

Dementia in Europe Yearbook 2011



with a focus on restrictions of freedom

Including the Alzheimer Europe Annual Report 2010

The Dementia in Europe Yearbook 2011 arises from the 2011 Work Plan of Alzheimer Europe, which has received funding from the European Union, in the framework of the Health Programme.

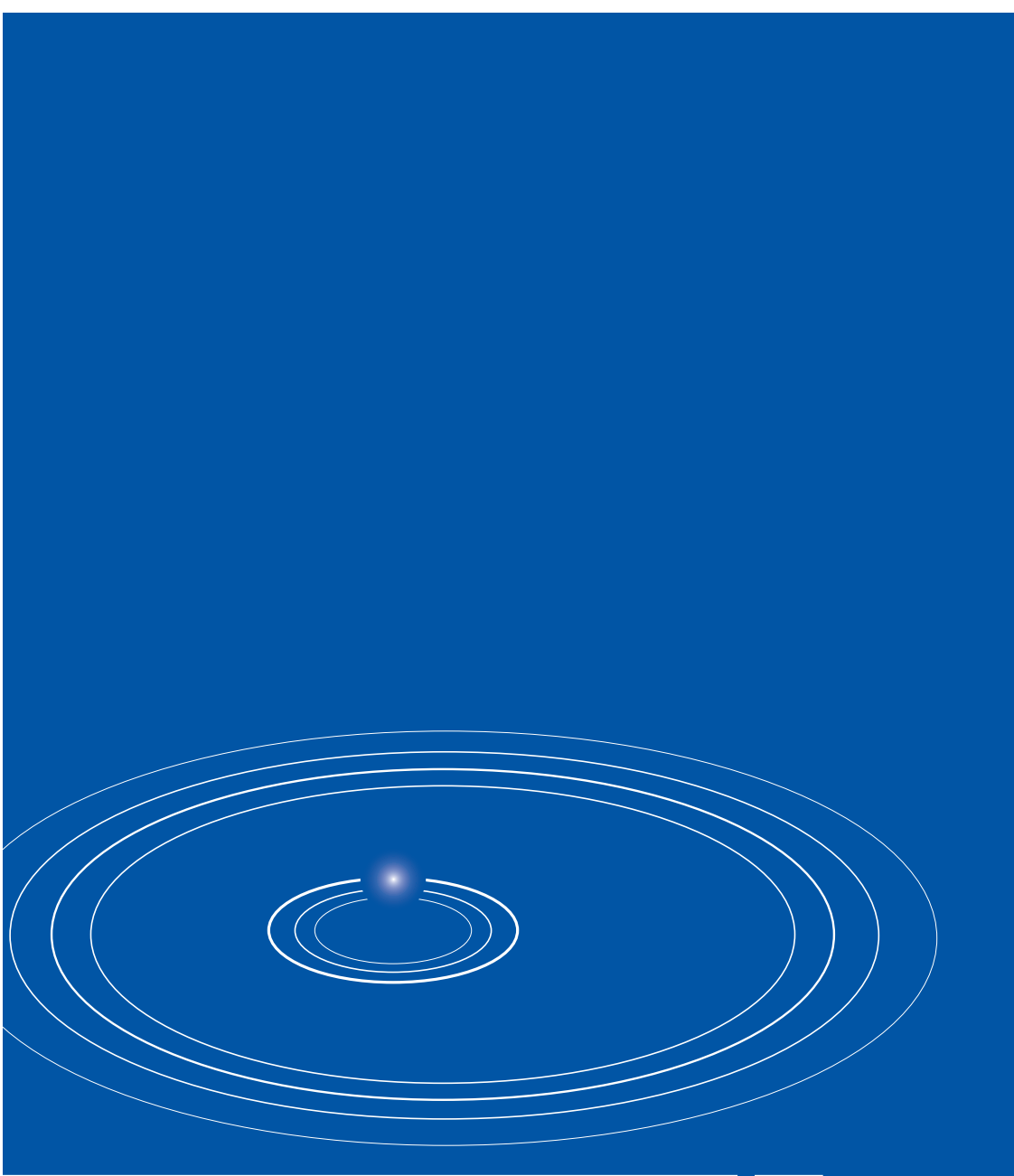
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Alzheimer Europe gratefully acknowledges the support it has received from Fondation Médéric Alzheimer for its project on restrictions of freedom and for the publication of this Yearbook.

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Introduction



It gives me great pleasure to present the Dementia in Europe Yearbook 2011. In addition to the Annual Report of Alzheimer Europe for 2010, it contains our work on the legal provisions relating to the restriction of the freedom of movement of people with dementia. The main topics addressed are involuntary internment, the use of coercive measures and restrictions relating to driving licences.

Involuntary internment is the term used to describe the situation whereby a person is obliged by law to reside in some form of institution. Usually, the grounds for this restriction of liberty are that the person has a mental disorder and is considered as a danger to him/herself or others. National laws are often ill-suited to the needs of people with dementia. In some countries, it only concerns internment in a psychiatric institution or ward which is not the ideal place to provide appropriate care and support for people with dementia.

The term “coercive measures” denotes methods that are used to restrain a person which involve restraint, force or threat. Examples would include bed rails, chair and bed belts, threatening behaviour or words, various electronic devices and the use of tranquilisers. Sometimes, coercive measures can be quite subtle such as forcing people to wear sleeping attire thereby making many people feel unable to leave the building. The use of coercive measures can sometimes be justified (e.g. to prevent a person from harming him/herself or others, or to enable medical staff to administer necessary medication or treatment). However, these measures infringe on people’s personal liberty which is a fundamental human right. Consequently, their use must be closely monitored. In the case of people with dementia, many of whom are older and frail, many forms of coercion are increasingly considered as abusive and to be avoided if at all possible. There is even evidence that the use of certain forms of restraint can increase the likelihood of falls or harm.

The withdrawal of one’s driving licence (or limitations on its use) is also perceived as a restriction of freedom of movement by many people with dementia. No longer having the opportunity to drive often entails a gradual restriction of one’s activities and social contacts. In the sections on driving, we look at the legal regulations and processes governing the renewal and withdrawal of driving licences.

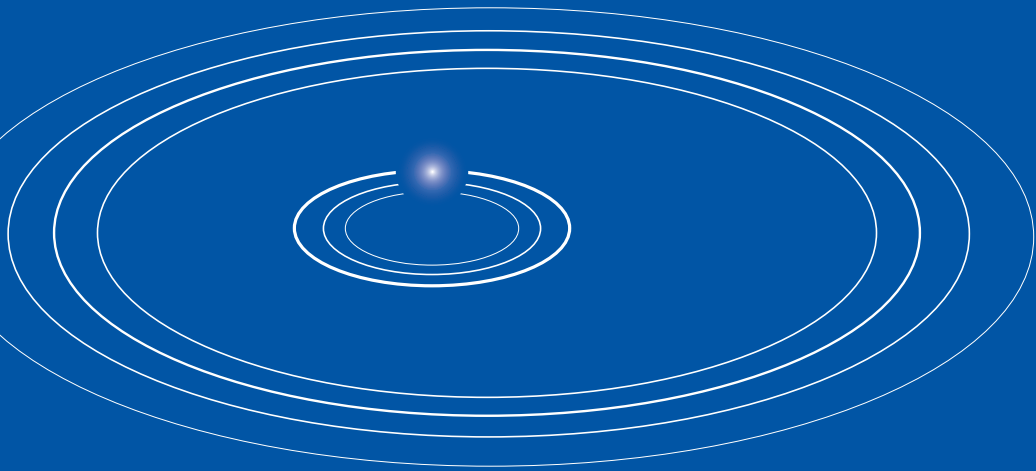
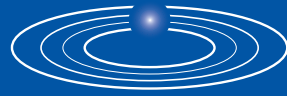
Dedicated lawyers and legal experts throughout Europe contributed their expertise and time to the drafting of a separate report for each country. This made it possible to publish a report on the legal issues relating to the restriction of liberty of people with dementia in 32 different countries. We would like to thank all the lawyers and legal experts for their work and for making this possible. You will find a list of all those who helped in this way and to whom we are deeply grateful at the end of this report in section 3. I would also like to thank Dianne Gove, Information Officer of Alzheimer Europe, for having prepared the reports for the countries in which we had no legal expert and for organising the compilation of this year’s Lawnet report.

We have made every possible effort to ensure that the information in this report is accurate. However, amendments and new laws are continuously being passed and existing laws repealed. We would therefore be pleased to be informed of any relevant developments in the period following publication of this report.

We hope that this publication will be of interest to policy makers, researchers, people with dementia and anyone with an interest in the legal protection and rights of people with dementia. An overview and comparison of the legal provisions in different countries may be helpful in highlighting areas where the rights and protection of people with dementia are lacking or inadequate, or on the contrary, countries in which the legal provisions provide an appropriate response to the protection and rights of people with dementia.

Jean Georges
Executive Director
Alzheimer Europe





National Reports

3.1 *Austria*

3.1.1 Involuntary internment

3.1.1.1 Internment in Psychiatric Hospitals or Wards

Under the 155th Federal Law of 1 March 1990 on the Internment of Mentally Ill Patients in Hospitals/clinics (Internment Law)¹, a person who is suffering from a mental illness can be involuntarily interned in a psychiatric hospital, clinic or psychiatric ward if s/he presents a serious and considerable risk to his/her own life or health or that of other people. Another provision for internment is that a person cannot be medically treated or cared for in any other way, particularly outside of an institution. In legal terms “internment” includes the holding of a person in a closed area or subjecting the person to any other form of restriction of movement. A closed area includes a ward where the exit is locked, but also any ward where a person has to ask for permission and to be helped by another person such as a nurse to leave.

3.1.1.2 Voluntary and involuntary internment

Internment can take place with or without the consent of the person concerned. A personal request for internment can only be accepted if the person is able to understand the reason for and significance of internment and can determine his/her will on the basis of this understanding. The request must be in writing and be made in person before admission.

A person can be interned against his/her will if a doctor in the public health service or a police doctor examines the person and certifies that the conditions for internment have been fulfilled. In practice, a hospital specialist re-examines whether the conditions for internment have been fulfilled. The justification for internment must be given in the certificate. At the request of the patient, of his/her legal representative (e.g. patient advocate or guardian) or the attending doctor a further specialist (i.e. psychiatrist) must issue a certificate to confirm that the requirements for internment have been met. Only when both medical certificates make the same statement may the internment be pursued.

Public security services agents can bring a person before a doctor for examination if they feel that internment would be justified. In case of emergency, the person can be interned without prior examination and certification. This can be done on arrival and duly recorded. As soon as a person has been involuntarily interned, the ward manager must notify the Court immediately and provide copies of the relevant medical reports.

3.1.1.3 The procedure for internment

Although doctors are responsible for the decision to intern a person in a psychiatric institution, judges are responsible for determining in the course of the court proceedings whether or not the decision was legal. The regulations governing the proceedings are as follows:

¹ Federal Law Gazette 1990/155 in the version FLG 2010/18 = BGBl 1990/155 idF (in der Fassung) BGBl I 2010/18

Within a period of four days a district court judge must hear the patient in person and review the admissibility of internment for the first time. If the internment requirements are met (i.e. mental illness, danger to oneself or others, no other treatment available), admissibility of internment is declared. Fourteen days later a further court review is held. The court summons experts (at least one psychiatrist who is not affiliated with the hospital) who examine the patient and draw up an assessment. In addition, the patient, the patient's advocate, the medical head of the ward and in some instances family members are interviewed. On the basis of the information obtained, the court again decides whether the internment requirements have been met and whether internment is admissible or not. If the mentally ill patient has to stay in a psychiatric institution, the decision is reviewed in court after 3 months, then after half a year and again after one year. The patient's advocate has to be informed about all procedural steps and all parties have the right to appeal against the court decision.

3.1.1.4 Patient advisors

The first paragraph of the Internment Law states that the rights of mentally ill patients who have been admitted to a hospital/clinic must be especially protected. It is further stated that the human dignity of mentally ill patients must be observed and maintained in all circumstances. The Federal Law of Organised Guardians, Patients' Advocates, Residential Advocacy [BGBl I 2006/92] is designed to provide the means to protect these rights and the dignity of people who are involuntarily interned.

The patient is represented by the association that is in charge of naming patient advocates. This association is supposed to name patient advocates that it has trained to the responsible court and the responsible psychiatric ward. These patient advocates have been granted the power of representation. The ward manager must inform this person of the identity of the patient's advocate and provide him/her with the opportunity to meet the latter. A person who has been voluntarily interned can also request a patient's advocate.

The patient's advocate must inform the person of intended actions to be taken on his/her behalf and of any other important matters or measures. S/he should also comply with the person's wishes if this would not be detrimental to his/her wellbeing and if it would be reasonable to expect this.

Apart from this mandatory representation each patient also has the possibility of availing him/herself of general patient representation:

Paragraph 11e of the Federal Hospital Establishment Law (KAKuG) of 1957 and subsequent amendments stipulates that the legislation of each "Land" must,

"lay down that independent bodies representing patients shall be available to examine any complaints and on request to look after the interests of patients (patients' spokesmen, ombudsman institutions or similar representation)".

3.1.1.5 Internment in Residential Homes and General Hospitals

Many mentally ill and mentally handicapped people, who lived in nursing homes or similar institutions, where there was no legal basis for using coercion, nevertheless suffered restrictions of freedom of movement or other coercive measures as part of the daily routine in most of these institutions. As a consequence, on 1 July 2005 a new law came into force, the Residential Stay Law (Heimaufenthaltsgesetz²). The new law has two central objectives: The protection of residents in nursing homes or other institutions for handicapped persons against restrictions of free movement as well as the support of staff in these institutions when faced with difficult decisions for or against such restrictive measures by providing them with straightforward legal provisions. This law also pertains to restrictive measures that may be taken in outpatient facilities (day clinics or day care facilities, vocational therapy and workshops for people with mental disabilities).

3.1.1.6 Residential Advocacy in Austria

To secure the implementation of the law a new profession has been created, that of residential advocates. Currently, 53 such residential advocates work within the framework of the associations for Guardianship. Their representation encompasses 1,880 homes with 132,151 residential places (31.12.2009). The residential advocates are social workers, professional nurses, but also psychologists, special pedagogues or lawyers. Within the association they underwent special training and have ongoing continuing education. To make the best use of their various professional backgrounds they work together in multi-professional teams. They represent people whose freedom of movement has been restricted. All measures restricting a person's freedom of movement have to be brought to the attention of the residential advocate. The residential advocate has to follow up this information, visit the residents in the homes and engage in talks. If they consider it necessary they can call in the court to review whether the measure taken is appropriate.

In addition to representing the rights of residents, the residential advocates attempt to engage in close cooperation with the staff of residential homes. In this way, they can serve as focus for the exchange of experience between institutions. In cooperation between residents and all other persons concerned, residential advocates aim at finding alternative solutions to prevent restrictions of free movement.

3.1.1.7 Admission into a care establishment or home

No one likes to leave their previous home for a care facility. Those affected often react with depression and confusion when they have to yield to their relatives' pressure or that of doctors and care personnel and express their consent to being admitted to a care home. The provisions of the Law on Guardianship, which have been in force since 2007, also stipulate in §284a of the General Civil Code that an individual or guardian be appointed and that the person affected decides about his/her residence as long as s/he is capable of understanding and making judgements. This means that an individual must be capable of assessing his/her own life situation independent from an existing guardianship measure (e.g. how much care s/he needs and whether there are sufficient finan-

2 Federal Law Gazette 1 2004/11 in the version of FLG 1 2010/18=BGBL I 2004/11 idF BGBl I 2010/18

cial and personal resources available). Usually, people in need of assistance also require care in a home and their will is thus “diminished”. Apart from these practical requirements that also exist for mentally healthy people, a guardian can decide on the place of residence (and thus also about admission into a care home) if for psychological reasons a person is not (or no longer) capable of assessing the pros and cons of the matter. The guardian’s decision requires preliminary approval from the responsible guardianship court if the proposed change of place of residence is to be permanent. If, however, the person affected still refuses to leave his/her home and if there is also a danger (as defined by the law on involuntary internment), this person may be brought by force to a psychiatric ward but not to a care facility (see 3.1.1.1). Often it is necessary to spend a long time dealing with the affected person’s case. These long periods of time may, however, as the legislator has stated in the amended law on guardianship, also be of great therapeutic importance as otherwise the legitimacy of coercive measures might result in less effort being made to try to persuade someone to accept the proposed measure.³

3.1.1.8 Search to find a missing person

According to § 24 (3) of the Law on Security Police, the security authorities are responsible for carrying out a search for a person who is unable to help him/herself or if s/he constitutes a serious and considerable risk to the life and health of others due to a mental handicap. According to Margarete Blaha⁴, the existence of a mental handicap must be substantiated, e.g. by proof that the person is subject to trusteeship or by a medical certificate. Although mental handicap is specified in § 24 (3) equal importance is given to the inability to help oneself and the possibility of risk. Consequently, it applies to people with dementia.

3.1.2 Coercive measures

3.1.2.1 Restriction of personal liberty

Unlawfully depriving a person of his/her freedom or restricting his/her personal freedom in any way constitutes a crime according to § 99 of the Penal Code. The prison sentence can be for up to three years. If, however, the deprivation of freedom lasts for longer than one month, if it is carried out in such a way as to entail particular suffering or in conditions which could be linked to extreme suffering, the prison sentence can be from one to ten years.

The Internment Law⁵ also addresses the issue of restriction of freedom or movement in any way. Paragraph 32 states that the nature, extent and duration of the restrictive measure (including medication and care) must be proportionate to the need and is in any case only permissible insofar as it is necessary to prevent danger to the life or health of the person restrained or to another person. A person should not be confined to one

³ Regierungsvorlage zum Sachwalterrechts-Änderungsgesetz 2006 1420 BlgNR XXII GP.

⁴ Information provided in connection with the Lawnet conference on 11 May 1999

⁵ 155th Federal Law of 1 March 1990 on the Internment of Mentally Ill Patients in Psychiatric Hospitals, Federal Law Gazette 1 2004/11 in the version of FLG 1 2010/18=BGBI 1990/155 idF BGBI I 2010/18

room. Without special notification of the patient advocate, s/he can only be restricted to several rooms or to particular spatial areas.

More drastic measures such as restricting the freedom of movement to one room or within a room must be specially ordered by the treating doctor, recorded along with reasons and notified immediately to the patient's representative. Restriction of movement within a room includes confining a person to a safety bed, to a straightjacket, fastening or tying a person to a chair or bed and/or administering strong sedatives to prevent a person from moving about. Such measures can only be used as a last resort. In all cases, both the patient's advocate and the person concerned are entitled to take legal action in order to review a restrictive measure.

