsory care				
Maximum duration of compulsory care	34b.1c	6 weeks	4:1.2b	determined in the SBD
Monitoring mechanism				
Monitoring mechanism	34n.4	Upon discharge, the health care inspectorate assesses whether compulsory care was compliant with the SBD	5:14.1 g and i; 5:17.4d and e	The type and frequency of the evaluation of compulsory care with the service user, representative, close one and confidential advisor must be described in the care plan

were described in the article on SBDs. In the Wvggz, by contrast, the mechanism of legal authorisation of compulsory care on the basis of an SBD is the same as that of standard compulsory care outside of crisis and emergency situations, namely the “care authorisation” (*zorgmachtiging*). The procedures for obtaining a care authorisation are described in separate articles. We will delineate the process for obtaining legal authorization of compulsory care on the basis of an SBD in section 3.

A further difference can be inferred from the basic principles of the laws. The Bopz made compulsory care subject to compulsory hospital admission and hence did not allow for compulsory care in the outpatient setting. By contrast, the Wvggz also allows for compulsory care in the community, including in the home situation. The underlying rationale is that compulsory care in the community would seem a less restrictive alternative in comparison with compulsory care in the mental health hospital. The scope of interventions that can be requested in an SBD is thus broadened in the new law: service users can also use SBDs to pre-arrange the provision of compulsory care in their home setting.

The new law specifies additional content requirements for SBDs. Under the Bopz, SBDs must contain information about the circumstances in which compulsory care should be arranged and about the type and duration of compulsory treatment. The new law strengthens the position of service users by enabling them to determine in the SBD what used to be fixed regulatory constraints under the Bopz. In addition to the content requirements contained in the Bopz, the Wvggz asks service users to specify the period of validity of the SBD in the SBD itself. This period was fixed at one year under the Bopz. Since the necessity of yearly updates makes it less attractive for service users to complete an SBD, the Wvggz asks service users to describe the period of validity in the SBD itself. Similarly, the maximum duration of compulsory care on the basis of an SBD was fixed at 6 weeks under the old law. The new law asks service users to determine this term in the SBD in consultation with the other parties involved in the completion process. Finally, the Wvggz asks service users to nominate persons who should be contacted during a mental health crisis to provide support. An SBD is valid only if it contains information on all these points.

The normative relevance of mental capacity to the completion and revocation of SBDs remained unchanged. Both laws pronounce that service users can complete and revoke an SBD only if they have mental capacity. Mental capacity is operationalized functionally in terms of service users’ ability to make a reasonable evaluation of their own interests with respect to the decision at hand. This operationalization implies not only that any determination of incapacity is valid only for a specific treatment decision at a specific point of time (see Art. 1:5 par. 1), but also that incapacity cannot be inferred from the fact that people have a psychiatric diagnosis or the fact that they make “unwise” treatment decisions (Scholten, Gather, & Vollmann, 2021).

A difference between the two laws can be observed in relation to the assessment of mental capacity. Whereas under the Bopz mental capacity had to be assessed by an independent psychiatrist, under the Wvggz this can also be done by an independent clinical psychologist. We evaluate this change positively because it underlines that mental capacity is a psycho-legal rather than a biomedical concept. Psychologist might even be more suitable for the task. Whereas psychiatrist might naturally be inclined to focus on psychopathology (which is at most indirectly relevant to mental capacity), psychologists will likely lay emphasis on the decision-making abilities that underly the construct of mental capacity.

Another novelty of the new law is that persons from the age of 12 to 16 years old can complete an SBD if they have mental capacity. The minimum age for SBD completion was set at 16 years old in the Bopz. The Wvggz requires that the legal representative be involved in the process when 12 to 16-year-olds want to complete an SBD. In the case of 12 to 16-year-olds, the parents or the guardians take up the role of legal representative (Art. 1:3 par. 2). SBDs of 12 to 16-year-olds are valid only if both the service user and the legal representative give their consent (Art 1:4 par. 2a). The inclusion of this provision in the law was controversial and it is expected that it will be cancelled in the near future. The reparation law proposal that is currently underway omits the paragraph that permits SBD completion for 12 to 16-year-olds ([Reparatiewet Wvggz en WZD, 2020](#)).

A final difference concerns the copies and the registry for SBDs.

Under the Bopz, the treating psychiatrist had to hand out a copy of the SBDs to the Healthcare Inspectorate. Under the Wvggz, the medical director (*geneesheer-directeur*) is responsible for handing out the copies. A change in relation to the recipients of the copy is that a copy of the SBD must now be sent to the public prosecutor rather than to the Healthcare Inspectorate. The rationale for this is probably that the public prosecutor plays a key role in the process for obtaining legal authorisation of compulsory care. It thus seems helpful when the SBD is filed at the office of the public prosecutor. As a consequence of this, however, there will no longer be a single registry where all SBDs are collected, and the Healthcare Inspectorate will no longer play an active role in evaluating whether compulsory care is provided in accordance with service users' SBDs.

3. Legal authorisation of compulsory care on the basis of an SBD

When discussing SBDs, philosophers often assume that compulsory care on the basis of an SBD can be initiated immediately once the circumstances described in the SBD obtain. This is not the case under Dutch law. Both the Bopz and the Wvggz make the provision of compulsory care on the basis of an SBD subject to legal authorisation (see Fig. 1).

There are notable differences between the Bopz and the Wvggz regarding the process for obtaining legal authorisation of compulsory care on the basis of an SBD. These differences are summarised in Table 2.

As is to be expected, both laws pronounce that compulsory care can be provided on the basis of an SBD only if the circumstances described in the SBD obtain. But this in itself is not sufficient for compulsory care, because additional material criteria must be satisfied for compulsory care on the basis of an SBD to be permissible.

There is a potential difference between the Bopz and the Wvggz in the role of the criterion of risk of harm to self or others. The Bopz explicitly stated that compulsory care can be provided in the

circumstances described in the SBD even if the service user poses no risk of harm to self or others. The reason for including this statement was probably that service users typically do not fulfil the criterion of risk to self or others at the moment at which they exhibit early warning signs. The statement thus aimed to facilitate early intervention in mental health crises in accordance with the wishes and preferences of service users.

A comparable statement cannot be found in the Wvggz. To the contrary, the new law states that SBDs must describe “the conditions under which compulsory care should be provided to the person concerned to avoid a serious disadvantage,” where the notion of serious disadvantage (*ernstig nadeel*) is glossed roughly as risk of harm to self or others (Art. 1:1 par. 2a-d). A potential explanation of this is that the statement in the Bopz was judged to be incompatible with the Wvggz's principles of proportionality and subsidiarity (see Art 2:1 par. 1–3 and Art 3:3a-c). The underlying argument could be that providing compulsory care when there is no risk of harm to self and others would be unnecessary and disproportional and hence alternatives on a voluntary basis must be sought in such cases. To the best of our knowledge, it is still an open legal question whether risk of harm to self or others is a necessary condition for compulsory care based on an SBD under the Wvggz. Since the range of risks that can constitute a serious disadvantage is rather broad (see Art 1:1 par. 2), this is unlikely to stand in the way of early intervention.

Neither law mentions lack of mental capacity as a necessary condition for compulsory care on the basis of an SBD. Although the wishes and preferences of service users who have mental capacity must in principle be honoured under the Wvggz (Art. 2:1 par. 6a), these wishes and preferences can be set aside when service users pose a risk of harm to self or others (Art. 2:1 par. 6b). In line with this, the Wvggz does not list lack of mental capacity among the necessary conditions for compulsory care in general (see Art. 3:3).

Suppose, however, that a person experiences a mental health crisis and the circumstances described in her SBD obtain. Suppose, furthermore, that the person refuses the care described in her SBD and has mental capacity in this respect. This is possible because a lack of mental capacity does not follow from the presence of a mental disorder or associated symptoms. In practice, it would not seem appropriate to enforce the SBD in such a case. After all, it would seem natural to interpret the capacious refusal of the care described in the SBD as a revocation of the SBD itself. To be sure, because mental capacity is essentially task-indexed, it is a conceptual possibility that the person has mental capacity with respect to the care decision at hand but not with respect to the revocation of her SBD. But it seems to us that conceptual analysis takes us a bit too far from reality here. The practical implication of the legal arrangement in the Wvggz thus seems to be that SBDs should not be enforced against the will of service users who have mental capacity with respect to the care decision at hand.