According to the Residential Stay Law, in nursing homes and similar institutions, all measures of which involve restricting people in their free movement have to be brought to the attention of the residential advocate, who is entitled to take legal action to review all restrictive measures⁶.

3.1.3 Mistreatment/abuse

If a doctor suspects that someone's actions have brought about the death of another or caused grievous bodily harm or if a person who is incapable of looking after his/her interests is mistreated, tortured, abandoned or sexually abused, s/he is obliged to communicate this to whoever is personally affected or to the relevant authorities (§ 54 (4) of the Physicians Law of 1998). In the case of abuse, neglect, torture or abuse of a legally incompetent adult, the doctor should also report his/her findings to the Court. This obligation does not conflict with the doctor's duty to maintain professional secrecy, provided that the potential benefit to the patient in reporting the facts outweighs that of maintaining secrecy. This obligation to make a report also applies if the perpetrator of the abuse is another doctor.

Paragraph 83 of the Penal Code states that it is an offence to cause bodily injury or to damage a person's health, even if this occurs as a result of negligence. Damage to a person's health or injury caused by neglect and as a result of mistreatment would be equally punishable.

The Second Protection against Violence Act of 2009 has a section on persistent perpetration of violence (Paragraph 107b of the Penal Code concerning continued use of violence) which results in the examination of acts of violence in their entirety over a prolonged period of time (rather than in terms of each isolated act) and also covers various forms of maltreatment not resulting in bodily injury such as slaps in the face (United Division for the Advancement of Women, 2011).

⁶ Residential Stay Law, Federal Law Gazette 1 2004/11 in the version of FLG 1 2010/18=BGBI I 2004/11 idF BGBI I 2010/18

Under the same act, a person who is the victim of violence in his/her own home can apply for a court injunction to order the perpetrator to leave the home and not return and this is not restricted to family members. The violent act could be in the form of physical assault, threat or behaviour which threatens the mental health of the victim (Paragraph 382b of the Enforcement Order).

3.1.4 Driving

A diagnosis of dementia does not automatically lead to the withdrawal of a person's driving licence⁷. Section 5 (§ 24 and 25) of the 120th Federal Law of 1997 on the Driving Licence deals with the withdrawal of, restrictions on and termination of the entitlement to drive.

According to this law, if a person is found to be lacking the capability which was previously a precondition for entitlement to a driving licence or is found to be unreliable when driving, his/her driving licence can be withdrawn. Alternatively, the validity of the licence can be limited by time and by temporal, spatial or material restrictions. This means that a person could be limited to only drive on certain roads, in a particular area, for a certain amount of time or between certain times.

Before a licence can be withdrawn or restricted on the grounds of insufficient suitability for health reasons, a specialist report issued by an official doctor must be obtained. If it is decided to withdraw or restrict a licence, the period of time for which the measure is to apply must be pronounced. If the withdrawal is due to unreliability in traffic, the period should not be less than three months.

3.1.5 References

The UN Secretary-General's database on violence against women (2011), Summary of the Second Protection against Violence Act 2009. Accessed on 9 February 2011 at:

<http://webapps01.un.org/vawdatabase/searchDetail.action?measureId=33129&baseHREF=country&baseHREFId=164>

Barth/Ganner (Hrsg), Handbuch des Sachwalterrechts², Wien (2008)

Barth/Engel, Heimrecht, Wien (2004)

Kopetzki, Grundriss des Unterbringungsrechts², Wien (2005)

Strickmann, Heimaufenthaltsrecht, Wien (2008)

⁷ Information provided by Margarete Blaha in connection with the Lawnet conference on 11 May 1999

3.2 *Belgium*

3.2.1 Involuntary internment

3.2.1.1 Involuntary confinement

Confinement of mentally disordered person is governed by the Law of 26 June 1990 on the personal protection of mentally disordered persons.

The conditions for the confinement of a mentally disordered person

According to Article 2 of Chapter 1 of the above-mentioned law:

"Failing any other suitable treatment, confinement measures may be taken in respect of a person with a mental disorder only if his or her condition so requires, either because he or she seriously endangers his or her own health and safety, or because he or she constitutes a serious threat to the life or integrity of others.

Lack of adaptation to moral, social, religious or political or other values cannot of itself be considered as a mental disorder."

The procedure

Placing under observation

Any interested party may file a petition for someone to be placed under observation with a view to possible confinement. A written petition must be filed with the Justice of the Peace of the place of residence of the mentally disordered person, failing which, the place of domicile of that person. If neither of these are possible, the petition can be filed with the Justice of the Peace of the place where the patient is present.

The petition must be signed by the petitioner or by his or her lawyer and must include the following details:

- The date (day, month and year);
- The surname, first name, occupation and domicile of the petitioner and the degree of kinship or the nature of the relationship which exists between the petitioner and the patient;
- The subject of the request and a summary of the reasons;
- The surname, first name, residence or domicile of the patient or, if not possible, the place where he or she is present;
- The designation of the judge who is to be made aware of the matter.

Wherever possible the petition should also include information on the place and date of birth of the patient and, where necessary, the surname, first name, domicile and status of his or her legal representative.

A detailed medical report must be attached to the petition. In order to be valid, this must provide a description of the state of health and symptoms of the patient, as well as confirmation that the conditions for confinement have been met. This must be based on a medical examination performed no more than fifteen days prior to the lodging of the petition.

This report cannot be prepared by a doctor who is a relation of, or related by marriage to, the patient or the petitioner, or attached in any way whatsoever to a psychiatric service where the patient is staying.

As soon as the petition is received, the Chairman of the Bar or the Bureau of Legal Aid must arrange for a lawyer to be appointed. Within 24 hours the Justice of the Peace must arrange an appointment to visit the patient and also the date and time of the hearing.

Within the same period, the clerk of the court must serve the petition on the patient and on his or her legal representative, if any. The patient is also informed that s/he has the right to choose another lawyer, a doctor-psychiatrist and a personal confidant.

On the date and time fixed, the Justice of the Peace hears the patient and all other people whom s/he considers it appropriate to hear. These hearings take place in the presence of the patient's lawyer and in court,⁸ unless the patient or his/her lawyer request otherwise.

The Justice of the Peace also collects all useful information of a medical or social nature, and may visit the patient at the place where he or she is staying. The latter could be useful in order to compare the findings of the medical report with the situation "on the ground".

After hearing all the parties, the Justice of the Peace publicly delivers a decision within ten days following the filing of the petition. The clerk of the court then serves a copy of the judgment on the parties concerned and informs them of the rights of appeal which are available to them. If the decision is taken in favour of confinement, it will also be notified to the director of the psychiatric institution in which the patient will be placed under observation. An unsigned copy of the judgment is also sent to the Attorney General⁹ and the patient's legal representative, doctor-psychiatrist and personal confidant.

Confinement for observation purposes may not exceed forty days. During that period, the patient is monitored and examined in depth.

⁸ "en chambre du conseil"/"in raadkamer"

⁹ "Le procureur du roi"/"de procureur des Konings"

Further confinement:

Section 2 of the Law of 26 June 1990 deals with the further confinement of a patient who is already under observation. If the condition of the patient justifies his/her being retained in hospital at the end of the period of observation, the director of the institution must send a detailed report, at least 15 days before expiry of the observation period, to the Justice of the Peace certifying the necessity of maintaining hospitalisation. The Justice of the Peace then takes a decision.

The duration of further confinement

If the Judge of the Peace decides to further confine the patient, s/he sets the duration of the further confinement period, which cannot exceed two years.

At the end of this period of further confinement, the director of the institution must allow the patient to leave unless it is judged that confinement should be extended for a further period, which again cannot exceed two years.

Revision of the Justice of the Peace's ruling

The Justice of the Peace may at any time revise his/her decision. The patient or any interested person may make a request for such revision, but the request must be supported by the opinion of a doctor. The person who made the original request is then notified. The Justice of the Peace takes the advice of the head doctor of the department and makes a decision once s/he has heard all interested parties.

The appeal procedure

The Justice of the Peace's ruling can be appealed pursuant to Article 30 of the Law of 26 June 1990. The appeal must be filed within fifteen days following the Justice of the Peace's decision and addressed to the President of the Court of First Instance. The effect of filing the appeal will be to suspend the measure taken by the Justice of the Peace with effect from one month after filing the appeal unless the Court of First Instance has already taken a decision by then. In any event, the Court of First Instance must reach a decision within three months of the filing of the appeal. Moreover, the measures taken by the Justice of the Peace will be suspended if the Court of First Instance does not come to a decision within one month following the filing of the appeal.

3.2.1.2 Emergency confinement

Article 9 of the Law of 26 June 1990 contains provisions for emergency confinement. The Attorney General of the place where the patient is staying has power to decide that s/he should be placed under observation in a psychiatric clinic.

The Attorney General can act only after obtaining the written opinion of a doctor designated for the patient or at the written request of an interested person accompanied by a report of the same kind as required for non-emergency confinement. The opinion or report must conclude that there is an emergency. The Attorney General notifies his/her decision to the director of the institution.

Within 24 hours of his/her decision, the Attorney General notifies the Justice of the Peace, the patient, his/her legal representative and the person who made the original request of his/her decision and of the petition. The same process is then followed as for non-emergency confinement.

However, if the Attorney General does not send the petition to the Justice of the Peace within 24 hours or if he does so but the Justice of the Peace does not reach a decision within ten days, the measure taken by the Attorney General comes to an end.

3.2.1.3 Confinement within the family environment

Chapter III of the Law of 26 June 1990 allows for a patient to be cared for in the family if his/her condition permits this. The issue is investigated by the Justice of the Peace in the same way as with a request for placing under observation.

A patient can be cared for in this way by a designated person and a doctor for a maximum period of forty days.

As with further confinement, the doctor sends a report to the Justice of the Peace 15 days before expiry of the period stating the necessity for maintaining the protective measure. The Justice of the Peace may then extend the period of care within the family for a maximum of two years, which can be extended by subsequent periods of maximum two years each.

3.2.2 Driving

Alzheimer's patients who intend to drive must in any event inform the local police of their infirmity.

The Belgian Highway Code requires that every driver must be physically capable of driving his/her vehicle. If a doctor diagnoses that someone suffers from Alzheimer's s/he can decide that the patient must be tested for his/her driving capabilities by CARA, an organisation under the authority of the Belgian Institute for Traffic Safety.

3.3 *Bulgaria*

3.3.1 Involuntary internment

3.3.1.1 Introduction

Chapter 5 of the Law of Health of 1 January 2005 (last amendment 14.06.2011) deals with mental health (referred to as psychic health in the English translation). According to article 145, the state, the municipalities and non-governmental organisations are responsible for protecting the mental health of certain risk groups, including the elderly. People with mental disorders, in need of special health care, are defined in article 146 and include people with vascular and senile dementia. This chapter covers the restriction of personal freedom and compulsory accommodation and treatment (referred to hereafter as involuntary internment).

3.3.1.2 The conditions for involuntary internment

People with dementia can be involuntarily interned if, due to the disease, they may commit a crime that constitutes a danger to other people and/or represent a serious threat to their own health (art. 155).

3.3.1.3 The procedure for involuntary internment

The district court, according to the current address of the person for whom the measure is intended, is responsible for the procedure for involuntary internment (art. 155 to art. 164). In case of emergency, the district court at the location of the medical establishment is responsible for the process. The involuntary internment can be requested by the prosecutor or in emergencies by the chief of the medical establishment (art. 154/3/).

The court sends copies of the request for involuntary internment to the person concerned who then has seven days to object to the proposed measure and to provide evidence (art. 158/1/). Within 14 days of the request, the court examines the case in an open session in the presence of the person concerned as s/he must be consulted personally. If necessary, s/he can be brought to court by force. The participation of a psychiatrist, a defender and a prosecutor is obligatory (art. 158/4/).

After hearing the psychiatrist's opinion concerning the existence of a mental disorder, the court obtains a judicial-psychiatric expertise in order to ensure that the conditions for involuntary internment are fulfilled. This expertise may take not more than 14 days and the following court session must take place no longer than 48 hours after the end of the expertise (art. 159).

If it is found that the person does not have a mental disorder or that the conditions for involuntary internment are not fulfilled, the court terminates the case (art. 159/4/). If the conditions for involuntary internment are fulfilled, the court pronounces its decision on the basis of the evidence collected after having heard the person's reaction to the findings of the judicial-psychiatric expertise (art. 162).

The court pronounces a decision on the need for involuntary internment and its duration designates the medical establishment where this will take place and states whether the person lacks the ability to express informed consent. If necessary, it also appoints one of the person's relatives to express informed consent to treatment on behalf of the person to be involuntarily interned (art. 162/2/).

3.3.1.4 The duration of involuntary internment

The duration of the involuntary internment is decided by the court (art. 162/2/).

3.3.1.5 The right to appeal

The decision of the court can be appealed by the interested parties within seven days. Seven days later, the regional court pronounces the decision which is not subject to appeal (art. 163). The compulsory treatment is terminated once the time for which it was established has passed or on the decision of the district court at the location of the medical establishment (art. 164).

3.3.2 Coercive measures

Article 150 of the Law of Health of 1 January 2005 states that patients with established mental disorders who are a direct and immediate danger to their own health or life, or that of other people, can be subjected to temporary physical restriction, subject to the following conditions:

- The measures must be applied solely to create the conditions for giving treatment and not as a substitute for active treatment;
- The application of physical restraint must be ordered by a doctor who defines the kind of measure to be used and its duration (which must not be longer than six hours);
- Such measures must be implemented by staff who have been trained in the use of restraint;
- Certain information must be entered into the medical file and a special book of the medical establishment. This includes the kind of restrictive measure used, the reasons for its use, its duration, the name of the doctor who ordered it and details of the medical treatment.
- The person who is subjected to physical restraint must be under the constant observation of a doctor or nurse.

3.3.3 Mistreatment/abuse

Physical abuse is covered by Art. 128 – Art. 134 of the Penal Code which deals with severe, medium and minor bodily harm, as follows:

Article 128

(1) A person who inflicts on another severe bodily injury shall be punished by deprivation of liberty for three to ten years.

Article 129

(1) A person who inflicts on another medium bodily injury shall be punished by deprivation of liberty for up to five years.

Article 130

(1) A person who inflicts on another impairment of health apart from the cases under Articles 128 and 129, shall be punished for trivial bodily injury by deprivation of liberty for up to two years or by corrective labour.

Exposure to danger is covered by Art. 137 – Art. 139 of the Penal Code:

Article 137

A person who exposes a person, deprived of the possibility to defend him/herself because of minority, advanced old age, sickness or in general because of his/her helplessness, in such a way that his/her life may be endangered, and being aware of this does not render assistance thereto, shall be punished by deprivation of liberty for up to three years.

Article 138

A person who consciously does not render help, in case s/he was able to do so, to a person for whom s/he was obliged to take care and who was in danger of his/her life and had no possibility to protect him/herself because of minority, advanced old age, sickness or in general because of his/her helplessness, shall be punished by deprivation of liberty for up to one year or by corrective labour.

Article 139

A person who, in the case of immediate danger for the life of another, does not run to his/her rescue which s/he was able to do without endangering him/herself or another, shall be punished by probation for up to six months or a fine from BGN one hundred to three hundred.

3.3.4 Driving

The requirements for special training and personal skills of the drivers of motor vehicles of various categories and sub-categories are set out in Ordinance No. 39 of 29.01. 2004.

According to Art. 2 of this Ordinance, drivers must have the necessary knowledge, skills and behaviour to enable them:

1. to observe the laws on road traffic and in particular those aimed at preventing accidents and ensure the flow of traffic;

2. to anticipate and recognise dangerous situations in traffic and assess their seriousness;
3. to control the vehicle so as to avoid dangerous situations and to respond effectively when they occur;
4. to detect technical malfunctions that threaten the safety of traffic and take appropriate measures;
5. to comply with all the factors that affect the driver's behaviour, so as to ensure at any given time maximum security conditions when driving;
6. not to endanger the safety of road users and to be careful and cautious with regard to vulnerable people such as pedestrians and drivers of two-wheeled vehicles.

People with dementia and other people under guardianship who do not meet the above conditions are not permitted to drive according to Bulgarian legislation.

3.4 Croatia

3.4.1 Mistreatment/abuse

The Act on Protection against Family Violence of 2003 covers the issue of violence perpetrated within families and therefore covers the case of violence towards a relative with dementia. The definition of violence is very comprehensive and includes restriction of freedom of movement and presumably various coercive measures.

"Family violence is any use of physical force or psychological pressure against the integrity of a person; any other behaviour of a family member which can cause or potentially cause physical or psychological pain; causing feelings of fear or being personally endangered or feeling of offended dignity; physical attack regardless of whether or not it results in physical injury, verbal assaults, insults, cursing, name-calling and other forms of severe disturbance; sexual harassment; stalking and other forms of disturbance; illegal isolation or restriction of the freedom of movement or communication with third persons; damage or destruction of property or attempts to do so." (Cited by the United Nations Division for the Advancement of Women, 2009).

3.4.2 Reference

United Nations Division for the Advancement of Women (2009), The UN Secretary-General's database on violence against women: extract on Croatia. Accessed online on 20 October 2011 at:

<http://webapps01.un.org/vawdatabase/searchDetail.action?measureId=6015&baseHREF=country&baseHREFId=388>

3.5 *Cyprus*

3.5.1 **Involuntary internment**

The 1997 Mental Health Law (with amendments in 2003 and 2007) replaces the law on the “mentally insane” which had been in existence for over half a century. The term “certified mental patient” has been abolished.

3.5.1.1 **Conditions for involuntary internment**

A seriously disturbed person who is disturbing public order can be detained in a secure centre for involuntary (compulsory) admission and treatment with a court order.

There are also open psychiatric centres for voluntary admission and treatment. The open centres offer in-patient treatment to non-violent patients on an informal voluntary basis.

A person representative (next of kin), the police or a social worker can make an application to have someone compulsorily admitted to hospital.

3.5.1.2 **Procedure for involuntary internment**

The person who is disturbing public order can be apprehended by the police and transferred to a secure establishment for 24 hours’ observation and treatment. Before a person can be involuntarily committed, they had a right to be heard and be accompanied by their own psychiatrist and lawyer at the court process.