Turn, finally, to the procedure for obtaining legal authorisation for compulsory care on the basis of an SBD. A first change in this procedure is that persons appointed by service users in their SBD can no longer initiate an application for legal authorisation of compulsory care. Only the treating mental health professional or the medical director can do so. A further change is that, unlike the Bopz, the Wvggz specifies a maximum term within which the public prosecutor must submit the application to the judge. This term is set at 4 weeks. A final change is that the maximum term in which the judge must make a decision has been reduced from five days to three days. We will assess the consequences of this procedure in section 5.

4. The promise of self-binding directives

SBDs can be particularly helpful to service users with mental disorders that may entail what has been called “fluctuating capacity” (Gergel & Owen, 2015). Notable examples are bipolar and psychotic disorders. These mental disorders can involve longer periods in which people have

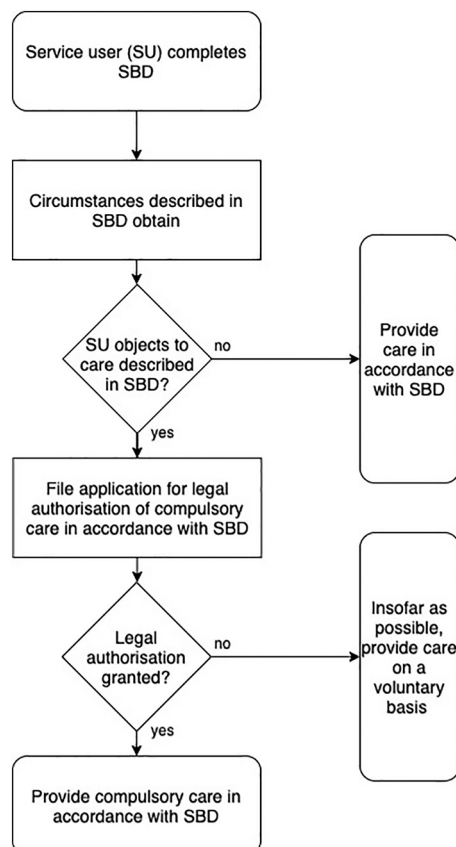


Fig. 1. Legal authorisation of compulsory care on the basis of an SBD.

mental capacity, followed by shorter episodes in which they lack mental capacity. Based on prior experience, service users may anticipate mental health crises in which they will refuse treatment while being unable to make a reasonable evaluation of their own interests. By completing an SBD at a time when they have mental capacity, service users can plan their treatment in advance and maintain control over their life and care (Scholten, Gieselmann, Gather, & Vollmann, 2019; Stephenson et al., 2020).

Numerous potential benefits of SBDs have been described in the literature. It has been argued that SBDs promote service user autonomy, make possible early intervention, promote service user wellbeing, reduce the duration compulsory care, improve the therapeutic relationship, reduce the burden on substitute decision-makers, and promote the integration of informal caregivers in the advance care planning process (Berghmans & van der Zanden, 2012; Bielby, 2014; Del Villar & Ryan, 2020; Gergel & Owen, 2015; Gremmen et al., 2008; Standing & Lawlor, 2019; Varekamp, 2004; Widdershoven & Berghmans, 2001; Widdershoven & Berghmans, 2007). Concerns have been raised as well. It has been argued that SBDs are paternalistic, lead to an increase of coercion, violate due process criteria, render service users susceptible to undue influence, preclude the possibility of changing one's mind, and contain invalid (because non-contemporaneous) consent (Dresser, 1981; Dresser, 1984; Winick, 1996). Going into this debate would go beyond the scope of this article, but it has been argued from a conceptual perspective that these concerns can be addressed successfully (Clausen, 2014; Gergel & Owen, 2015; Quante, 1999; Spellecy, 2003; Standing & Lawlor, 2019; Widdershoven & Berghmans, 2001). In our opinion, however, questions about the ethical opportunities and risks of SBDs cannot be answered fully by means of philosophical reflection on the concept of SBDs alone. This is because the ethical justifiability of SBDs depends strongly on the particularities of the accompanying legal arrangement.