A more liberal amendment of the law allows for up to 72 hours’ detention for treatment without consent in an open centre. This necessitates a written recommendation from two doctors (at least one of whom must be a psychiatrist) and the Mental Health Commission must be informed immediately. If after the 72-hour period, the person does not consent to the continuation of treatment, the procedure for compulsory treatment and admission to a secure centre is started.

3.5.1.3 **Duration of involuntary commitment**

The initial court order is for 28 days for evaluation and treatment followed by periodic reevaluations every two months for up to a year. A Mental Health Commission is informed of all involuntary admissions and gives permission for the continuation or not of the measure. Voluntary hospitalisation can be terminated on the patient’s request at any time.

3.5.1.4 **Patient advisors**

We do not have any information about patient advisors. However, mail boxes have been placed in each ward of the Psychiatric Hospital (which is the only secure centre for involuntary admission and treatment in Cyprus). Patients and their relatives can put their complaints and suggestions in these boxes which are opened by the secretary of the Mental Health Commission every week.

3.5.2 Mistreatment/abuse

Law 119 (I) of 2000 on the Prevention of Violence in the Family and Protection of Victims covers violent acts carried out by one member of a family against another. Violence is defined as being any unlawful act, omission or behaviour which results in the direct infliction of physical, sexual or mental injury to any member of the family by another member of the family and includes violence for the purpose of sexual intercourse without the consent of the victim as well as for the purpose of restriction of his/her liberty. Members of the family include husbands and wives, parents, children and the grandchildren and any minor residing with any of the aforementioned people.

In addition to the punishment imposed in the context of this law, the law also results in more severe sentences for cases of violence or abuse already covered by the Criminal Code. For example, in the case of grievous bodily harm inflicted by a family member the term of imprisonment would be increased from 7 to 10 years or in the case of common assault from 1 to 2 years.

No specific reference is made to the elderly or to vulnerable or incapable adults. Consequently, an incapable adult residing with other people who is not a parent would presumably not be covered by this law. S/he would, however, be covered by the general provisions of the Criminal Code relating to violence and abuse.

3.5.3 Driving

After 65 to 70 years of age, a person must have a medical and neuropsychiatric exam to assess their fitness to drive. Doctors are not obliged to report diagnoses of dementia to the licensing authorities. However, medical ethics allows for the circumvention of confidentiality in cases of public danger.

3.5.4 Reference

Messis, C. (2007), *The 1997 mental health law (amendments of 2003 and 2007) and the rights of mental patients in Cyprus*, Cyprus Mental Health Commission. Accessed online on 24 October 2011 at: <http://mentalhealthcommission.org.cy/en/law/>

3.6 *Czech Republic*

3.6.1 **Involuntary internment**

3.6.1.1 **The conditions for involuntary internment**

The Act on Civil Procedure Code no. 99/1963 Sb. (CPC) deals with involuntary internment.

According to §191a (CPC), a person can be admitted into an institution without his/her written consent for any one of a few reasons (Health Care Act no. 20/1966 Sb. § 23 subsection 4). One such reason is that the person has a mental disorder which renders him/her a danger to him/herself or to other people and the environment. Another reason is that the patient is in an acute or life-threatening situation and it is not possible to obtain his/her consent due to the severity of the health impairment.

3.6.1.2 **The procedure for involuntary internment**

In such cases, the institution must inform the court in which the institution is located within 24 hours. Similarly, if a person is held against his/her will in an institution, having originally entered into the institution on the basis of written consent, the court must be informed within 24 hours.

If the person who has been involuntarily interned has no legal representative, the court shall appoint a curator for the proceedings. The court then carries out an investigation to determine whether the involuntary internment is lawful. The court may examine the person and consult the attending doctor (§191b CPC).

The court must decide whether the person was lawfully interned within 7 days of that person's entry into the institution. The person concerned, his/her curator and the institution must be informed of the decision. The institution may then decide to release the person even if the court ruled that the internment was lawful. Otherwise, the court determines whether the person should be held longer (§191b CPC).

In practice, it is likely that many people with dementia who are not able to express themselves are admitted into healthcare establishments simply on the basis of presumed consent. Moreover, the above-mentioned procedure only applies to health care institutions and not social care institutions (Holmerová et al., 2008).

3.6.1.3 **The duration of involuntary internment**

After the initial involuntary internment, the court may decide to prolong the person's stay for up to one year. After this time, the court must decide again on the lawfulness of keeping the person in the institution against his/her will for a longer period of time. Decisions regarding the duration of the involuntary internment do not prevent the institution from releasing the person earlier (§191e CPC).

3.6.1.4 The right to appeal and suspension of the ruling

The person who has been involuntarily interned and who is capable of legal acts, his/her representative (the curator) and people who are close to him/her may request a new examination and decision before the expiry of the duration of the involuntary internment if there are reasons to believe that continued detention is unnecessary (§191f CPC).

3.6.1.5 Patient advisors

In 2006, the amended Law on the Czech ombudsman came into force (no. 349/1999 Sb). The ombudsman is responsible for checking the wellbeing of people whose freedom has been restricted irrespective of whether such restriction is the result of a legal ruling or, on the other hand, due to other circumstances. This is ensured by visits to the place where the person is staying/being held. The ombudsman checks what kind of treatment they are receiving, tries to ensure that their fundamental rights are being respected and takes measures to protect them from mistreatment (Holmerová et al., 2008).

3.6.2 Coercive measures

3.6.2.1 Social Services

The Czech legal rules are now based on the principle that personal freedom of everybody should be granted (in considerable contrast to previous communist legislature). Therefore, the restriction of personal freedom has been made possible only in cases and under conditions explicitly stated by the Law. This pertains to §89 of the Law of Social Services, which permits the use of measures restricting the freedom of movement only in cases where the health or life of the person involved is endangered (or the health and life of other people). When applying the measures which restrict the freedom of movement, the least restrictive ones should be used. If verbal reassurance is of no avail, physical measures should be used. Furthermore, according to the Law, placing the patient in a room designed to ensure safety should be arranged. Only after this delay is the attendant/invited doctor authorised to prescribe sedative medication. This should be administered in his/her presence.

3.6.2.2 Health Care

According to the Regulation of the Ministry of Health of the Czech Republic on the use of restrictive devices in the health facilities of the Czech Republic, any of these restrictive measures can be used

- a) restricting the patient's freedom of movement by belts,
- b) placing the patient in the net bed,
- c) placing the patient in a safe room,
- d) the use of a strait-jacket, restricting the movement of the upper limbs,
- e) acute parenteral (tranquillizing) drug application,

Restrictive measures can be applied, either individually or combined, but only to avert the threat to the life, health or security of the patient or of other people. In any case, only the measure with optimal effectiveness and with the lowest risk to the patient should be used. The measures used should not exceed the time justified. The use of measures and the sort of device used will be decided by the treating doctor or by the doctor on emergency duty in the medical facility involved.

3.6.3 Mistreatment/abuse

According to § 198 of the Penal Code: A person, who torments an individual who is in his/her care or education, will be imprisoned, depending on the resulting injury, for the term of one to twelve years.

Since 2004, domestic violence has been considered a penal offence. Since 2007, the police can prevent a violent person from entering the household where s/he committed the violent act and since 2009, the police are permitted to prevent this person from all contact with the abused person. Comprehensive measures, taken by municipal social departments together with doctors and the police etc., are necessary. Abuse is still largely hidden and only a few studies have been carried out on this issue.

3.6.4 Driving

General practitioners are obliged to report to the driving authorities any patient whose capacity to drive could be affected by their medical condition. In addition, drivers over the age of 60 have to have regular medical check-ups and this can be controlled by the police (Act no. 361/2000 Sb., Traffic Act).

3.6.5 Reference

Holmerová, I., Rokosová, M., Jurašková, B., Vaňková, H., Čvančarová, H. Karmelitová, P. and Provazníková, E. (2008), Practice of competence assessment in dementia: Czech Republic. Ed. Gabriela Stoppe (2008), *Competence assessment in dementia*, Springer Wien New York.

3.7 Denmark

There is a distinction in the Danish legislation between coercive means in treatment and coercive measures in the social area.

Coercive means in treatment are described below and in sections 3.7.1.1 – 3.7.2.5 and coercive means in the social area is described in section 3.7.2.6.

There are currently no rules that permit the coercive treatment of people with dementia in nursing homes, and others who do not understand what the treatment involves, and therefore instinctively resist the treatment.

The Ministry of Health is, however, currently considering legislation to allow this and it is also mentioned in the National Dementia Plan of 2010.

The Law N° 1729 on Coercive Measures in Psychiatry of 2010¹⁰ only applies to psychiatric institutions and therefore the provisions of the law do not extend to other wards which may nevertheless provide services to people suffering from a mental disorder. It does not apply to people with a mental disorder (i.e. dementia) who live in nursing homes.

Deprivation of a person's liberty is a coercive measure. Nevertheless, in the general provisions of the law (chapter 2), it is stated,

"In order to avoid as far as possible the use of coercion, the hospital authorities shall offer hospital stay, treatment and care that correspond to good hospital standards. The patient's consent should be sought on a constant basis with regard to proposed treatment."

The other forms of coercive measures dealt with by this law can be found in the section on coercion.

3.7.1 Involuntary internment

3.7.1.1 The conditions for involuntary internment

According to Law N° 1729 on Coercive Means, a person must be mentally ill or suffering from a similar condition and fulfil one of two conditions:

1. The outlook for a recovery or a significant and decisive improvement of the condition would otherwise be materially worsened OR
2. The person in question constitutes an obvious and considerable danger to him/herself or others

The first condition is not really applicable to people with dementia as it entails the necessity of treatment in order to cure or improve the person's condition. Consequently, it

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would be illegal to intern a person with dementia in a psychiatric hospital simply because there was no room in a nursing home. On the other hand, it could be argued that a person with dementia was an obvious danger to him/herself or others and could therefore be interned in accordance with the second condition.

3.7.1.2 The procedure for internment

If a person who is assumed to be mentally ill does not voluntarily seek treatment, his/her nearest relatives have an obligation to call a doctor. If they do not do so, it is the responsibility of the police. However, before any measures can be taken to intern a person against his/her will, s/he must be informed of the nature, background and aims of the proposed internment and the doctor must try to obtain the patient's consent.

A doctor then examines the person, makes a declaration and judges whether forced internment is called for. His/her decision is based on whether the conditions for forced internment (mentioned above) have been fulfilled. The declaration must not be issued by a doctor who is employed by the psychiatric establishment to which the person is to be admitted or by a disqualified doctor.

Concerning the examination carried out by the doctor, if the person is to be admitted in accordance with condition 2, it must have been carried out within the last 24 hours. If the person is to be admitted on the basis of condition 1, it must have been carried out within the last 7 days.

A consultant decides to what extent the conditions for involuntary internment have been fulfilled.

Once a decision has been made, the person must be interned immediately (if condition 2 has been fulfilled) or within 7 days (if the internment is based on condition 1). The doctor should be informed when this will be. Furthermore, the doctor who is responsible for the involuntary internment must be present until the police leave the site together with the person who is to be interned.

3.7.1.3 The duration of forced internment and the process of review

The consultant, who decides whether the conditions for forced internment have been met, must constantly monitor whether such deprivation of liberty is not being unnecessarily imposed. If the conditions for internment are no longer valid, the person must be immediately released. A reassessment of the need for involuntary internment must be made 3, 10, 20 and 30 days after the start of the internment and subsequently every four weeks.

3.7.1.4 Patient advisors

In accordance with chapter 8 of the Law on Coercive Measures in Psychiatry, a patient advisor is appointed for every person who is coercively admitted, coercively detained or coercively treated in a psychiatric establishment. The role of the patient advisor is to

guide and advise the patient on all issues relating to admission, stay and treatment. S/he may also assist with the implementation and completion of any complaints. The patient advisor also ensures that coercive measures are not used to a greater extent than necessary.

Patient advisors are appointed by the regional state administrations and a list then distributed among the individual psychiatric wards. If a situation arises whereby a patient advisor is needed, the nurse who is on duty appoints one as quickly as possible, taking simply the next name on the list. If the patient objects to the person chosen, s/he can make a request for a different one to be appointed from the list. The regional state administrations make the final decision. A person can be appointed who is not on the list. In this case, the person is provisionally appointed until the regional state administrations can decide whether this person should be fully appointed.

As soon as a patient advisor is appointed, s/he must visit the patient within 24 hours, then on a weekly basis and as required. S/he is entitled to free and unhindered personal, written and telephone contact with the patient. Hospital personnel must provide the Patient Advisor with any information necessary to allow him/her to carry out his/her duties effectively. However, the Patient Advisor should not be provided with any information that for medical grounds has not been given to the patient.

3.7.2 Coercive measures

The Law on Coercive Measures in Psychiatry specifies the different kinds of coercive measures used in psychiatric hospitals and psychiatric wards, sets rules and provides some form of protection against abusive use of such measures. There are also more explicit rules on coercive treatment, the use of physical force and protective fixation which are set by the Minister of Health.

It is illegal to use coercive treatment in nursing homes.

Chapter 2 of the above-mentioned law contains general stipulations on the use of coercion. These include the following:

Coercion should not be used until all possible steps have been taken to obtain the patient's voluntary co-operation.

The use of coercion must be reasonably linked to what is hoped to be achieved. If less extreme measures would be sufficient, then they must be used.

Coercion should be performed as gently as possible and with the greatest concern for the patient so that unnecessary affront or inconvenience is avoided.

Coercion should not be used in a greater measure than is necessary.

3.7.2.1 Coercive treatment

According to §12, coercive treatment can only be used for people who have been interned against their will. In such cases, the treatment must involve the use of proven drugs in normal doses and with the fewest possible side effects. The consultant is responsible for deciding when coercive treatment can be administered and for determining the degree of force that can be used in order to carry out the treatment (if necessary). The consultant who is responsible for the ward where the treatment is to be carried out must also be involved in decision making concerning coercive treatment. The consent of the patient is not needed if the treatment is necessary to avoid considerably endangering his/her life or health.

Chapter 7 of the Law on Coercive Measures in Psychiatry provides special rules on psycho-surgical interventions and on experimental treatment. According to §§22 and 23 any psycho-surgical intervention requires the consent of the patient and must be approved by the Council of Doctors appointed by the National Health Service. The intervention may be carried out on a patient who is unable to consent provided that s/he has been declared incapable of managing his/her own affairs and that an appointed guardian has given written consent. Patients who have been interned against their will cannot be subjected to experimental treatment. Those who are voluntarily interned cannot be coercively subjected to experimental treatment.

3.7.2.2 Coercive fixation

Chapter 5 of the Law on Coercive Measures in Psychiatry deals with fixation and the use of physical force. According to §14 coercive fixation may include the use of belts, hand and foot straps and gloves. It can be used only to the extent that it is necessary in order to prevent a patient from:

- exposing himself/herself or others to obvious danger of bodily injury or impairment of health.
- pestering or otherwise similarly grossly molesting fellow patients or
- causing significant vandalism

Before coercive fixation can be used, a doctor must have seen the patient. However, if nursing staff feel that fixation with belts is necessary in consideration of the patient's own safety or that of other people, it would be irresponsible to wait for the doctor's supervision. In such cases, the nursing staff may take the decision themselves and have the patient fixated with belts. Immediately after, they must summon the doctor who then decides whether the fixation was justified and should be continued. Once coercively fixated with belts, the patient must be constantly supervised. Only a consultant can authorise the use of hand or foot straps in addition to the use of belts.

§18 of the above-mentioned law deals solely with protective fixation which is described as the use of any means to prevent a patient from unintentionally exposing him/herself

to considerable danger. Protective fixation can only be employed after a doctor has seen the patient and decided upon the kind of protective medium to be used.

3.7.2.3 The use of physical force

The justification for the use of physical force is covered by §17. A person who has been admitted to a psychiatric ward can be secured and transferred by force to another place of abode in the hospital if the conditions for fixation have been fulfilled. Force can be used if necessary in order to secure the continued presence in the ward of a person who has been interned against his/her will.

According to § 18g a consultant can decide to use physical force in personal hygiene situations if it is necessary in consideration of the patient himself, other patients or the staff.

3.7.2.4 The use of electronic means

According to § 17a a doctor can decide to use a personal alarm, a paging system or special door opening devices for patients with dementia to prevent the patient from unintentionally exposing him/herself to considerable danger by leaving the hospital.

3.7.2.5 Control of the use of coercion and the right to complain

A record must be kept whenever coercive measures are used and the consultant has continual responsibility to ensure that coercive treatment and fixation are not used to a greater extent than is actually necessary. In the case of protective fixation, a review of the situation is made 3, 10, 20 and 30 days after the original decision and thereafter at least every 4 weeks. A new decision can be made on its continued use whenever conditions warrant it.

Whenever, any kind of coercive measure is used, the patient must be informed about the complaints procedure.

According to the provisions of chapter 10, the patient or his/her patient advisor can complain to the hospital authority against the use of coercive measures. They also have the right to submit a complaint verbally. In each regional state administration there is a Psychiatric Patient Complaints Board. It is comprised of a Chief Administrative Officer who acts as chairperson and two other members, who are selected by the Danish Medical Association and the Co-operative Invalid Organisations.

The hospital authority must submit all complaints to the Psychiatric Patient Complaints Board. This should include the relevant file, including a transcript of the coercion protocol, as well as a declaration made by the consultant. If the Board requires additional information, it will take the necessary steps to obtain it and may even decide to visit the psychiatric ward. A decision should normally be made as soon as possible and within 14 days.

If the patient or the patient advisor wishes to complain about the Psychiatric Patient Complaints Board's decision there is a distinction.

If the patient or the patient advisor complains about forced internment, coercive fixation or protective fixation they are obliged to submit it to the court (Byretten) in accordance with the rules set out in chapter 43a of the Administration of Justice Law ("Retsplejeloven").

If the patient or the patient advisor wishes to complain about treatment, use of alarms, paging systems, special door opening and the use of physical force the Psychiatric Patient Complaint Board is obligated to submit all complaints to the National Agency for Patients' Rights and Complaints

If the Psychiatric Patient Complaint Board decides that the decision is legal, the patient can only resubmit a request for release 2 months after the date of the board's decision.

3.7.2.6 Use of coercive measures in the social area

Act No. 81 on Social Services of 4 February 2011 has been amended to ensure the rights of people with mental incapacity are respected by staff employed by the municipality. In chapter 24, the various coercive measures, which can be used in the professional social care of persons with mental incapacity (including people with dementia), are specified.

The municipal council can, under certain conditions, allow their staff to use:

- personal alarm or paging systems,
- special door opening devices,
- physical force by way of restraint to prevent a person from leaving the home or to take him/her back to the home,
- restraint by means of a fabric brace fastened to a wheelchair or any other aid, bed, chair or toilet so as to prevent falls.

According to § 126, the municipal council may decide to allow the use of physical force in restraining a person or leading a person to another room where there is an imminent risk that the person may cause substantial injury to him/herself or others, and it is absolutely necessary in the given situation.

By way of exception, the municipal council may decide to allow the use of physical force for a limited period to restrain a person where this must be deemed to be absolutely necessary in order to exercise the duty of care in personal hygiene situations. At the same time, attempts must be made through the occupational action plan to ensure that forcible measures are avoided in future personal hygiene situations.

The person or relatives can complain to the Regional Social Complaints Board.

According to § 129, the municipal council may recommend that the Regional Social Complaints Board should decide that a person opposing removal or lacking the capacity to give informed consent thereto, is to be admitted to a specific accommodation facility, where:

- it is absolutely required in order to ensure that the person in question receives the necessary assistance; and
- the assistance cannot be provided in the person's existing home; and
- the person in question cannot understand the consequences of his/her actions; and
- the person in question risks exposing him/herself to substantial personal injury; and
- it would be irresponsible not to arrange for the person to move.

The municipal council may recommend that the regional social complaints board in exceptional cases moves a person to a nursing home to be closer to relatives, if it is in the interest of the person.

The Regional Social Complaints Board's decision shall be made no later than two weeks after receipt of the municipal board's recommendation.

The municipal council may make decisions regarding admission to a specific accommodation facility for a person with substantial and permanent impairment of mental function, who does not oppose removal to that facility, but who lacks the capacity to give informed consent to a such a move, and where the mental functional impairment is a consequence of an age-related or subsequently acquired mental impairment that is progressive, provided that the municipal council's recommendation is accepted by the guardian appointed by the state administration, where:

- admission to a residential accommodation facility with associated service is necessary for the person in question to receive the necessary help; and
- in the specific case it is assessed as the most expedient care solution for the person in question.

If any spouse, cohabiting partner or other relative can no longer provide the necessary assistance for and supervision of the person in question, this should be included in the assessment made by the municipal council.

2.7.3 Mistreatment/abuse

The issue of restraint and coercion, which if not handled correctly could constitute abuse, is dealt with in the Law on Coercive Means in Psychiatry. However, this law is limited to care in psychiatric establishments, which is not generally the place of residence of people with dementia.

Under the Guardianship Act (No. 1015) of 20 August 2007, a guardian can be held responsible for any damage caused either intentionally or through neglect to the person under guardianship. S/he can also be forced to pay compensation. Although not explicitly stated, this would seem to cover financial issues.

There is no actual mention of abuse in the consolidating Act of Health No. 913 of 13 July 2010.

3.7.4 Driving

Before a person can be issued with a driving licence, s/he must pass a medical examination. A driving licence is normally valid until the person reaches the age of 70.

When the person reaches 70 years of age, the driving licence can be extended by:

- four years, if the person is 70 years old
- two years, if the person is 74-80 years old
- one year, if the person is more than 80 years old

if the person passes the medical exam.

The Danish Ministry of Justice has implemented the Directive 2006/126/EC of the European Parliament and of the Council of 20 December 2006 on driving licences, which means that the driving licence cannot be valid for more than 15 years. This change will come into force on 19 January 2013. It is still possible to get the driving licence extended beyond the age of 70 as mentioned above.

If the doctor considers the person incapable of driving safely the doctor is obliged to inform the Public Health Medical Officers. The Public Health Medical Officers will consider the case, before forwarding it to the police.

3.8 *Estonia*

3.8.1 Involuntary internment

3.8.1.1 Introduction

The following laws deal with involuntary internment:

1. The Mental Health Act of 12 February 1997
2. The Social Welfare Act of 8 February 1995
3. The Code of Civil Procedure of 20 April 2005

3.8.1.2 The conditions for involuntary internment

The Mental Health Act deals with psychiatric inpatient care whereas the Social Welfare Act deals with the placement of a person in a social welfare institution without his/her consent or that of his/her legal representative. This is possible if the person is of unsound mind, failure to place him/her in a social welfare institution would mean that the person was a danger to him/herself or others and the application of previous measures was insufficient or the use of other measures is impossible. An application for placement can be made to a court along with an application for guardianship and the court can place the person for up to 1 year. Once the guardianship measure has been arranged, the court may decide to prolong the placement one year at a time. Full details of the court procedure are not available.

The Code of Civil Procedure deals with the placement of people with mental disorders in psychiatric hospitals, social welfare institutions and closed institutions together with deprivation of liberty. In the Code of Civil Procedure, the placement of people in closed institutions follows on from guardianship measures. The procedure, which can be found in Chapter 54 of the Code of Civil Procedure, is described below.

3.8.1.3 The procedure for involuntary internment

Court proceedings for involuntary placement in a closed institution can be started on the basis of a petition by the rural municipality or city government of the place where the person with the mental disorder resides and for whom the measure is intended.

Placement may be immediate if the court has reason to believe that a delay would result in danger, provided that documents exist concerning the person's state of health, that a representative has been appointed to the person in the proceedings and that the person him/herself has been heard, as well as the rural municipality or city government, the spouse, the guardian or trustee and the head of the closed institution. In case of absolute emergency, these people can be heard as soon as possible after placement.

In addition to hearing the person for whom the measure is intended, as well as those mentioned above, the court must obtain an expert opinion from a psychiatrist who has personally examined the person in question.

However, a person who is already in a medical institution or another similar institution may be deprived of liberty also on the basis of documents pertaining to his/her state of health.

A court ruling is pronounced stating who should be placed in a closed institution, a description of the measure, the duration of the involuntary placement and the possibility for appeal.

3.8.1.4 The duration of involuntary internment

The person may be placed in an institution for up to 1 month for observation if this is necessary for an expert observation to be made.

In emergency cases, immediate placement is possible, i.e. before the full court procedure. This cannot exceed 3 months but can be extended to 6 months once the court has heard an expert. On completion of the court procedure, a person can be involuntarily placed in a closed establishment for up to 3 years from the date of the ruling.

3.8.1.5 The right to appeal and suspension of the ruling

When a ruling is made concerning involuntary placement in a closed institution, the person is informed of his/her right to appeal.

The court may decide to suspend the placement of a person in a closed institution for up to one year based on the application of the petition, the person him/herself or at the initiative of the court. Such suspension may be dependent on compliance with conditions and obligations. If the person fails to comply with these conditions or obligations, the court may annul the suspension.

3.8.2 Coercive measures

3.8.2.1 Restriction of personal liberty

Paragraph 136 of the Penal Code states that the unlawful deprivation of liberty of another person is punishable by a fine or up to 5 years' imprisonment. However, the Social Welfare Act of 1995 contains provisions for the lawful deprivation of freedom. It is stated in paragraph 20 that the head of the social welfare institution or his/her substitute can restrict a person's right to move freely insofar as this is necessary to prevent that person from leaving without supervision and to protect the rights and freedom of other people. The person can also be isolated from other people staying in the institution if s/he is considered a danger to him/herself or others. This must not be for longer than 24 hours and the isolated person must be under the constant supervision of the employees of the social welfare institution.

3.8.2.2 Restraint

The Mental Health Act of 12 February 1997 covers the involuntary placement of people with mental disorders in psychiatric institutions. Paragraph 14 covers the use of means

of restraint but seems to refer solely to people with a mental disorder who have been involuntarily committed to a psychiatric institution for emergency psychiatric care.

Reference is made to the use of isolation and physical restraint including the use of mechanical means such as straps and special clothing in order to restrict a person's freedom of movement. It is stated that this can take place in an isolation room under the supervision of medical staff. The use of restraint is decided by doctors and must be documented in the person's medical file along with details of the reasons for its use. It must be discontinued as soon as the danger which led to its use has ceased to exist.

3.8.3 Mistreatment/abuse

Physical abuse is covered in paragraph 121 of the Penal Code which states, "Physical abuse causing damage to the health of another person, or beating, battery or other physical abuse which causes pain, is punishable by a fine or up to 3 years' imprisonment."

Paragraph 120 covers threats made by one person to cause damage to the health or significant damage to the property of another person.

Paragraph 123 states that placing or leaving another person in a situation which is life-threatening or likely to cause serious damage to the health of that person is punishable by a fine or up to 3 years' imprisonment.

Driving

According to the Estonian Alzheimer's Association, doctors cannot prevent patients from driving and they cannot inform the driving licence registration authority. However, family doctors are responsible for issuing health certificates, and for people of a certain age, those certificates have to be renewed at least every five years. If specialists have informed a family doctor that a patient has dementia, the family doctor would not normally renew the health certificate for driving a car for that patient.

3.8.4 Reference

Website of the Ministry of Justice, section on English translations of Estonian legal acts. Please see: <http://www.legaltext.ee/indexen.htm>

3.9 *Finland*

3.9.1 **Involuntary internment**

Under section 7 of the Constitution, it is stated that there shall be no interference in personal integrity or deprivation of liberty without legitimate grounds prescribed by an Act of Parliament. The lawfulness of any other form of deprivation of liberty may be submitted to judicial review.

The Mental Health Act (No. 1116) of 1990 lays down guidelines for mental health work and the organisation of mental health services. It is also an Act of Parliament, which provides a framework for legitimising the deprivation of liberty in that it deals with involuntary treatment in a psychiatric hospital.

3.9.1.1 **The conditions for involuntary internment**

For a person to be committed for treatment against his/her will the following three criteria must be met:

1. The person has been diagnosed as mentally ill;
2. S/he must be in need of treatment for mental illness which, if not treated, would become considerably worse or would severely endanger his/her health or safety or that of other people; and
3. All other mental health services are inapplicable or inadequate.

If the police are of the opinion that there is a person who might meet the criteria for involuntary treatment, they must report this to a health centre. In urgent cases, they can take the person to the health centre to be examined. Similarly, if the chief health centre doctor considers that the criteria have been met, s/he should issue a referral for observation and, if necessary, arrange for the person to be taken to hospital.

3.9.1.2 **The procedure for involuntary internment**

In order to determine whether the three criteria have been met, the person must be admitted to hospital for observation. First, however, the person must be examined by a doctor. If the doctor considers that treatment is necessary, s/he draws up a written statement (known as a referral for observation) which must contain a well-founded opinion of whether the conditions for commitment are likely to be met. On the basis of this statement, which must not be older than 3 days, the person is admitted to hospital for observation. The doctor carrying out the observation must produce a written statement no later than four days following admission.

According to paragraph 11, before the person can be involuntarily admitted to hospital for treatment, his/her opinion must be sought. It is stated that the parents or guardians of minors should be heard during the decision-making process. However, there is no

reference made to guardians of adults who lack mental capacity and are hence unable to give their opinion on the matter.

The chief doctor in charge of psychiatric care is responsible for deciding on internment. This cannot be the same person who made the referral for observation. His/her decision must be in writing and based on the referral for observation, the statement on observation and the case history. The decision must state whether the conditions have been met and the person must be informed of the decision.

According to section 27 of the Mental Health Act, the Administrative Court or the Supreme Administrative Court can appoint a legal counsel to a person who has been ordered to treatment against his or her will if the person asks for it or the court otherwise considers it necessary. This is covered by the Legal Aid Act (257/2002).

The Administrative Court or the Supreme Administrative Court can appoint a legal counsel even if the person has not requested one. In such cases, the appointment of the counsel and appropriate fees and reimbursements to be paid to the counsel are subject to the provisions of the Legal Aid Act irrespective of whether the person ordered to treatment has been or will be granted the legal aid referred to in the Legal Aid Act.

3.9.1.3 The duration of involuntary internment

The person may be detained for up to 3 months. This period can be extended unless the person objects, in which case a new observation would have to be made. The decision to prolong the period of involuntary treatment and detention must be made by the chief doctor who made the original decision. The person must be informed without delay and the approval of the provincial administrative court must be obtained. Treatment can be prolonged for a period of six months after which a new observation must be made. If during any period of detention of involuntary treatment it is found that the conditions which led to internment are no longer valid, the person must be immediately discharged if s/he so desires.

3.9.1.4 The right to appeal

According to §24 an appeal may be lodged with the provincial administrative court against the hospital doctor's decision to order a person to treatment, to continue treatment against a person's will, to take possession of a patient's personal property or to limit his/her contact. The appeal must be lodged within 14 days of notification of the decision. Otherwise all appeals are subject to the provisions of the Administrative Judicial Procedure Act (586/1996).

Appeals can also be lodged against a decision of the National Institute for Health and Welfare to order a person to treatment or to continue treatment against the person's will or to order a person to hospital examination in a case referred to in section 21 (criminal cases), and against a decision concerning special care given against a person's will.

Alternatively, an appeal can be made to the chief doctor in charge of psychiatric treatment in the hospital or to another person appointed for this purpose within the appeal period. The chief doctor sends the petition, documents relating to the appeal and his/her statement about the appeal to the relevant authority without delay.

However, once the decision has been made to involuntarily intern a person for treatment or to treat him/her against his/her will, it is immediately enforced irrespective of whether the decision has been submitted to another authority for confirmation or whether an appeal has been made. On the other hand, once an appeal has been received the relevant authority may forbid enforcement of the decision.

3.9.1.5 Patient advisors

According to section 11 of the Act on the Status and Rights of Patients, No. 785 of 1992, there must be a patient ombudsman in every health care unit. His/her tasks include:

- advising patients on issues contained in above-mentioned Act (No. 785 of 1992),
- helping patients to formulate complaints,
- informing patients of their rights,
- acting in favour of the promotion and implementation of patients' rights.

3.9.2 Coercive measures

3.9.2.1 Restriction of personal liberty

Section 6 of the Constitution states that everyone has the right to life and personal liberty, physical integrity and security of person and that no-one should be tortured or otherwise treated in a degrading manner. Furthermore, it is stated that there shall be no interference in personal integrity or deprivation of liberty without legitimate grounds prescribed by an Act of Parliament.

3.9.2.2 Restraint and other coercive measures

The Mental Health Act contains several paragraphs which address the issues of coercive measures, abuse and unlawful deprivation of freedom. However, this only applies to involuntary treatment in psychiatric hospitals or wards. People with dementia are usually treated elsewhere, e.g. in nursing homes where coercive measures are sometimes used.

There is still no adequate legislation in Finland covering the use of coercive measures in ordinary hospitals or nursing homes. For this reason, the National Supervisory Authority for Welfare and Health (Valvira)¹¹ has produced guidelines: "Use of restraints for patients".

¹¹ Valvira is the National Supervisory Authority for Welfare and Health and a centralised body operating under the Ministry of Social Affairs and Health. Its statutory purpose is to supervise and provide guidance to healthcare and social services providers, alcohol administration authorities and environmental health bodies and to manage related licensing activities. The most important task is to protect the right of all Finnish residents to a living environment that promotes their health and welfare and to assure their access to social and healthcare services that are both safe and adequate.

According to the Valvira, the use of restraint for patients is only permitted to prevent serious harm to a patient's health or safety. It further states that:

- a doctor must make a written/documented statement of his/her decision concerning the use of restraint for a patient,
- the need for restraint has to be evaluated regularly,
- the proper equipment must be used in accordance with guidelines on the use of restraint.

In 2010, the Ministry of Social Affairs and Health established a working group whose aim was to assemble the provisions relating to the deprivation of liberty and self-determination of all patients/clients of social and welfare, within the same act if possible. The reform of the legislation specifically addresses the deprivation of liberty in the care of people with mental disabilities and dementia. Its goal is also to strengthen the multidisciplinary co-operation and the availability and development of services in such a way as to lessen the need to limit liberty and self-determination. The term of office of the working group ends on 31.12.2011.

Concerning the way patients are treated in the healthcare setting, the Act on the Status and Rights of Patients, No. 785/92 of 17 August 1992 provides details on how patients should be treated. Section 3 states that the care of the patient should be arranged in such a way that:

- his/her human dignity is not violated
- that his/her beliefs and privacy are respected
- that his/her mother tongue, individual needs and culture are taken into account as far as possible in his/her medical care and other treatment.

3.9.3 Mistreatment/abuse

3.9.3.1 Assault/bodily harm

Sections 5 to 8 of the Penal Code of Finland (39/1889 with subsequent amendments) cover assault:

Section 5 - Assault (578/1995)

(1) A person who employs physical violence on another or, without such violence, damages the health of another, causes pain to another or renders another unconscious or in a comparable condition, shall be sentenced for assault to a fine or to imprisonment for up to two years.

(2) An attempt is punishable.

Section 6 - Aggravated assault (654/2001)

(1) If in the assault

- (1) grievous bodily injury or serious illness is caused to another or another is placed in mortal danger,
- (2) the offence is committed in a particularly brutal or cruel manner, or
- (3) a firearm, edged weapon or other comparable lethal instrument is used

and the offence is aggravated also when assessed as a whole, the offender shall be sentenced for aggravated assault to imprisonment for at least one year and at most ten years.

(2) An attempt is punishable.

Section 7 - Petty assault (578/1995)

If the assault, when assessed as a whole and with due consideration to the minor significance of the violence, the violation of physical integrity, the damage to health or other relevant circumstances, is of minor character, the offender shall be sentenced for petty assault to a fine.

3.9.3.2 Negligence, endangering others and abandonment

The following extracts from the Penal Code of Finland (39/1889 with subsequent amendments) cover bodily injury resulting from negligence, including that which endangers the life or health of another person and abandonment:

Section 10 - Negligent bodily injury (578/1995)

A person who, through negligence, inflicts significant bodily injury or illness on another shall be sentenced for negligent bodily injury to a fine or up to six months' imprisonment.

Section 11 - Grossly negligent bodily injury (578/1995)

If in the negligent bodily injury the bodily injury or illness is inflicted through gross negligence, and the offence is aggravated also when assessed as a whole, the offender shall be sentenced for grossly negligent bodily injury to a fine or to imprisonment for up to two years.

Section 13 - Imperilment (578/1995)

A person who intentionally or through gross negligence places another in serious danger of losing his/her life or health, shall be sentenced, unless the same or a more severe

penalty for the act is provided elsewhere in the law, for imperilment to a fine or to imprisonment for at most two years.

Section 14 - *Abandonment* (578/1995)

A person who renders another helpless or abandons a helpless person of whom s/he should take care, and thereby endangers the life of the said person, shall be sentenced for abandonment to a fine or up to 2 years' imprisonment.