We will illustrate this by focusing on a key benefit of SBDs, namely their potential to make possible early intervention in accordance with service users' wishes and preferences. Conceptually, SBDs hold the promise of reconciling early intervention with respect for autonomy. Compulsory care on the basis of an SBD first of all respects what is often called "precedent autonomy" (Dworkin, 1994). SBDs furthermore promote the autonomy of service users by giving them the opportunity to describe the circumstances in which compulsory care should be initiated, the types of compulsory care they would prefer, the maximum duration of compulsory care, and the circumstances under which compulsory care should be ended. Given that SBDs contain an expressed preference for compulsory care in defined circumstances, it would seem permissible to bypass some of the time-intensive procedures for standard compulsory care in order to facilitate the provision of timely care in accordance with service users' preferences. As we will demonstrate now, however, the Wvvgg hinders timely intervention in mental health crises due to long bureaucratic procedures.

5. Positive and problematic aspects of the current legal arrangement

Before turning to the problematic aspects of the current legal arrangement, let us first discuss two features of the Wvvgg which strengthen the position of service users and facilitate the implementation of SBDs. The first positive aspect is the basic principle of the law that the wishes and preferences of service users must be documented and honoured as far as possible in the preparation, execution and termination of compulsory care (Art. 2:1 par. 5–6). The Wvvgg translates this basic principle into several concrete measures. One of these is the so-called "care card" (*zorgkaart*). The care card is an optional document in which service users can describe their wishes and preferences with regard to compulsory care in consultation with the treating mental health professional and the service user's representative (Art. 5:12). Furthermore, the care plan (*zorgplan*) should describe the way in which

the preferences of the service user are taken into account (Art. 5:14 par. 1d). Finally, after an application for compulsory care has been submitted, service users should be given the opportunity to propose their own approach to preventing mental health crises (*plan van aanpak*) in consultation with family and close ones (Art. 5:5). We think that these documents provide an excellent occasion and starting point for service users to write an SBD.

The second positive aspect is the basic principle that family members and close ones must be involved in the process of compulsory care to give advice and support (Art. 2:1 par. 7). This basic principle is translated into the requirement that the views of family members and close ones be described in the care plan (Art. 5:14 par. 1e; Art. 5:13 par. 4). Since family members and close ones may exert undue influence on service users (Scholten & Gather, 2018), the Wvvgg creates the role of a so-called "person of trust for the family" (*familie-vertrouwens-persoon*) to minimise this risk. The task of this person is not only to inform, advise and support service users and their informal caregivers, but also to mediate in potential conflicts between service users, informal caregivers and care providers (Art. 12:1 par. 1–2). The stronger involvement of family members and close ones facilitates the implementation of SBDs because these persons typically play a key role in signalling early warning signs.

As we will show now, the current legal arrangement for SBDs in the Wvvgg hinders the timely provision of compulsory care on the basis of an SBD due to long bureaucratic procedures. The source of the problem is that the Wvvgg makes the provision of compulsory care based on an SBD subject to legal authorisation in the form of a care authorisation, the standard legal basis for non-urgent compulsory care outside of crisis and emergency situations.

Care authorisations in general are subject to an extremely complex procedure in which many people are involved. These include the treating mental health professional, the medical director, an independent mental health professional, a lawyer, the public prosecutor and the judge. People in these professional roles typically have lots of other responsibilities. The time frame for obtaining a care authorisation will thus typically be long and the coordination of all the steps in the administrative process will be challenging. The treating mental health professional and the medical director should prepare an application for a care authorisation and send it to the office of the public prosecutor. The public prosecutor should assess whether the criteria for compulsory care are met and file a request for a care authorisation to the judge within 4 weeks (Art. 5:16 par. 1 and Art. 5:17 par. 1). The judge should grant or reject the care authorisation within 3 weeks (Art. 6:2 par. 1a).

The law provides for an expedited procedure for granting a care authorisation of compulsory care on the basis of an SBD by reducing the maximum term for the judge's verdict from 3 weeks for standard care authorisations to 3 working days for care authorisations on the basis of an SBD (Art. 6:2 par. 1d). Yet the time frame within which the public prosecutor must send the request to the judge remains 4 weeks. The availability of an SBD is unlikely to save time here. The reason is that the public prosecutor must submit to the judge, besides the SBD (Art. 5:17 par. 5), all the documents required for a standard care authorisation (Art. 5:17 par. 3). Though in practice the time frame can sometimes be shorter, the legally specified maximum term for intervention based on an SBD is all in all 4 weeks and 3 working days.

The long procedure stands in the way of timely intervention and will likely render SBDs ineffective in practice. The reason is that decompensation typically occurs within a few days in bipolar and psychotic disorders. Service users will thus typically show the types of behaviour they intended to prevent by completing an SBD long before legal authorisation of compulsory care is obtained (see Fig. 2). The long procedure for obtaining legal authorisation thus makes timely intervention based on an SBD very hard, if not impossible.