3.9.4 Driving

Since 2004, doctors have been legally obliged to report to the police any patient with a medical condition which makes him or her unfit to drive. Whilst many doctors object to this obligation, hundreds of reports have been made, resulting in numerous withdrawals of licence, some of which were for people with dementia (Sulkava, 2008).

However, it is important to note that a diagnosis of dementia does not automatically lead to the withdrawal of a person's driving licence. According to Sulkava (2008), a person with dementia can keep his/her driving licence if the following criteria are met:

1. His/her dementia must be mild (this usually means an MMSE score of more than 20).
2. There must be information from the relatives and friends that s/he is driving safely and has no traffic offences due to dementia.
3. S/he must undergo a clinical examination by a doctor (usually a neurologist or geriatrician). This examination includes a clock drawing test (to reveal possible agnosia).

In case of doubt, an "on the road" driving test or laboratory traffic test is carried out.

People with mild dementia may be permitted to drive for just one year or even a shorter period of time but must report any deterioration in symptoms and are advised not to drive alone, either at night or in bad conditions.

Professional driving licences, on the other hand, are always withdrawn when cognitive disorders are detected. Furthermore, certain impairments and difficulties always result in the withdrawal of the driving licence even if the person only has mild dementia, e.g. in the case of obvious impairments in executive functions (as in the case of fronto-temporal dementia), lack of insight and/or a marked slowing of movement and thinking.

3.9.5 Reference

Sulkava, Raimo, (2008), Practice of competence assessment in dementia: Finland. In Stoppe Gabriela (Edit.), *Competence Assessment in Dementia*. EDCON 2008. p.109-111.)

3.10 France

3.10.1 Involuntary internment

The right to freedom of movement is a principle of constitutional value. Article 66 of the French Constitution states that: “No one can be arbitrarily detained. The judicial authority, guardian of the freedom of the individual, shall ensure compliance with this principle in the conditions laid down by statute”¹². Furthermore, the right to freedom of movement is ensured by international treaties that are directly applicable before French Courts¹³.

In the French legal system, the protection of the person's right to freedom of movement is established by different laws. Provisions to protect the rights of people in need of psychiatric care are determined in the Law of 5 July 2011¹⁴ that thoroughly reformed involuntary psychiatric internment. Provisions to protect the rights of persons in need of geriatric care are laid out in the law of 2 January 2002¹⁵.

3.10.1.1 Provisions for the protection of rights of persons in need of psychiatric care

In France, legal provisions on involuntary internment *stricto sensu* only apply to involuntary internment in psychiatric institutions. This primarily means that those provisions do not apply to involuntary internment in hospitals or in nursing homes. It also means that those legal provisions mainly apply to people with mental disorders, and rarely to people with dementia, since few people with dementia reside in psychiatric hospitals.

Until recently, involuntary psychiatric internment (13% of internments in psychiatric institutions) was governed by the Law of 27 June 1990¹⁶. This law distinguished between two situations: involuntary internment when there is a threat to the person him/herself (*hospitalisation à la demande d'un tiers* / involuntary internment at a third party request) and involuntary internment when there is a threat to other individuals or to public order (*hospitalisation d'office*)¹⁷.

A new law entered into force on the 1st August 2011¹⁸. This law reaffirms that mental health disorders cannot justify restraining the person's rights; thus, any restriction on the exercise of individual freedom must be proportionate, necessary and adapted to the

12 Constitution de la Ve République française du 4 octobre 1958

13 Convention de sauvegarde des droits de l'homme et des libertés fondamentales/ Convention for the Protection of Human Rights and Fundamental Freedoms, article 5

14 Loi n°2011-803 du 5 juillet 2011 relative aux droits et à la protection des personnes faisant l'objet de soins psychiatriques et aux modalités de leur prise en charge

15 Loi n°2002-2 du 2 janvier 2002 rénovant l'action sociale et médico-sociale

16 Loi n°90-527 du 27 juin 1990 relative aux droits et à la protection des personnes hospitalisées en raison de troubles mentaux et à leurs conditions d'internement

17 In 2008, the first procedure applied to approximately 60,000 people each year, the second for 10,000 people each year.

18 Loi n°2011-803 du 5 juillet 2011 relative aux droits et à la protection des personnes faisant l'objet de soins psychiatriques et aux modalités de leur prise en charge

person's mental state. What's more at every step of the procedure, the person must be informed of his/her rights and the reasons why s/he is kept against his/her will¹⁹.

The Law of 5 July 2011 contains three main innovations:

Firstly, in order to reduce the number of internments, it introduces the notion of "soins psychiatriques sous contrainte" (involuntary psychiatric care). Beside full-time internment, it enables involuntary part-time internment (e.g. day care or night care), involuntary outpatient care, and involuntary home care (with frequent consultations and therapeutic activities).

Secondly, in order to compensate for the frequent lack of a third party requesting the person's internment, the law creates - in case of serious and impending danger for the person - the possibility of involuntary internment without any third party request even if there is no threat to public order.

Thirdly, in order to comply with the obligation imposed by the French Constitutional Council, the law initiates a systematic control by the common law judge of the appropriateness of every full-time internment within 15 days.

3.10.1.2 Involuntary psychiatric care when there is a danger for the person him/herself

Conditions for involuntary psychiatric care

According to article L. 3212-1 of the Public Health Code, "a person suffering from mental disorders may require psychiatric care by decision of the director of a care institution [...] only if the two following conditions are met:

His or her disorder renders his or her consent impossible;

His or her state requires immediate treatment."

People entitled to request the internment are (a) family members of the person, (b) the guardian/curator of the adult under legal protection, or (c) anyone acting in the person's best interest (with the exception of any person employed in the psychiatric institution).

General procedure for involuntary psychiatric care

Before admission

The request must be accompanied by two medical certificates. The first certificate cannot be issued by a doctor employed by the psychiatric institution and must give details of the person's mental condition and explain why his/her state requires treatment. If the

19 Code de la santé publique, article L.326-3

second certificate confirms the first one, the director of the psychiatric institution pronounces the admission.

After admission

An initial phase of full-time internment (up to 72 hours) is systematically implemented in order to assess the person's mental state and to ascertain the necessity of involuntary psychiatric care.

One psychiatric assessment must be carried out during the first 24 hours; another assessment must take place within the first 72 hours of internment.

If one of those assessments concludes that the person does not need psychiatric care, the director of the institution must release the person²⁰. If the necessity of psychiatric care is established, a care programme is proposed by the psychiatrist and decided by the director; whether in the form of full-time or part-time internment, or through outpatient care, home care or therapeutic activities.

Between the 6th and the 8th day after admission a new assessment takes place, in order to verify that the care programme is still adapted to the person's needs. On the basis of this assessment, the director can maintain the care programme for a one month period. S/he can also decide to adapt the care programme, e.g. to turn partial internment into full-time internment or to turn full-time internment into outpatient care²¹.

Every month a detailed medical certificate must assess the evolution of the disorder and indicate clearly whether the conditions for an involuntary care programme are still justified. When the period of involuntary psychiatric care is longer than a year, the person's mental state must be examined in detail by a *collège* composed by one psychiatrist involved in the care programme, one who is not, and one member of the psychiatric team.

At any time, the person's opinion can be sought and the psychiatrist can propose to modify or terminate the care programme in order to comply with the mental state of the person.

Procedure in case of *péril grave et imminent* (serious and impending danger)²²

Exceptionally and in case of a "grave and impending danger" to the person's health, one of the persons mentioned in 1.1.1. can make a request on the basis of only one certificate that can be provided by one of the institution's psychiatrists. In that case, the two medi-

20 Code de la santé publique, article L. 3212-4

21 When outpatient care is decided, the psychiatrist in charge of the person establishes a timetable in order to regularly monitor the person's mental state within the hospital. In case of failure to cope with the timetable, the director of the institution notifies the *préfet* (local representative of the government). The latter can order a new internment.

22 Code de la santé publique, article L. 3212-1 sq.

cal certificates produced within the 72-hour initial period must be delivered by different psychiatrists.

In the same conditions of “grave and impending danger”, if those people are not able to lodge a request, the director of the psychiatric institution may decide to proceed with involuntary internment on the basis of one medical certificate that cannot be issued by one of the institution’s psychiatrists.

Control by the judge

Right to appeal

An appeal against the involuntary care programme²³ may be lodged at any time by simple request to the *juge des libertés et de la détention* (liberty and custody judge) of the place where the psychiatric institution is located. The right to appeal applies to full-time internment as well as to part-time internment, outpatient care, home care and therapeutic activities.

The people who are entitled to lodge an appeal are (a) the person him/herself, (b) the spouse or partner, (c) any relative, (d) any person acting in the best interests of the person, (e) the guardian, (f) the person who initiated the request for internment, and (g) the local public prosecutor. The *juge des libertés et de la détention* may also introduce a control on his/her own initiative if alerted (or notified) by a third person.

Specific control in case of full-time internment

The new law stipulates that an involuntary full-time internment cannot be maintained for more than 15 days without being controlled by the judge. In order to ensure the appropriateness of the full-time involuntary internment, the *juge des libertés et de la détention* can order a complementary assessment to be made by two psychiatrists at two different times.

In principle, the judgment shall be delivered in open court. The person in psychiatric care shall be heard (s/he can be assisted by a legal counsel/lawyer) at the *Tribunal de grande instance* (regional Court); if the situation renders it impossible, the hearing may take place at the hospital or by videoconference. If the hearing is contrary to doctor’s order, the person is represented by his/her legal counsel.

Thereafter, the *juge des libertés et de la détention* must control both the necessity and the proportionality of the measure according to the same procedure every 6 months.

23 Code la santé publique, article R. 3211-8

The end of involuntary psychiatric care

The person must be released if:

- the request is vitiated (rendered invalid) by formal irregularities;
- a decision made necessary by the procedure is not completed within the allocated time;
- the end of involuntary psychiatric care is proposed by the psychiatrist and decided by the director of the psychiatric institution;
- the judge decides that the care programme is no longer adequate in the circumstances.

3.10.1.3 Involuntary psychiatric care when there is a threat to other individuals or to public order

Procedure

The *préfet* (local representative of the government) can order involuntary psychiatric care for a person:

if s/he requires psychiatric care;

and s/he is seriously disturbing public order or is a threat to the safety of other individuals²⁴.

A medical certificate (delivered by a psychiatrist not employed by the institution) must state the grounds for a psychiatric care²⁵.

After admission, involuntary psychiatric care in case of public disturbance or dangerous behaviour follows the same procedure as described in 1.1.2. apart from the fact that the *préfet* decides, not the director of the psychiatric institution. If the *préfet* decides not to follow the psychiatrist's advice, a new medical certificate must be issued by a second psychiatrist.

After the first 72 hours, psychiatric care can be prolonged by the *préfet* for a period of 1 month. It can subsequently be prolonged for 3 months and then for 6 months according to the same procedure.

The end of psychiatric care

People mentioned in 1.1.4. can make a request to the *juge des libertés et de la détention* to review or to put an end to the measure.

²⁴ Code de la santé publique, article L. 3213-1

²⁵ In case of impending danger to the safety of individuals, a person may be interned on the basis of a medical certificate by the Mayor or in Paris by the *commissaire de police* (Police commissioner). The *préfet* must then be notified within 24 hours in order to decide whether involuntary psychiatric care is justified.

The measure ends:

- when the request is vitiated by formal irregularities,
- a decision made necessary by the procedure is not completed within the allocated time,
- the end of involuntary psychiatric care is proposed by the psychiatrist and decided by the director of the psychiatric institution,
- when the judge decides that the care programme is no longer adequate in the circumstances,
- when decided by the *Commission Départementale des Hospitalisations Psychiatriques* (regional psychiatric hospitalisation committee).

At any time, the *préfet* may decide to assess the mental state of any interned person in order to review their situation. The medical expert must not be employed by the institution and is chosen from a list of experts.

3.10.1.4 Provisions for the protection of the rights of people in need of geriatric care

With regarding to social and medical-social facilities (e.g. nursing homes), the Law of 2 January 2002 introduced in the *Code de l'action sociale et des familles* (social action and family code) that “the exercise of individual rights and liberties is guaranteed to any person in institutional care [...]. [People] are insured of: the respect of their dignity, their integrity, their privacy, their intimacy and their security”²⁶.

People with full capacity

As long as the person is able to express his/her will, s/he can freely choose to enter and to leave the social or medical-social facilities²⁷. Put simply, s/he cannot be interned against his/her will.

The law provides tools to ensure the exercise of the client's rights. Every client must receive the *livret d'accueil* (resident's booklet), which contains the *Charte des droits et libertés de la personne accueillie* (Charter of the residents' rights and liberties) and the rules governing the functioning of the establishment²⁸. Moreover, a *contrat de séjour* (residence agreement) must be established. This agreement must contain the person's opinion regarding the nature and objectives of the care programme.

²⁶ Code de l'action sociale et des familles, article L. 311-3

²⁷ Code de l'action sociale et des familles, article L. 311-3, 3°

²⁸ Code de l'action sociale et des familles, article L. 311-4

People under legal protection

When the person is unable to express his/her will, the legal framework is to be found in the new guardianship law²⁹.

According to this law, the guardian or the curator cannot decide on the person's behalf to move the latter into a social or medical-social facility without the person's consent or assent³⁰, except when there is a serious threat to the person's health. But even in that case, the guardian must inform the guardianship judge³¹.

When there is a conflict between the person and his/her guardian regarding the person's place of residence, the advice of the latter cannot substitute the opinion of the person; s/he must obtain the authorisation of the *Conseil de famille* (family council) or the guardianship judge.

People without legal protection

However, as noted in the Third Alzheimer's Plan, "while the new provisions of the 5 March 2007 law respond to situations of accommodation against the client's will or without their consent [...], those provisions only apply to people under guardianship."³² Actually, no provisions exist when the person cannot consent to his/her admission, or when his/her capacity to decide is unclear, and when the person is not under guardianship.

3.10.2 Coercive measures

Moreover, as the Law of 2 January 2002 emphasises the clients' right to security, the clients' rights to freedom of movement is sometimes challenged within the institution. According to the Third Alzheimer's Plan: "In the client's own interest, caring for the client may involve using techniques that seriously restrict his/her freedom (closed units, magnetic bracelets, restraint belts). Without questioning medical protocol and the reality of these methods being indicated, it must be admitted that the consequent deprivation of liberty must be legally supervised. This question is familiar in the field of psychiatry. But the legal provisions in force in this area do not apply to medical-social institutions. The result is a legal vacuum that needs to be filled"³³.

29 Loi n° 2007-308 du 5 mars 2007 portant réforme de la protection juridique des majeurs

30 Code civil, article 459-2

31 Code civil, article 459-4

32 Plan Alzheimer 2008-2012, mesure 39

33 *Ibid.*

3.10.3 Mistreatment/abuse

Definition

In France, national reports on mistreatment have emerged in the last ten years. They were aimed at analysing where those acts were committed and at identifying the victims as well as the offenders.

Despite the fact that no legal definition of mistreatment can be found within the Criminal Code, the definition given in 1992 by the Council of Europe³⁴ seems to be generally accepted³⁵. This definition specifies the different forms of mistreatment: physical, sexual, psychological or financial abuse; negligence, abandonment and deprivation.

Professional secrecy

As a rule, the doctor is bound to professional secrecy. However, it is his/her duty to take the necessary measures to protect the patient from being abused³⁶.

In case of a person of particular vulnerability, defined in the Criminal Code as being one who is "unable to defend him/herself due to his/her age or physical/mental state", the doctor notified of the abuse should inform the relevant authorities.

With the necessary approval of the victim or the family, the doctor is given the opportunity to notify the *procureur de la République* (public prosecutor) of the abuse. The doctor must report the facts and not the name of the offender.

Sanctions

The general framework is provided by the *principe de légalité des délits et des peines* (principle of legality of criminal offences and penalty) which requires that only the relevant punishable conducts described in the Criminal Code may be punished. Under this provision, a few acts are defined as acts of mistreatment. They may be both voluntary and involuntary, and committed by a natural or a legal person.

More specifically, the Criminal Code expressly covers the protection of people of particular vulnerability. In this respect, alongside general incriminations (physical and sexual mistreatment, breach of trust...), the protection of vulnerability is envisaged in two ways:

34 "A non-accidental act or omission, which undermines the life, the physical and psychological integrity of an older person or harms the development of his or her personality and/or undermines or damages his or her financial security".

35 A. Koskas, "Rapport de la mission sur la maltraitance financière à l'égard des personnes âgées dans les établissements sanitaires, sociaux et médico-sociaux", 2011.

36 Code de déontologie médicale, article 44.

it includes vulnerability as an aggravating circumstance of the offence. This means that the penalty imposed on the offender is aggravated when the victim is recognised as being particularly vulnerable.

it also creates specific punishable offences. Conducts such as neglect (wherever it takes place) and minor acts of violence may be considered as offences solely on the basis of the particular vulnerability of the person. It must be noted that for minor acts of mistreatment, such vulnerability must be known to the offender or be visible.

In any case, both the length of the sentence and the fine depend on the gravity of the act of mistreatment, on the consequences on the person's body and mind and on the level of vulnerability of the person.

3.10.4 Driving

Obligation to inform the person

The doctor cannot forbid a person to drive. Nevertheless, the doctor is legally bound to inform and warn the person of the risk that a treatment or a cognitive impairment may affect his/her ability to drive, e.g. frequent or serious risks that are normally foreseeable³⁷. At every medical consultation or when modifying treatment, the doctor must renew the information. The doctor may be liable under civil or criminal law if it is proved that s/he failed to inform the person of the risks normally foreseeable. Nevertheless, it is still the person's responsibility to inform the relevant authorities.

When the person's mental state renders the expression of his/her will impossible, the *personne de confiance* (trustee/trusted person), if s/he has designated one, can receive the information in order to help the person.

The Insurance Code requires, for running contracts, that any change in circumstances that may increase risks or create new ones be declared³⁸. If people hide the risk from the insurer, the contract may be considered void and in case of traffic accident, they run the risk of not being insured and reimbursed.

Medical assessment

With the exception of a few categories of workers, people do not need to pass a medical examination to be issued with a driving licence³⁹. Under the provisions of the Highway Code, once the driver's licence has been issued, the *préfet*, on the basis of convincing relevant information that someone may be unable to drive, may decide to order a medical examination by the *Commission médicale primaire départementale* (departmental pri-

37 Code de la santé publique, Article L. 1111-2

38 Code des assurances, article L. 113-2

39 Code de la route, articles R. 221-10 et R. 221-14

mary medical commission) to assess the person's mental state. The *préfet* can also order an assessment if the person is involved in a traffic accident.

When there is a danger for the person's health and security, the doctor, a member of the family or a relative may also send a request for medical examination to the *Commission médicale primaire départementale*.

Based on that medical assessment, the *préfet* may pronounce the renewal of the licence with regular medical control, the suspension or the revocation of the driving licence⁴⁰.

3.10.5 Acknowledgements

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⁴⁰ Article R. 221-14 refers to a ministerial decree of the 7th May 1997 that foresees a list of affections that allows the *préfet* to decide on the suspension or the withdrawal of the driving licence. If Alzheimer's disease is not explicitly mentioned this procedure may nevertheless apply to people with cognitive impairment.

3.11 Germany

3.11.1 Involuntary internment

Personal freedom is dealt with in article 2, section 2, of the Constitution:

“Everyone has the right to life and to physical integrity. The freedom of the person is inviolable. Intrusion of these rights may only be made pursuant to a statute.”

Paragraph 1906 of the German Civil Code⁴¹ which governs guardianship has constituted one such statute since 1992. In addition, each “Land” has its own requirements for the protection and care of people who are suffering from a mental illness or disorder. These regional laws provide more detailed guidelines concerning the process and conditions of forced internment. In this section, I will refer to both §1906 of the Civil Code and the Law of Lower Saxony on Aid and Protective Measures for the Mentally Ill (No 12/1997) which is an example of legislation in one such “Land”⁴². Conditions for involuntary internment

3.11.1.1 The conditions for involuntary internment

According to §1906 of the Civil Code, forced internment of a person for whom a guardian⁴³ has been appointed is only permissible if it is required for his/her wellbeing, because:

due to the fact that the person under care suffers from a mental illness or a mental handicap there is a danger that s/he will kill him/herself or cause considerable damage to his own health, or

a health examination, medical treatment or surgery is required, which cannot be carried out without the person being committed and the person under care, because of a mental illness or mental handicap does not recognise the necessity for commitment or cannot act in accordance with this understanding.

The Law of Lower Saxony regulates the aid and commitment of people who are or have been ill or handicapped as a result of a mental disturbance or who have the symptoms of such illness or handicap. The conditions for internment are that the person (to whom this law applies) is at the present time a source of considerable danger to him/herself or others and that this danger cannot be averted by other means.

3.11.1.2 The procedure for involuntary internment

§1906 of the Civil Code states that commitment is only possible with the approval of the Court of Guardianship. If it is not possible to obtain approval and delay could be dangerous, it is still possible to intern a person and obtain approval immediately afterwards.

41 In German, the Civil Code is called the Bürgerliches Gesetzbuch or BGB for short.

42 From this point on, this law will be referred to simply as the Law of Lower Saxony.

43 The term “guardian” will be used in this report instead of “carer”, which is used in the translation of the Bürgerliches Gesetzbuch (BGB).

According to §13 of the Law of Lower Saxony, if there are grounds to believe that commitment cannot be averted by the provision of aid, the Social Psychiatric Service can arrange for a person to be examined by a doctor of his/her choice. This doctor is then authorised to report the results of the examination to the Social Psychiatric Service. Alternatively, the person can be summoned by the Social Psychiatric Service for an examination. If there are urgent grounds to believe that the conditions for internment have been met, the person concerned can be brought for examination. If necessary, his/her residence may be entered in order to bring him/her for examination. If it is reasonable to do so, the doctor should inform the person of the results of the examination.

The Court of Guardianship decides on forced internment, as well as on provisional internment in order to establish whether the conditions have been met. A medical certificate must be submitted to the Court of Guardianship, which must not have been issued by a doctor who is acting on behalf of the administration in the internment procedure.

If it is not possible for the court to come to a decision straight away, the person can be admitted to a suitable hospital until the end of the following day. For this to be possible, the conditions for internment must be indicated in the medical certificate, which must have been issued by a doctor who is experienced in the field of psychiatry and be based on a finding made no earlier than the previous day.

Once the court has made a decision on internment, the person in question is informed of the legal assistance to which s/he is entitled and is given the opportunity to notify a person of his/her choice. A medical examination is carried out as soon as the person has been interned in order to determine therapeutic treatment and develop a treatment plan.

3.11.1.3 The duration of involuntary internment and the process of review

There is no fixed period of internment mentioned in §1906 of the Civil Code or the Law of Lower Saxony. Presumably, the initial duration of internment is decided by the Court of Guardianship. Both laws stipulate that the internment must be terminated if the conditions which led to it are no longer valid.

3.11.2 Coercive measures

3.11.2.1 Restriction of personal liberty

Paragraph 239 of the Penal Code deals with the wrongful deprivation of personal liberty and does not include any limitation of time. It states:

“Whosoever locks up or deprives a person of his/her freedom in another way will be punished by a prison sentence of up to 5 years or a fine.”

3.11.2.2 Restraint and other coercive measures

The provisions in the Civil Code for internment also apply to the deprivation of a person's freedom for a long period of time or on a regular basis by mechanical apparatus, medica-

tion or in another manner. This is applicable regardless of whether the person under care is in an institution, a home or another establishment.

Similarly, the Law of Lower Saxony also applies in the case of further restriction of liberty once interned by means of mechanical devices, medication or by other means over a lengthy period of time or on a regular basis. In such cases, the management of the hospital must apply for authorisation from the Court of Guardianship.

3.11.3 Mistreatment/abuse

Paragraph 233 of the Penal Code states that whoever mistreats the body of another person or causes damage to their health will be punished by a prison sentence of up to three years or a fine.

The legally unjustified restriction of a person's freedom or free movement can be considered as a form of abuse, as can various measures of restraint described above, according to paragraph 1906 of the Civil Code and paragraph 239 of the Penal Code. Consequently, people in daycare centres (or indeed any other place) cannot be detained against their will unless they have been officially committed. This would be the case if doors were locked or there were complicated systems, making it difficult for people to leave the building.

The use of measures of restraint (such as belts, straps, special chairs or medication etc.) must be authorised by the Guardianship Court. However, the use of such measures would only be considered as abusive if they were used against the person's will or if s/he was unable to consent to them⁴⁴. For example, a strap could justifiably be used to prevent a person from falling out of bed provided that the person was able to consent to this measure, that s/he was legally competent and capable of undoing the strap at any time.

3.11.4 Driving

According to §4 of the Tenth Road Traffic Law of 19 December 1952 (and subsequent amendments), the traffic administration authorities must withdraw the licence of any person who reveals him/herself to be unfit to drive. The licence expires immediately on withdrawal. The authorities have the right to check a person's ability to drive. According to §7 of this law:

"If, in the operation of a motor vehicle, a person is killed, physically injured or his/her health is damaged or a tangible object is damaged, the owner of the vehicle shall be obliged to compensate the injured party for the damage caused."

§ 69 of the Penal Code also covers withdrawal of driving licences. If a person has committed an illegal act (e.g. endangering traffic) in connection with the driving of a vehicle,

⁴⁴ Bundesministerium der Justiz (1996), Das Bundesministerium der Justiz informiert: Das neue Betreuungsrecht, Klett Druck G.m.b.H.

but has not yet been sentenced as it cannot be proved or ruled out that s/he is in a state of incapacity, the court shall withdraw the driving licence if it is evident from the illegal act that s/he is unfit to drive. Once convicted of the offence, the verdict shall include confiscation of the driving licence.

The Law of Lower Saxony also addresses the issue of driving as well as the handling of firearms. According to §34 of this act, the Social Psychiatric Service or the hospital must inform the competent authorities if they consider that a person who has been involuntarily committed would be a danger to him/herself or others by driving a motor vehicle or handling arms. This law applies to Lower Saxony. Other "Länder" may have slightly different provisions.

The issue of confidentiality and unfitness to drive:

In a court case involving a woman with schizophrenia, the Federal High Court ruled that a doctor could inform the traffic authorities of a person's unfitness to drive. This could equally apply in cases of dementia. The judgement was as follows:

"A doctor, despite his basic duty to maintain confidentiality, can be justified, according to the principles on the weighing up of conflicting duties or interests, in informing the traffic authorities if his patient drives a motor vehicle on the road despite no longer being capable, on account of his illness, of driving a motor vehicle without endangering himself and others. The precondition, however, is that the doctor has previously made the patient aware of the condition of his health and of the dangers that would arise if he drove a motor vehicle, unless, from the outset, there would be no point – due to the nature of the illness or lack of understanding on the part of the patient – in the doctor trying to persuade him." (BGH, Urt.v. 8.10.1968 – VIZR 168/68 – Schizophrenie (KG Berlin))

This judgement was justified on the grounds that although confidentiality forms the basis for the relationship between doctor and patient, the doctor is bound by a higher interest which is to protect public safety. The interest in preventing a person who is unfit to drive from driving is considered to outweigh the interest the public and the individual have in the doctor's maintenance of confidentiality in this case.

3.12 Greece

3.12.1 Involuntary internment

According to Lecca Marcati⁴⁵, people who have been diagnosed as having Alzheimer's disease are not admitted to psychiatric hospitals as none of the Greek psychiatric hospitals accept patients with this disorder. However, some may be committed in the early stages of the disease due to a misdiagnosis, but they are released when a diagnosis of Alzheimer's disease can be made. The following provisions for involuntary commitment (insofar as this relates to people with dementia) are therefore only applicable in cases of emergency.

3.12.1.1 The conditions for involuntary internment

The Hospital Law of 1992 (N° 2071) together with the more recent N.2447/96 on the involuntary commitment of people suffering from mental diseases are the relevant laws in this case. A person can be interned against his/her will (whether or not s/he is subject to judicial assistance) for either of the following reasons:

1. The patient is incapable of judgement concerning his/her health, and lack of hospitalisation would render treatment impossible or would lead to a further deterioration of his/her health or
2. The hospitalisation of the patient is necessary in order to avoid acts of violence against him/herself or others.

The law restricts those who can apply to the Public Prosecutor for involuntary commitment of the patient to the wife or husband, relatives (without restriction in a straight line for blood relatives and up to a second degree for others) and to the carer or judicial assistant.

3.12.1.2 The procedure for internment

Despos⁴⁶ describes the procedure for involuntary commitment and the conditions of internment as follows:

The application should be accompanied by two recommendations from two recognised psychiatrists. If an application is made to the court without these two recommendations, the Public Prosecutor is obliged to take care of this matter. If the procedure is exercised *ex officio* by the Public Prosecutor, or the application clearly states that the examination of the patient by doctors was impossible due to his/her refusal to comply, the court orders the examination and assessment in a public psychiatric ward. However, the admission of the patient to the ward should be done in accordance with the law, that is under circumstances which ensure the respect of his/her personality and dignity. The admission to the ward for the purpose of assessment cannot be for longer than 48 hours. It should

⁴⁵ Information provided in connection with the Lawnet conference on 11 May 1999

⁴⁶ Information provided in connection with the Lawnet conference on 11 May 1999

be noted that according to the new article 1687 of the Civil Code, the Public Prosecutor alone cannot order this admission, but is obliged to ask the court to decide.

The patient has the right to be present in court to represent him/herself. However, in practice, the patient is not usually present. Even if absent, s/he can take legal measures against the decision of the court.

Concerning the procedure itself, if the court judges that the recommendations of the two psychiatrists differ, or considers them inadequate, it can appoint a third psychiatrist, preferably the scientific director of a public health care facility.

3.12.1.3 What are the conditions and duration of involuntary commitment?

The conditions of the involuntary commitment should serve the needs of therapy. The necessary restrictive measures should not preclude therapeutic efforts, for example permission for a day off, organised excursions, or living in supervised hostels outside the ward. The conditions of internment and the organisation of the therapy are determined by the Ministry of Public Health and Care. Particular emphasis is placed on the respect of the personality of each patient during hospitalisation. Also, it is stressed that restrictions imposed on the personal freedom of the patient should serve his/her health and the aim of the hospitalisation.

Finally, the duration of hospitalisation cannot be longer than 6 months. After the first three months, the scientific director of the facility plus a second psychiatrist of the section of mental health, submit a report to the Public Prosecutor on the state of health of the patient. The Public Prosecutor has the right to send this report to the court, asking for the termination or continuation of hospitalisation. It should be noted here, that the law fails to determine a time limit within which the report should be submitted by the Public Prosecutor to the court.

3.12.1.4 Compulsory removal from the home

Compulsory removal from the home is allowed for safety reasons. The consent of a social worker appointed by the court and the district attorney is necessary. This measure is particularly relevant in cases where the person lives alone. S/he is always removed to a residential home or hospital but never to a psychiatric hospital (Lecca Marcati⁴⁷)

3.12.2 Coercive measures

In the Greek Constitution (article 7, par. 2), it is stated that it is prohibited and a crime punishable by law to engage in torture, any kind of bodily ill-treatment or injury to health, or to resort to the use of psychological pressure or any other offence against human dignity.

47 Information provided in connection with the Lawnet conference on 11 May 1999

Respect of the person's dignity by medical professionals is addressed in article 1 of the Rules of Medical Ethics and Deontology (RMED). Concerning abuse, article 18 states that doctors must never use their knowledge, abilities or experience for the purposes of cruel, inhuman or degrading actions, regardless of the reasons for such treatment.

3.12.3 Driving

According to article 13 of the Highway Code, a person who is deprived of his/her required physical and mental ability is not in a fit state to drive. Moreover, this article 13 gives transport authorities the right to demand a reappraisal of any driver in case of doubt concerning his/her ability to drive and to demand a medical reappraisal in case of doubt regarding the person's physical or mental state.

In Greece, there are certain measures which help limit the consequences of the withdrawal of a driving licence. For example, all mentally disabled people under the age of 65 are entitled to purchase a car for private use (up to 1600cc) without paying the import tax, which amounts to about 40% of the cost price. The car can be driven by one family member other than the person with dementia. In addition, all people suffering from a mental disorder are entitled to holiday bonuses, as well as reduced fares (of up to 50%) on all forms of public transport (Lecca Marcati⁴⁸).

48 Information provided in connection with the Lawnet conference on 11 May 1999

3.13 Hungary

3.13.1 Involuntary internment

According to the Act CLIV of 1997 on Healthcare, a patient may be restricted in exercising his/her rights only for the period of time justified by his/her state of health, and to the extent and in the way provided for by law. Among the general rules the Act on Healthcare states that the patient's personal freedom may be restricted by physical, chemical, biological or psychological methods or procedures exclusively in case of emergency, or in the interest of protecting the life, physical safety and health of the patient or others. Medical emergency is a sudden change in health, which, in the absence of urgent medical care, would endanger the patient's life, or result in severe or permanent health impairment. The other exception applies to the rules of coercive measures in psychiatric care. This provision also applies when a patient with a severe contagious disease is not allowed to leave the healthcare facility (due to possible endangerment of other's health and physical safety).

3.13.1.1 The conditions for involuntary internment

If a patient manifests "immediately dangerous behaviour" because of a mental disorder or an addiction, and if the danger can be averted only by immediate admission to and treatment in a psychiatric institute, the doctor observing this behaviour shall take immediate measures to transport the patient to the proper psychiatric institute. If necessary, police shall assist in transporting the patient.

Dangerous behaviour: the patient, as a result of a disturbance in his/her mental condition, may pose a significant threat to his/her own or others' physical wellbeing or health, while the nature of the disorder does not warrant urgent institutional treatment.

Immediately dangerous behaviour: the patient, as a result of an acute mental condition, poses an immediate and serious threat to his/her own or others' life, physical wellbeing, or health.

3.13.1.2 The procedure for involuntary internment

Within 24 hours of admission of the patient, the person in charge of the psychiatric institute shall notify the court and initiate a court finding that there were grounds for the admission, and request a court order for mandatory treatment of the said patient in a psychiatric institute. The court shall issue a decision within 72 hours of notification. Until the court decision is rendered, the patient may be temporarily detained in the institute. The Parliamentary Commissioner on Civil Rights released a report in April 2011 in which he stated that in some cases these deadlines, set as a guarantee, are not met in practice.

The court shall order compulsory treatment of a patient in a psychiatric institute when the said patient exhibits dangerous behaviour because of a mental disorder or an addic-

tion, but when there is no cause for emergency treatment. The procedure for ordering compulsory treatment shall be initiated by the specialist doctor in the psychiatric institute who determines the need by notifying the court, and shall recommend the psychiatric institute where the treatment is to occur.

The court shall render a decision on ordering mandatory institutional treatment within 15 days of receipt of notification. Prior to rendering its decision the court shall hear the patient, the expert opinion of an independent forensic psychiatrist - who is not participating in treatment of the patient - who has been subpoenaed to attend the hearing of the patient, and the specialist initiating the procedure. If the patient does not appear when subpoenaed, the court may order that s/he be brought before the court.

If the court orders compulsory institutional treatment for the patient, and the patient does not appear at the psychiatric institute set forth in the order within three days of receipt of the legally binding decision, the doctor initiating the proceedings shall act to have the patient brought in. When necessary, police shall participate in the transport of the patient.

3.13.1.3 The duration and review of involuntary internment

The court shall periodically review the need for compulsory institutional treatment every 30 (inpatient care) or 60 (rehabilitation care) days.

A patient ordered to submit to compulsory treatment shall be discharged from the institute when there is no longer cause for the said treatment.

3.13.1.4 Admission into a social care home

For people who have been placed under guardianship, detention in a social care home is treated as a voluntary process. There are no established standards or procedural protections. Even though a guardianship authority may be required to approve a social care home placement, this is a purely administrative review process.

3.13.2 Coercive measures

3.13.2.1 Restriction of personal liberty

Article 10 (4) of the Health Care Law of 1997 (known as CLIV which came into force in 1998) allows for the temporary restriction of a patient's liberty during treatment with physical, chemical, biological or psychological means in case of necessity, i.e. to protect the life, physical inviolability and health of the patient or other people. Such measures cannot be applied for the purpose of punishment, cannot be degrading or inhuman and can only last as long as the need exists. During the application of these measures, the patient's needs must be monitored and recorded in his/her medical files.

Such restraint/deprivation of liberty must be ordered by a doctor who must note the reason and duration of the measure in the patient's medical file, preferably before the

measure is applied. In the absence of constant medical supervision a nurse can assign such measure but the written approval of the doctor must be obtained within 16 hours. In the absence of such approval the measure must be stopped.