It is unlikely, however, that mental health services and the authorities will refrain from intervening in such cases. In practice, compulsory care is likely to be initiated based on a "crisis measure" (*crisismaatregel*).

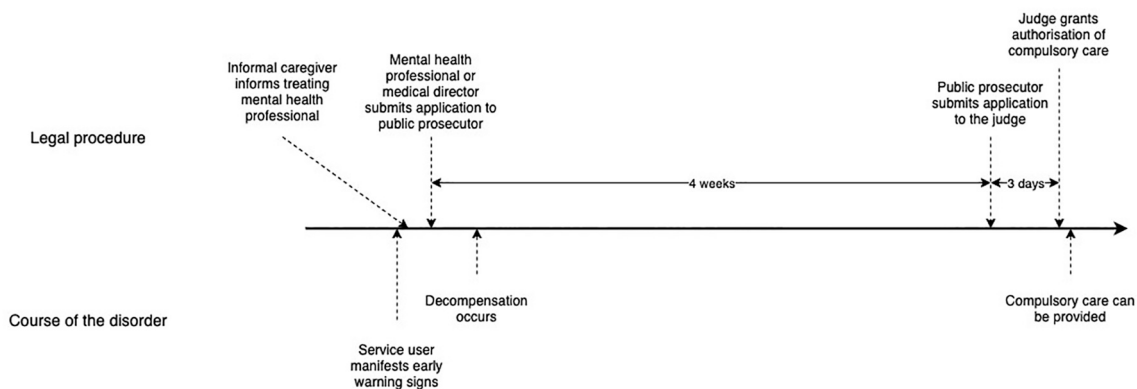


Fig. 2. Time frame for obtaining legal authorisation of compulsory care.

A crisis measure is a measure for maintaining public order, which can be taken by the mayor in consultation with a psychiatrist. Crisis measures are not subject to legal authorisation (Art. 7:1) and they are valid for a maximum of three days (Art. 7:4). They can be extended by another three weeks (Art. 7:9) upon authorisation by the judge (Art. 7:8). Importantly, SBDs play no role in the articles delineating the criteria for taking a crisis measure. This implies that the mayor is under no legal obligation to honour an SBD when arranging compulsory care on the basis of a crisis measure. Consequently, there is a high likelihood that SBDs will not be considered.

In sum, under the Wvvggz there is no legally designated way in which SBDs can make possible timely intervention in mental health crises in accordance with service users' wishes and preferences. As a consequence of this, the uptake of SBDs will expectedly remain low.

6. A proposal for legal reform

How should the law be amended for SBDs to be able to fulfil their promise? It is essential that the procedure for legal authorisation of compulsory care on the basis of an SBD be simplified and shortened. But the question is how. First consider a proposal that we do not endorse. Someone might suggest that compulsory care on the basis of an SBD could be made subject to authorisation in the form of a crisis measure rather than a care authorisation. This would enable mental health professionals to bypass the long procedure for obtaining a care authorisation, and hence the time frame within which compulsory care on the basis of an SBD can be provided would be drastically shortened. We reject this proposal, however, because connecting SBDs to approval in the form of a crisis measure has important practical and ethical downsides.

A practical downside of the proposal is that the aim of a crisis measure is at least in part maintaining public order. This is evident from the key role played by the mayor in the application of crisis measures. Crisis measures are not tailored to the specific needs of service users, and the mayor will often not even be aware of the fact that a service user has an SBD. An ethical downside of the proposal is that crisis measures are not subject to legal authorisation – that is, unless they are extended beyond the first three days (Art. 7:4 and 7:7). This is problematic because it would seem that involuntary hospitalisation remains a deprivation of liberty even in the case where service users expressed a preference for compulsory admission in their SBD. Moreover, SBDs can be used to specify a lower threshold for compulsory care to facilitate tailored care. There are thus good reasons to make compulsory care based on an SBD subject to legal authorisation.

We therefore recommend that a special mechanism for legal authorisation of compulsory care on the basis of an SBD be created. The

outlines of the proposed mechanism are as follows. Service users should appoint in their SBD a close one who knows their values and preferences and who is in the position to observe early warning signs. This appointed person should also be involved in the drafting process to support the service user. An application for compulsory care on the basis of an SBD can be initiated jointly by the treating mental health professional and the appointed person. An on-call legal service, available seven days a week from 9 am to 9 pm, will ensure that a judge will come to see and hear the service user within 24 h. If possible, this should take place in the community and otherwise at the admission ward. The judge authorises compulsory care as defined in the SBD if and only if the conditions specified in the SBD and the other conditions are fulfilled. The patient representative or confidential advisor should be involved in the process as far as possible to make sure that the perspective of the service user is sufficiently taken into account.

Some may think that our proposal is infeasible. One could, for example, raise the concern that obtaining legal authorisation within 24 h is infeasible within the current legal system. Our reply is that if obtaining legal authorisation within 24 h is infeasible within the current legal system, then that system should change. It is encouraging that in Germany it is standard practice for all types of compulsory care that legal authorisation is granted or refused within 24 h. We think that the current Dutch system is sufficiently flexible to accommodate the proposed changes on the premise that sufficient resources are made available. Here, it should be noted that the current procedures for arranging compulsory care are costly as well. Whether SBDs can be made to work and whether mental health service users' autonomy will be respected is in part a matter of political choice and priority setting.

Someone might raise the further concern that it would be a disproportionate investment to set up a special on-call legal service for the few SBDs that have been completed thus far. Our first reply is that the uptake of SBDs might increase significantly once a workable legal arrangement is in place. More importantly, we would suggest that the scope of responsibility of the proposed on-call legal service can be broadened. In particular, we think that the legal service can play a useful role in the authorisation of crisis measures. As mentioned earlier, crisis measures are not subject to legal authorisation for the first three days. The Wvvggz currently provides checks and balances for crisis measures by imposing upon the mayor the legal obligation to ensure that service users have the opportunity to be heard before the measure is taken (Art. 7:1 par. 3b). It is reported, however, that mayors usually defer the judgment about the appropriateness of compulsory care to psychiatrists (Belt, n.d.). In some cases, they even delegate the responsibility for the hearings to commercial call centres with underqualified staff (Koopman & Spijkerman, 2020). This means that the current control mechanism for crisis measures is of poor quality. Timely decisions on the authorisation of crisis

measures by the proposed legal service could thus have the additional advantage of providing better checks and balances for crisis measures.

In the event that setting up the proposed on-call legal service proves infeasible, we suggest as a fallback that legal review be organised retrospectively, at the latest three days after compulsory care on the basis of an SBD was initiated. Although this is certainly not our preferred option, its feasibility is ensured given that this type of legal review is standard practice under the Wvvgg for the extension of crisis measures beyond three days.

The proposed expedited procedure for obtaining legal authorisation of compulsory care on the basis of an SBD will likely make completing an SBD more attractive to service users. Admittedly, it will leave other barriers to the completion of SBDs untouched. But there is hope. A UK-based survey study among persons with bipolar disorder showed that 69% of respondents were in favour of including a self-binding clause in their psychiatric advance directive (Hindley et al., 2019). Furthermore, a US-based study showed that the uptake of psychiatric advance directives increases radically if support is offered during the completion process (Swanson et al., 2006). There is no reason to think that this would not apply to SBDs in the Netherlands. We therefore encourage mental health professionals to inform service users about SBDs and to support them during the completion process.

7. Conclusion

SBDs have the potential to make possible timely intervention in mental health crises in accordance with service users' wishes and preferences. For SBDs to be able to fulfil this promise, the procedure for obtaining legal authorisation for compulsory care on the basis of an SBD must be simplified and shortened. Service users must also be supported in completing SBDs. We have proposed a novel mechanism for legal authorisation which facilitates timely intervention in accordance with service users' wishes and preferences. Further empirical research is necessary to identify and remove barriers to SBD completion, monitor completion rates and identify opportunities and challenges of SBDs. Based on the results of this research and the upcoming evaluation of the Wvvgg, the proposed legal arrangement can be worked out in more detail.

Author contributions

All authors made substantial contributions to the conception and design of the work. MS and LvM reviewed the legal provisions for SBDs in the two laws and worked out the outlines of the arguments. MS prepared the various drafts of the abstract, sections 1, 4, 5, 6 and 7 as well as Figs. 1 and 2. LvM prepared the first draft of sections 2 and 3 and Tables 1 and 2, and MS prepared the further drafts of these sections and tables. LvM and GW revised the various drafts critically for important intellectual content. All authors agree with the article's arguments and conclusions and gave approval for the final version to be published.