3.13.2.2 The procedure for the use of coercive measures

The application of restrictive methods or procedures shall be ordered by the patient's attending doctor. Prior to applying such coercive measures, or if it is not possible, within the shortest possible time after the initiation of their application, the attending doctor shall enter the coercive methods or procedures in the medical record, indicating precisely the reasons for and the duration of application. In the absence of continuous medical supervision, in exceptionally justified cases, a registered specialist nurse may also give temporary order for the restriction. The attending doctor shall be informed of the restriction without delay, and shall be required to approve it in writing within sixteen hours. In the absence of such approval, the restriction must be terminated. If restrictive methods and measures are applied, the patient's condition and physical needs shall be observed regularly, in compliance with professional rules. The observation and the findings shall be entered into the patient's medical records.

The Act on Healthcare regulates involuntary treatment and coercive measures that can be applied to psychiatric patients in a separate chapter. According to the definition, people with dementia can fall under the term of psychiatric patients. Psychiatric patients are those who are diagnosed under F00-F99 or X60-X84 according to the International Classification of Diseases.

The rights of a psychiatric patient, as set forth under the general rules on patients' rights, shall be restricted, while receiving healthcare services, only in keeping with the specifications of the Act on Healthcare, and only to the degree and for the duration of time absolutely necessary, and only if the patient's behaviour qualifies as dangerous or immediately dangerous. However, the right to human dignity shall not be restricted, even in this case.

3.13.2.3 The duration of the use of coercive measures

Only a patient who exhibits dangerous or immediately dangerous behaviour shall be restricted in his/her personal freedom in any manner whatsoever. The restriction shall only be maintained, and shall only be employed to the extent and in the manner that is absolutely necessary to avert the danger. The general rules explained above on coercive measures shall be applied in ordering restraints and in the mode of restriction. The doctor shall immediately be notified of the restriction, and said doctor shall have to approve the measure within 2 hours. If this is not forthcoming, the restriction shall be immediately terminated. During the course of the coercive measure the condition of the patient shall be monitored continuously.

The Act on Healthcare defines three types of psychiatric treatment: voluntary, emergency and compulsory. The court shall review the necessity of the treatment periodi-

cally (every 30 or 60 days) in the case of voluntary treatment as well. A patient admitted voluntarily shall not be discharged if in the course of treatment s/he displays dangerous or immediately dangerous behaviour and the need for institutional treatment exists for that reason.

3.13.2.4 The use of coercive measures in social care homes

If someone exhibits dangerous or immediately dangerous behaviour in a social care home, the coercive measures can be applied according to the chapter on psychiatric patients in the Act on Healthcare. The attending doctor is the doctor of the social care home. If the said doctor is not available, the head of the social care home shall appoint a registered nurse to enter the restrictive measures. In this case, the head and the doctor of the social care home shall be informed without delay. The head of the social care home shall inform within 48 hours the legal representative of the patient and the clients' rights representative about the restrictive measures taken.

The above information was taken from the report "Human Rights and Mental Health: Hungary (1997).

3.13.2.5 Coercive measures to make a person change his/her decision

A patient or person who has refused life-saving or sustaining treatment in accordance with Article 22 of the Act CLIV of 1997 on Health Care during the rejection of the treatment cannot be coerced to change his or her decision.

3.13.3 Mistreatment/abuse

According to the Hungarian Civil Liberties Union's (HCLU) survey conducted in 2002, there are serious violations of law and human rights in the area of measures restricting the liberty of psychiatric patients. (Patient Rights in Hungary – Rules and Practice, Published by HCLU, 2002 January, Budapest)

3.13.4 Driving

Article 59 of Act IV of 1978 on the Criminal Code does not specifically refer to dementia but covers the prohibition from driving vehicles of people who are not fit to drive. It states:

Prohibition from driving vehicles shall be of definitive effect or shall be of definite duration. Such person may be prohibited with definitive effect, who is unsuitable for driving vehicles. The shortest duration of prohibition of definite duration shall be one year, its longest duration shall be ten years.

Articles 18 and 19 of Act LXIX of 1998 on the Summary Offences also name the prohibition from driving vehicles as a possible action to be taken in case of committing the offence while breaking the rules of driving vehicles. The shortest duration shall be one

month, the longest shall be one year. However, the prohibition from driving vehicles cannot be of definitive effect in this case.

3.13.5 Reference

Rosenthal, E., Okin, R., Bauer, E. et al. (1997), *Human Rights and Mental Health: Hungary*, Mental Disability Rights International, Accessed online on 11 October 2011 at:

<http://www.disabilityrightsintl.org/wordpress/wp-content/uploads/Hungary.pdf>

3.14 *Iceland*

3.14.1 Involuntary internment

3.14.1.1 Involuntary internment of a legally competent person

In the Act on Legal Competence of 1997 (ALC), the term “involuntary commitment” is used to refer both to the transfer of a legally competent person to a hospital against his or her will followed by detention there, and to continued detention in hospital of a person against his or her will, who was already in hospital and had up to that point consented to being there. In section 19, it is stated that people possessing personal legal competence cannot be committed to a hospital against their will. However, the following sections make it clear that it is possible to do so as long as certain conditions are fulfilled. This section is about the involuntary commitment of people who have not been deprived of their legal competence. Once interned, a process for the deprivation of legal competence may be initiated.

The procedure for involuntary internment

A request for involuntary commitment of a person to hospital can be made to the Ministry of Justice by:

- The person's spouse, his/her relatives by direct descent and siblings
- The person's guardian or administrator
- The social security office or a corresponding municipal authority at the person's place of stay at the time a request for deprivation of legal competence is considered advisable as a result of his or her own petition or that of his or her next of kin, doctor or friends, or by reason of knowledge of his or her situation otherwise obtained.

A form must be filled out and the request must be accompanied by a medical certificate not more than three days old containing the doctor's description of the mental and physical condition of the person in question, the diagnosis if available and his or her opinion that the internment of the person is necessary (section 21).

The Ministry of Justice then processes the request on the basis of the completed form and attached medical certificate. If more information or evidence is needed, it is obtained. The Ministry may engage a consultant doctor to provide an opinion before making a decision. The consultant doctor can examine the condition of the person who has been committed at any time. The Ministry of Justice finally makes a decision and informs the relevant parties (sections 22-23).

A person who has been involuntarily committed can refer the decision to the courts. A judge will then without delay initiate the relevant legal procedure (section 30).

The duration of involuntary internment

A person can be transferred to hospital against his or her will for not more than 48 hours. If approved by the Ministry of Justice, the person can then be committed for a period not exceeding 21 days (provided that it is unavoidable in the opinion of a doctor). In both cases, the involuntary commitment may never last longer than the chief doctor considers necessary (section 29).

3.14.1.2 Involuntary internment of people deprived of legal competence

If the guardian of a person deprived of personal competence wants to have that person committed to an institution, he or she can only do so if a doctor deems that the life or health of the person is in danger (section 58 of the ALC). If this is the case, the guardian may decide to commit the person deprived of personal competence to an institution operated in accordance with the Health Services Act or the Act on the Affairs of the Disabled. He or she must then inform the supervisor of guardians. The guardian is entitled to ask for the assistance of the police to transfer the person deprived of personal competence to hospital and the doctor may accompany him or her if this is deemed necessary (section 19).

Personal advisors (councillors)

Section 27 of the Act on Legal Competence outlines the role of councillors in the case of involuntary internment. According to this section, a person subject to involuntary internment is entitled to the counsel and support of a specially appointed councillor with whom he or she can speak in private and on a regular basis (provided that his/her condition does not render this meaningless). The councillor can consult the person's medical file and must ensure that any information that he or she discovers in the course of his or her functions is treated with confidentiality. The State Treasury pays the councillor's fees.

3.14.2 Coercive measures

Article 226 of the Penal Code states that anyone depriving another person of his/her freedom shall be subject to imprisonment for up to 4 years.

A penalty of imprisonment for no less than 1 year and up to 16 years or for life may be applied in certain circumstances, namely:

- if the deprivation of freedom was committed for the purpose of gain
- if the deprivation of freedom was of an extended duration
- if the person was illegally admitted to a lunatic asylum, removed to other countries or handed over to unauthorised people

3.14.3 Reference

Act on Legal Competence, N°71 of 1997. Accessed on 25 October 2011 on the Ministry of the Interior website at:

<http://eng.innanrikisraduneyti.is/laws-and-regulations/english/legal-competence/>

3.15 Ireland

3.15.1 Involuntary internment

Article 40.4.1 of the Constitution states that nobody can be deprived of personal liberty save in accordance with the law. Therefore, in order to admit and detain a person in a psychiatric institution an application must be made to the courts in accordance with this article of the Constitution.

There are in theory two possibilities. The first possibility is that at the same time as making a person a ward of court, the judge makes a wardship order under section 15 of the 1871 Act. This contains an instruction that the ward be detained in a hospital or an institution. The other possibility is that the person is detained against his/her will in accordance with the Mental Health Act of 2001. (It should be noted that a review of the 2001 Act is imminent having been announced in a Government press release on September 7, 2011.⁴⁹)

In practice, however, it should be noted that many people with dementia are effectively detained outside the Mental Health Act 2001. The majority of people with dementia in nursing homes, for example, are not free to leave and would be stopped if they attempted to do so. It is to be supposed that many people with dementia fall within similar circumstances to those in the “Bournewood” case where they are incapable of consenting to what is in effect detention. The courts have yet to consider a case of this nature, where a person is effectively detained in what is not an approved centre under the 2001 Act. In relation to approved centres, the Irish High Court has interpreted “voluntary” to include the situation where a patient is incapacitated but compliant⁵⁰, arguably in conflict with the European Convention on Human Rights.

3.15.1.1 Conditions for involuntary internment

A person may be involuntarily admitted to an approved centre and detained there on the grounds that s/he is suffering from a mental disorder (but not uniquely because s/he is suffering from a personality disorder, is socially deviant or is addicted to drugs or intoxicants) (§8)

Earlier in the Act, in §3 (1), the definition of mental disorder provides further information about the conditions linked to involuntary internment. Mental disorder is defined as a mental illness, severe dementia or significant intellectual disability where:

- a. *because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons,*
OR

49 <http://www.dohc.ie/press/releases/2011/20110907b.html>

50 *EH v St Vincent's Hospital and Ors*[2009] IESC 46

- b. *because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, AND*
- c. *the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.*

This is one of the few Acts on involuntary internment which specifically refers to dementia. The following definitions of mental illness and severe dementia are provided in §3 (2):

“mental illness” means a state of mind of a person which affects the person’s thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons;

“severe dementia” means a deterioration of the brain of a person which significantly impairs the intellectual function of the person thereby affecting thought, comprehension and memory and which includes severe psychiatric or behavioural symptoms such as physical aggression;

3.15.1.2 The procedure for involuntary internment

The request/application for involuntary internment

According to §9, a request to involuntarily admit a person to an approved centre can be made to a registered medical practitioner by:

- The spouse or a relative of the person,
- an authorised officer or,
- a member of the Garda Síochána,
- any other person, with the exception of the following:
 - a person under 18 years of age,
 - an authorised officer or a member of the Garda Síochána who is a relative of the person or of the spouse of the person,
 - a member of the governing body, or the staff, or the person in charge, of the approved centre,
 - someone who has an interest in the payment (if any) to be made in respect of the taking care of the person concerned in the approved centre,
 - any registered medical practitioner who provides a regular medical service at the approved centre,

- the spouse, parent, grandparent, brother, sister, uncle or aunt of any of the four above-mentioned categories of people (i.e. except for the under 18 year olds) regardless of whether they are related by blood.

In order to make such a request the person must have seen the one s/he is applying to have admitted within 48 hours of the date of the request. If someone, for the purposes of or in relation to an application, makes any statement which is to his/her knowledge false or misleading in any material particular, s/he shall be guilty of an offence.

The recommendation

§10 provides details of the process leading to the involuntary internment of the person and the role of the medical practitioner in that process. It is stated that if, upon examining the person for whom the measure is being requested, a registered medical practitioner is satisfied that the said person is suffering from a mental disorder, the medical practitioner shall make a recommendation to involuntarily admit that person to a specified approved centre (other than the Central Medical Hospital). This must be sent by the registered medical practitioner concerned to the clinical director of the approved centre concerned and a copy of the recommendation must be given to the applicant concerned. Such recommendations are valid for seven days from the date they were made, after which they expire.

The person for whom the measure is intended must be examined within 24 hours of receipt of the application. S/he must be informed of the purpose of the examination unless the registered medical practitioner feels that the provision of such information might be prejudicial to the person's mental, wellbeing or emotional condition.

The registered medical practitioner is not authorised to make a recommendation for involuntary internment if s/he:

- has an interest in the payments (if any) to be made in respect of the care of the person in the approved centre concerned,
- is a member of the staff of the approved centre to which the person is to be admitted,
- is a spouse or a relative of the person, or
- is the applicant.

If the application to have a person involuntarily interned is refused and the applicant would like to make a further application, s/he must inform the registered medical practitioner of the details of the prior application (§11).

Where a member of the Garda Síochána has reasonable grounds for believing that a person is suffering from a mental disorder and that because of the mental disorder there is a serious likelihood of the person causing immediate and serious harm to himself or

herself or to other persons, the member may either alone or with any other members of the Garda Síochána take the person into custody. If necessary, s/he or they may enter by force into the place where the person is believed to be (§12-1). After having taken a person into custody in this way, the member of the Garda Síochána must make an application to a registered medical practitioner for a recommendation. If the application is later rejected, the person must be released from custody immediately.

The admission order

Whenever a recommendation for involuntary internment is received by the clinical director of an approved centre, s/he must arrange for a consultant psychiatrist on the staff of that approved centre to examine the person. If the consultant psychiatrist is satisfied that the person is suffering from a mental disorder, s/he may make an “admission order” for the reception, detention and treatment of the person (who, in the context of the Act, is then referred to as the patient). A consultant psychiatrist, medical practitioner or registered nurse of the approved centre may take charge of the patient and detain him/her for a maximum of 24 hours in order to carry out such an examination. The consultant psychiatrist cannot be the spouse or relative of the patient or the applicant. (§14)

Once an admission order or a renewal order has been made, the consultant must send a copy of the order to the Commission and inform the patient in writing of the decision and this must be done within 24 hours (§16). The statement to the patient must include the following details:

- that s/he is being detained pursuant to section 14 or 15 as the case may be,
- that s/he is entitled to legal representation,
- that s/he will be provided with a general description of the proposed treatment that s/he will receive,
- that s/he has the right to communicate with the Inspector,
- that his/her detention will be reviewed by a tribunal,
- that s/he is entitled to appeal to the Circuit Court against the decision of the tribunal if s/he is the subject of a renewal order,
- that s/he may be admitted to the approved centre as voluntary patient s/he so wishes.

The court procedure

On receipt of an admission or renewal order the Commission must as soon as possible refer the matter to a tribunal and assign a legal representative to the patient unless the patient proposes one him/herself. The tribunal must also issue a “direction” to a member of the panel of consultant psychiatrists to examine the patient concerned, interview the consultant psychiatrist responsible for the patient’s care, interview the consultant psychiatrist, review the patient’s records in order to determine whether the patient is suf-

fering from a mental disorder and to provide a full report within 14 days which must be given to the legal representative of the patient. Anyone who obstructs or fails to cooperate with the consultant psychiatrist to whom a “direction” has been given shall be guilty of an offence (§17).

When an admission order or renewal order is referred to a tribunal, the tribunal must, not later than 21 days after the order was made, review the legitimacy of the detention and either affirm or alternatively revoke the order and order the release of the patient from detention (§18). The period of 21 days can be extended by a period of 14 days and then if the patient requests it by a further period of 14 days (if the tribunal is satisfied that this would be in the patient’s interests).

However, before making a decision, the tribunal must see the report produced by the consultant psychiatrist. The decision made by the tribunal and the reasons for it must be communicated to the Commission, the consultant psychiatrist, the patient and his/her legal representative and any other person to whom the tribunal is of the opinion that they should receive it.

3.15.1.3 The duration of involuntary internment

Once an admission order has been established, the patient may be detained and treated for a period of 21 days from the date of the order and shall then expire. This may be extended by means of a “renewal order” which must be made by the consultant psychiatrist who is responsible for the care and treatment of the patient concerned for a further period of up to 3 months (§15). This may in turn be extended by order made by the consultant psychiatrist by a period of up to 6 months beginning on the expiration of the renewal order. After that, the period may be extended by periods of up to 12 months each by means of a renewal order made by the consultant psychiatrist. For each of these renewal orders to be valid, the consultant psychiatrist must have examined the patient not more than one week before making the order and must confirm that the patient is still suffering from a mental disorder.

3.15.1.4 The process of review

The patient may appeal to the Circuit Court against the tribunal’s decision to affirm an order about him/her on the grounds that s/he is not suffering from a mental disorder (§19). The appeal must be made in writing by the patient or by his/her legal representative within 14 days of the notice of detention or prolongation of detention. The Circuit Court shall, depending on whether it is convinced of the patient’s claim not to be suffering from a mental disorder, either affirm or revoke the order.

The consultant psychiatrist concerned, the tribunal, the clinical director of the approved centre and any person specified by the Circuit Court shall be informed of any proceedings in connection with the appeal. Only officers of the Court, people directly concerned, *bona fide* representatives of the Press and any other people that the Court sees fit, may be present in Court during the hearing. Nothing shall be published in a written publica-

tion available to the public or broadcast which might enable members of the public to identify a patient who is or has been the subject of such proceedings. Anyone who publishes or broadcasts such information would be guilty of an offence.

3.15.2 Coercive measures

A person who has been involuntarily interned cannot be placed in seclusion or restrained by mechanical means unless such seclusion or restraint is in accordance with the rules provided by the Commission and is necessary for the purposes of treatment or to prevent the said person from injuring him/herself or other people (§69 of the Mental Health Act of 2001). This also applies to voluntary patients. A person who contravenes this rule shall be guilty of an offence and may be fined up to £1,500.

3.15.3 Mistreatment/abuse

While there has been progress in the development of awareness and an operational framework around the prevention of elder abuse, there is still no statutory framework for dealing with the mistreatment or abuse of adults. In 2007, the Health Service Executive introduced Guidelines on Elder Abuse. There is a dedicated Officer for Elder Abuse (a senior social worker) in each HSE region. The absence of a statutory framework and statutory powers for Elder Abuse Officers remains an issue. Where an adult who lacks capacity is found to be being abused, currently the only –and drastic– legal option would be to have them made a Ward of Court and removed from the situation.

3.15.4 Driving

Paragraph 26 (3) of the Road Traffic Act of 2010 states that the Bureau may from time to time arrange for research into the physical and mental fitness of drivers of vehicles.

The licensing of drivers is governed by the Road Traffic (Licensing of Drivers) Regulations 2006, Statutory Instrument 537 of 2006, as amended 2010.