Funding

Matthé Scholten and Laura van Melle received funding from the German Federal Ministry of Education and Research (SALUS, grant number 01GP1792).

Acknowledgements

We would like to thank Jakov Gather, Johan Legemaate and the anonymous reviewers for their helpful comments on earlier drafts of this article. The views expressed in this article remain our own.

References

- Atkinson, J. M. (2007). *Advance directives in mental health*. London: Kingsley.
- Bell, K. (2015). Thwarting the diseased will: Ulysses contracts, the self and addiction. *Culture, Medicine and Psychiatry*, 39(3), 380–398.
- Belt, J. (2018, December 10). Burgemeester is zeker geen psychiater. *Algemeen Dagblad*, 2.
- Berghmans, R., & van der Zanden, M. (2012). Choosing to limit choice: Self-binding directives in Dutch mental health care. *International Journal of Law and Psychiatry*, 35(1), 11–18.
- Bielby, P. (2014). Ulysses arrangements in psychiatric treatment: Towards proposals for their use based on "sharing" legal capacity. *Health Care Analysis*, 22(2), 114–142.
- Clausen, J. A. (2014). Making the case for a model mental health advance directive statute. *Yale Journal of Health Policy, Law, and Ethics*, 14(1), 1–65.
- Davis, J. K. (2008). How to justify enforcing a Ulysses contract when Ulysses is competent to refuse. *Kennedy Institute of Ethics Journal*, 18(1), 87–106.
- Del Villar, K., & Ryan, C. J. (2020). Self-binding directives for mental health treatment: when advance consent is not effective consent. *Medical Journal of Australia*, 212(5), 208–11.e1.
- Dresser, R. S. (1981). Ulysses and the psychiatrists: A legal and policy analysis of the voluntary commitment contract. *Harv C R C L L Rev.*, 16, 777–854.
- Dresser, R. (1984). Bound to treatment: The Ulysses contract. *The Hastings Center Report*, 14(3), 13–16.
- Dworkin, R. (1994). *Life's dominion*. New York: Vintage Books. XIII, 272 S.
- Eftting, M. (2019, November 12). Psychiaters: nieuwe wet is bureaucratisch monster. *De Volkskrant*.
- Eerste Kamer der Staten Generaal. (2020). *Verbetering uitvoerbaarheid Wet verplichte geestelijke gezondheidszorg en de Wet zorg en dwang*, 35.456. Retrieved 9 October from https://www.eerstekamer.nl/wetsvoorstel/35456.verbetering_uitvoerbaarheid.
- Gergel, T., & Owen, G. S. (2015). Fluctuating capacity and advance decision-making in bipolar affective disorder - self-binding directives and self-determination. *International Journal of Law and Psychiatry*, 40, 92–101.
- Gremmen, I., Widdershoven, G., Beekman, A., Zuijderhoudt, R., & Sevenhuijsen, S. (2008). Ulysses arrangements in psychiatry: A matter of good care? *Journal of Medical Ethics*, 34(2), 77–80.
- Henderson, C., Swanson, J. W., Szmukler, G., Thornicroft, G., & Zinkler, M. (2008). A typology of advance statements in mental health care. *Psychiatric Services*, 59(1), 63–71.
- Hindley, G., Stephenson, L. A., Ruck Keene, A., Rifkin, L., Gergel, T., & Owen, G. (2019). Why have I not been told about this? *Wellcome Open Research*, 4(16).
- Kane, N. B. (2017). Ulysses in the United Kingdom: Difficulties with a capacity-based justification for self-binding in bipolar disorder. *Journal of Evaluation in Clinical Practice*, 23(5), 1038–1044.
- Koopman, E., & Spijkerman, K. (2020). De mens verdwijnt uit beeld. *De Groene Amsterdammer*. https://www.groene.nl/artikel/de-mens-verdwijnt-uit-beeld?utm_source=De+Groene+Amsterdammer&utm_campaign=f98a0308a3-Dagelijks-2020-07-23&utm_medium=email&utm_term=0_853cea572a-f98a0308a3-72743041.
- Meurs, P. (2019, November 27). De Wet verplichte geestelijke gezondheidszorg lijkt al voor invoering een procedureel mijnenveld. *Het Financieel Dagblad*. woensdag;Sect. EXPERT; Blz. (col. 920 words).
- Ministerie van Volksgezondheid, Welzijn en Sport. (2020). *Spoedreparatiewetsvoorstel Wvvgg en Wzd*. Retrieved 19 August from <https://www.dwanginzorg.nl/actueel/nieuws/2020/03/17/reparatiewet>.
- Quante, M. (1999). Precedent autonomy and personal identity. *Kennedy Institute of Ethics Journal*, 9(4), 365–381.
- Raphael, A. J. (2020). Fluctuating capacity and the strategic role of self-binding directives in preserving autonomy. *Journal of Medical Law and Ethics*, 8(1), 15–31.
- Reparatiewet Wvvgg en WZD. (2020). Retrieved 19 August from <https://www.interneconsultatie.nl/reparatiewetwvvggzwd>.
- Sarin, A. (2012). On psychiatric wills and the Ulysses clause: The advance directive in psychiatry. *Indian Journal of Psychiatry*, 54(3), 206–207.
- Scholten, M. (2020, February 7). Nieuwe ggz-wet tast privésfeer van patiënten ernstig aan. *NRC Handelsblad*, 18. <https://www.nrc.nl/nieuws/2020/02/06/nieuwe-ggz-wet-tast-privésfeer-van-patiënten-ernstig-aan-a3989594>.
- Scholten, M., & Gather, J. (2018). Adverse consequences of article 12 of the UN convention on the rights of persons with disabilities for persons with mental disabilities and an alternative way forward. *Journal of Medical Ethics*, 44(4), 226–233. <https://doi.org/10.1136/medethics-2017-104414>.
- Scholten, M., Gieselmann, A., Gather, J., & Vollmann, J. (2019). Psychiatric advance directives under the convention on the rights of persons with disabilities: why advance instructions should be able to override current preferences. *Frontiers in Psychiatry*, 10(631). <https://doi.org/10.3389/fpsy.2019.00631>.
- Scholten, M., Gather, J., & Vollmann, J. (2021). Equality in the informed consent process: Competence to consent, substitute decision-making, and discrimination of persons with mental disorders. *The Journal of Medicine and Philosophy*, 46(1), 108–136. <https://doi.org/10.1093/jmp/jhaa030>.
- Shields, L. S., Pathare, S., van der Ham, A. J., & Bunders, J. (2014). A review of barriers to using psychiatric advance directives in clinical practice. *Administration and Policy in Mental Health*, 41(6), 753–766.
- Spellecy, R. (2003). Reviving Ulysses contracts. *Kennedy Institute of Ethics Journal*, 13(4), 373–392.

- Standing, H., & Lawlor, R. (2019). Ulysses Contracts in psychiatric care: helping patients to protect themselves from spiralling. *Journal of Medical Ethics*, 45(11), 693–699.
- Stephenson, L. A., Gergel, T., Gieselmann, A., Scholten, M., Keene, A. R., Rifkin, L., & Owen, G. (2020). Advance Decision Making in Bipolar: A Systematic Review. *Frontiers in psychiatry*, 11(1020). <https://doi.org/10.3389/fpsy.2020.538107>.
- Swanson, J. W., Swartz, M. S., Elbogen, E. B., van Dorn, R. A., Ferron, J., Wagner, H. R., et al. (2006). Facilitated psychiatric advance directives: A randomized trial of an intervention to foster advance treatment planning among persons with severe mental illness. *The American Journal of Psychiatry*, 163(11), 1943–1951.
- Varekamp, I. (2004). Ulysses directives in the Netherlands: Opinions of psychiatrists and clients. *Health Policy*, 70(3), 291–301.
- Walker, T. (2012). Ulysses contracts in medicine. *Law and Philosophy*, 31(1), 77–98.
- Widdershoven, G., & Berghmans, R. (2001). Advance directives in psychiatric care: A narrative approach. *Journal of Medical Ethics*, 27(2), 92–97.
- Widdershoven, G., & Berghmans, R. (2007). Coercion and pressure in psychiatry; lessons from Ulysses. *Journal of Medical Ethics*, 33(10), 560–563.
- Winick, B. (1996). Advance directive instruments for those with mental illness. *University of Miami law review*, 51(1), 57–95.