Requirement for medical report

In general applications for a driving licence do not require a medical report (other than, in all cases, an eyesight report) except

- a) When the vehicle is classified as category B, i.e. higher risk vehicles such as lorries, buses
- b) When the applicant is over 70 years of age.
- c) Where the applicant has one of the conditions listed in the regulations as requiring a medical report. Dementia is not one of the specifically listed conditions.

Certification may be for a limited period with a requirement for review.

Period of licence

Generally, licences are issued for 3 or 10-year periods. However, where the applicant is aged between 60 and 67, they may apply for a 3-year licence or a licence that will expire the day before their 70th birthday.

If the applicant is older than 67 but under 70 years of age, they may apply for a 3-year licence. Over the age of 70, only one-year or three-year licences are issued and medical certification of fitness to drive is required on each renewal of the licence.

There are no specific legal provisions as to what should happen if someone becomes unfit to drive during their licence period. It is possible that an insurance policy may become void if a condition is not notified to the insurer and therefore the offence of driving without insurance may be committed.

3.16 Italy

3.16.1 Involuntary internment

According to Law no. 180 of 13 May 1978 on Voluntary and Obligatory Health Assessments and Treatment, people can be admitted to hospital for treatment without consent if their mental condition renders urgent treatment necessary and this can only be carried out in a hospital (Delpérée, 1991).

In line with article 33 Law no. 180 of 13 May 1978 on Voluntary and Obligatory Health Assessments and Treatment, obligatory health treatment must be carried out with respect for the person's dignity and his/her civil and political rights which are guaranteed by the Constitution. On the basis of a request from a doctor, the Mayor decides on the necessity to administer obligatory health assessments and treatment. Any person may appeal against this decision and a decision must be made within 10 days.

If a person is suffering from a mental disorder, the tutelary judge judges the affair within 48 hours and informs the mayor of his/her decision. It is also the responsibility of the tutelary judge to take the necessary measures to protect the person's possessions. The person concerned by the obligatory treatment and any other interested party may appeal against the judge's decision, as can the mayor.

3.16.2 Coercive measures

Article 51 of the Italian Code of Medical Ethics of 2006 states that in the case of obligatory medical treatment, the doctor must not solicit or engage in coercive measures, except in case of real need and on the condition that the person's dignity respected and that this is in accordance with the law.

Under the Italian Code of Ethics of Nursing of 2009, it is stated that nurses shall ensure that restraint is only used under exceptional circumstances (art. 30). Should a nurse discover the existence of abuse or deprivation, s/he must take all measures to protect the patient and, if necessary, report this to the relevant authorities (art. 33).

3.16.3 Driving

To avoid the risk of harm to themselves or others resulting from people with dementia driving a car, a relative (up to fourth degree), the support administrator or guardian, a special prosecutor or the prosecutor may file an application to the Office of Motor Vehicles, which in turn will inform the person concerned of the need to undergo a medical test at the Local Medical Committee for Driving Licences (established in each province at the local health unit) and asking him/her to refrain from driving pending a decision.

Article 119 of the Highway Code states that the normal primary care doctor can request that the person with dementia goes to the Local Medical Committee for Driving Licences if the outcome of clinical, instrumental and laboratory tests arouses doubts concerning that person's suitability and ability to drive safely.

3.16.4 Reference

Delpérée, N. (1991), *La protection des droits et des libertés des citoyens âgés*, La Nef

3.17 Latvia

3.17.1 Involuntary internment

3.17.1.1 The conditions for involuntary internment

Outpatient or inpatient examination and treatment of a patient against his or her will is covered by section 68 of the Medical Treatment Law of 1997 (with amendments up to 10 December 2009). According to this law, it may only be performed in the following situations:

1. if the behaviour of the patient is, due to a mental disorder, dangerous to him/herself or to the lives of other people (e.g. threatening to injure him/herself or others) and a medical practitioner has determined that s/he has a mental health disorder;
2. if the patient shows signs of an inability to care for him/herself or for a person under his/her guardianship and a medical practitioner has determined that s/he has a mental health disorder which may result in an unavoidable and serious deterioration of his/her health.

3.17.1.2 The procedure for involuntary internment

If a patient is hospitalised by force, the Council of Psychiatrists must examine the patient within 72 hours and make a decision about further treatment. The council must immediately inform the patient, his or her family members, or if none exists, his or her closest relatives or legal representatives (trustee, guardian) about the decision. If it is impossible to inform any of these people immediately through a meeting, a written notice must be sent and registered in the patient's file.

If the Council of Psychiatrists has decided that psychiatric treatment is necessary, the psychiatric medical institution must inform in writing the district court within 24 hours and send original copies of the relevant documents justifying internment.

On receipt of these documents and notification, the judge immediately informed the district public prosecutor, as well as the representative of the patient and the psychiatric medical treatment institution of the day, time and place for the examination of the relevant documents.

The judge holds a closed sitting in the psychiatric medical treatment institution in which the patient has been placed and the patient attends this meeting if his/her condition permits this, along with the public prosecutor and the representative of the patient or the advocate.

The judge hears all present and takes a decision regarding the provision of psychiatric assistance for up to two months or to release the person. This decision is implemented without delay. If further treatment is considered necessary, an application can be made to extend the treatment for a period of up to six months.

3.17.2 Coercive measures

Unlawful deprivation of liberty is dealt with in section 152 of the Criminal Law. The sentence is more severe if the deprivation of liberty was carried out in a way that endangered the life or health of the victim, caused him or her physical suffering, lasted for more than a week or occurred on a regular basis.

3.17.3 Mistreatment/abuse

Chapter XIII of the Criminal Law (sections 125 and 126) deals with serious and moderate bodily injury inflicted either intentionally or through negligence.

According to section 141 of the Criminal Law, it is a crime to knowingly abandon (leave without assistance) a person whose life or health is endangered or who is unable to save him/herself due to “juvility, advanced age, illness, or feebleness” if the offender was able to provide assistance and had an obligation to take care of that person.

Section 171 of the Criminal Law states that a person who uses guardianship or trusteeship to the detriment of the person subject to the guardianship or trusteeship measure may be sentenced to custodial arrest, community service or a fine not exceeding twenty times the minimum monthly wage.

3.17.4 Reference

Valsts valodas centrs (State Language Centre), *Medical Treatment Law*, Latvian Legislation Portal (accessed on 25 October 2011)

3.18 Lithuania

3.18.1 Involuntary internment

3.18.1.1 The conditions for involuntary internment

A person with a severe mental illness who refuses hospitalisation may be admitted against his/her will only if it is clear from his/her actions that there is a real danger that by his/her actions s/he may cause serious harm to his/her health or life or to the health or life of other people (article 27 of Law No. I-924 on Mental Health of 1995). Hospitalisation in this law is defined as admission to psychiatric institution as a patient.

3.18.1.2 The procedure for involuntary internment

If the above conditions have been fulfilled, the person shall be taken by the police for involuntary hospitalisation at the request of his/her representative or in accordance with a doctor's instructions or an order of the district court judge. A medical doctor must be present during the involuntary hospitalisation of the person (Article 28).

The person may then be involuntarily admitted to hospital and treated for a period not exceeding 72 hours without the consent of the Municipal Mental Health Commission (MMHC).

If authorisation from the MMHC is requested by the administration of the mental health facility within 72 hours, it may be possible to extend the involuntary hospitalisation and treatment of the patient for no longer than one month from the date of initial admission to hospital. The decision whether to extend the involuntary hospitalisation is made by the MMHC on the basis of a psychiatrist's recommendations.

A person with a mental disorder who is being involuntarily admitted to a mental health facility must acknowledge that s/he has been informed of this fact and of his/her rights. If he or she is unable or unwilling to sign such a statement, it must be testified in writing by two witnesses who may be mental health facility staff members but not psychiatrists (article 30).

If a person's hospitalisation is in violation of the requirements of the Law on Mental Health, the person responsible for the illegal hospitalisation shall be held liable according to the laws of the Republic of Lithuania (article 31).

3.18.1.3 The duration of involuntary internment

Should it be necessary to extend the involuntary hospitalisation and treatment further than that mentioned above (article 28), the administration of the mental health facility may apply to the district court. The latter may decide to either prolong or terminate the hospitalisation, each time for a period not exceeding six months. The hospitalisation may be terminated before the end of a six-month period by the administration of the mental health facility on the recommendation of the attending psychiatrist.

3.18.2 Coercive measures

Coercive measures, according to the Law No. I-924 on Mental Health of 1995, are strongly linked to the involuntary internment and are regulated in Articles 16 and 13.

Part 3 of the Article 16 states that *‘a patient can be submitted to a coercive treatment only if he was involuntarily admitted to hospital according to the rules set out in Article 28’* (see above).

In Part 2 of the Article 13 it is stated that:

“The actions of the patient can be restricted only in cases when there is a real danger that the person, by his/her own actions, can cause an essential damage to his/her health or life, or to the health and life of the others. Such coercive treatment measures have to be immediately noted in his/her case-record (medical record) by his/her psychiatrist.”

3.18.3 Mistreatment/abuse

According to the Article 20 of the Law No. I-924 on Mental Health of 1995, the patient, or his legal representative has the right to report any breach of patients’ rights, which are set out in this law, to the administration of the psychiatric facility, Ministry of Healthcare or the court.

Any involuntary internment of the patient which was not carried out according to the rules set out in Articles 27-30 of the Law on Mental Health of 1995, will be punished on the basis of Article 146 of the Criminal Code of Lithuania which is governing the unlawful deprivation of liberty of persons.

3.18.4 Driving

All drivers or persons, who are trying to obtain a driver’s licence, have to undergo a regular medical check-up to assess their physical and psychological suitability for becoming a driver. The procedure is regulated by ministerial order, signed by the Minister of Healthcare. At the moment it is Order No. 301 (year 2000, updated in 2008) of the Minister of Healthcare.

In the case of mental or behavioural disorders, such as serious mental disorder, which are inborn or caused by illness, trauma or neurological surgery, severe dementia or severe behavioural disorders due to ageing.

Periodicity of regular medical check-ups is the following:

- persons under 55 years of age - once in 10 years,
- persons under 69 years of age - once in 5 years,
- persons under 79 years of age - once in 2 years,
- persons above 80 years of age - once a year.

3.19 Luxembourg

3.19.1 Involuntary internment

According to article 434 of the Penal Code, anybody who unlawfully arrests or detains another person without authorisation is guilty of an offence and liable to a prison sentence (please see sub-section on coercive measures for more details).

However, the Law of 10 December 2009 on the placement of people suffering from mental disorders provides the legal justification to detain people with dementia in the psychiatric departments of hospitals or in specialised psychiatric establishments. It does apply to placement or the deprivation of liberty in day care centres or other establishments.

3.19.1.1 The conditions for involuntary internment

The procedure for involuntary internment involves two stages. First, there is a procedure to detain a person for the purposes of observation and second, there is a procedure for the involuntary placement of the person in question.

Article 3 states that a person who is suffering from a mental disorder should be treated in the locality in which s/he lives to the extent that this is possible. The person can be interned in a closed psychiatric establishment or department according to the provisions of this law only if s/he:

- is suffering from a mental disorder and
- this makes him/her a danger to him/herself or other people.

A diminution of mental faculties due to ageing is not, in itself, sufficient grounds for a placement.

3.19.1.2 The procedure for involuntary internment

The following people can request internment: the curator or tutor of an incapable adult, a member of the family or another interested person. If a person represents a threat to public order or safety, the request may be made by the mayor of the commune, the deputy mayor, the chief of the police brigade or station or his/her replacement appointed by the mayor or the State Prosecutor.

The person making the request must explain his/her reasons and provide a medical certificate (not more than three days old) from a doctor who has examined the patient on the day it was written. The doctor cannot be the person's spouse, a relative or a future inheritor. Neither can s/he belong to the establishment where the person would be interned. In cases of urgency, the medical certificate is not demanded at the time of the patient's placement, but must be produced within 24 hours.

The director of the establishment then receives the person and must notify the State Prosecutor and Chairman of the Supervisory Commission within 48 hours. The patient is placed under observation for a period of 15 days, during which the doctor observes the patient and carries out the relevant examinations in order to determine whether or not s/he should remain in care and in order to make the diagnosis. After this period, the doctor decides whether the patient should be kept in hospital or released and informs the State Prosecutor and the Chairman of the Supervisory Commission. S/he informs the patient of the decision, as well as the person who made the request for internment.

3.19.1.3 The right to appeal and review process

After one year has passed since the decision to intern the patient was made, a commission composed of a judicial magistrate, a doctor specialised in psychiatry or neurology and a community health worker or health visitor (not attached to the establishment) consult with the treating doctor and gather the necessary information in order to decide whether the patient's detention remains justified. If it is decided to maintain the patient in hospital, the committee meets again in two years' time and then every two years.

The patient may at any time apply to the court of the district in which the establishment is located in order to request that s/he be discharged. Any other interested party may also make such a request. However, once an appeal has been rejected, it is necessary to wait a year until making another appeal, as otherwise it will not be considered.

3.19.1.4 Confinement at home

An alternative to internment in a psychiatric establishment is the possibility to sequester a person who is suffering from a mental disorder at home. The person who proposes this must obtain a medical certificate and make the request to the tutelary judge. The judge then arranges for a medical examination of the person to be guarded by a specialist in psychiatry or neurology. Authorisation can only be given if both doctors agree on the necessity of this protective measure and that the person can be cared for at home. If this is the case, the judge fixes the conditions and informs the State Prosecutor of the decision.

The two magistrates can then visit the person whenever they see fit, although the judge must make a visit whenever the designated doctor considers it necessary and at least once every three months. The doctor must inform the judge if at any time s/he considers it necessary for the person to be interned due to a deterioration of the latter's condition or if the person responsible for care and lodging has not observed the conditions previously agreed upon.

3.19.1.5 Patient advisors

According to article 30 of the Law of 26th May 1998 on the placement of people suffering from mental disorders in closed psychiatric establishments or departments, the Ministry of Health designates a civil servant in each establishment who is responsible for informing patients of their rights, notably in connection with the said law. This civil servant can also advise them in legal or general matters which concern them.

3.19.2 Coercive measures

3.19.2.1 Deprivation of freedom

The illegal deprivation of a person's liberty carries a prison sentence of between 3 months and 2 years and a fine of between EUR 251 and EUR 2,000 for the person responsible for such act (art. 434 of the Penal Code). The duration of imprisonment and the amount of the fine are considerably higher if the duration of illegal and arbitrary deprivation of liberty was over 10 days or 1 month (articles 435 and 436 of the Penal Code), i.e. up to a maximum of EUR 5,000 and of 5 years' imprisonment.

3.19.3 Mistreatment/abuse

According to article 398 of the Penal Code, whoever voluntarily injures or strikes another person will be punished with a prison sentence and a fine or just one of these punishments. If the act was carried out with premeditation, the sentences can be increased to a maximum of one year's imprisonment and a fine of EUR 2,000.

A person who voluntarily injures or hits another person may be fined between EUR 251 and EUR 5,000 and receive a prison sentence of between 6 months and 5 years if that person is, for example, his/her partner, parent, sibling or someone who is particularly vulnerable due to their age, an illness, a physical or mental deficiency of which the perpetrator is aware (article 409 of the Penal Code). If the violence is carried out by a person who lives with the victim, the former may be ordered to maintain a certain distance from the home and from the victim and to refrain from contacting the victim.

3.19.4 Driving

Article 77 of the Road Traffic Regulations with amendments up to 6 May 2010 (Arrêté grand-ducal du 23 novembre 1955 portant règlement de la circulation sur toutes les voies publiques) stipulates that in order to obtain or renew a driving licence, a person must have a medical test to ensure that s/he is not suffering from an infirmity or disorder liable to affect his/her ability or capacity to drive. A person who is already in possession of a valid driving licence may be requested at any time by the Ministry of Transport to have a medical examination if there is a doubt concerning his/her ability and capacity to drive. One of the aims of the medical examination is to determine whether or not the person is suffering from a mental disorder. Concerning mental disorder, subsection 6 of article 77 states:

"If the interested party is affected by mental disorder due to illness, trauma or an operation on the central nervous system or obvious mental retardation, or if s/he is suffering from a serious psychotic disorder, the driving licence is only issued or renewed on the advice of the Medical Commission. The same applies to candidates presenting serious behavioural disorders due to ageing or a major disorder in the capacity of judgement, behaviour or adaptation linked to the personality."

3.20 Malta

3.20.1 Involuntary internment

The fundamental rights and freedom of the individual are guaranteed by Chapter IV of the Constitution of Malta.

Involuntary internment is covered by Chapter 262 of the Mental Health Act of 1976 as amended by Acts XIII of 1983 and VI of 2001.

3.20.1.1 The conditions for involuntary internment

A person may be admitted to a hospital for observation or treatment if:

- s/he is suffering from mental disorder of a nature or degree which warrants the detention of the patients in a hospital and
- it is necessary that s/he be so detained in the interests of his/her own health or safety or with a view to the protection of other people.

In the context of this law, the term "hospital" is understood as referring to Mount Carmel Hospital, the Chambrai hospital, any other hospital declared by the Minister by notice in the Gazette to be a hospital for the purposes of this act and also a mental nursing home. A mental nursing home is a place that is not a hospital, which provides nursing or other medical treatment to "mentally disordered patients", either exclusively or together with other categories of patients (article 14).

3.20.1.2 The procedure for involuntary internment

An application for admission must be based on the provision of two written recommendations from medical practitioners, given either jointly or separately, which confirm that the two conditions mentioned above are applicable. In the case of admission for treatment, they must also give detailed reasons for their opinion, specify whether other methods of dealing with the patient exist and if they do, why such methods are not appropriate (article 14).

If admission is considered urgent, one written recommendation is sufficient, preferably from a practitioner with previous acquaintance of the person concerned. However, in this case, the person must be released after 72 hours unless a second medical recommendation has been produced (article 15).

Applications for admittance to hospital may be made by the nearest relative or a mental welfare officer provided that the person making the request has personally seen the patient in the last fortnight (article 16).

If a patient is already an inpatient in a hospital but not liable to be detained there, an application for observation or treatment in that hospital can still be made (article 18).

3.20.1.3 The duration of the involuntary internment

A person who has been admitted to hospital for observation can be detained for up to twenty-eight days after which s/he must be released unless s/he has become liable to be detained for reasons other than observation.

A person who has been admitted to hospital in pursuance of an application for treatment may be detained for up to one year unless the authority for his/her detention is renewed. If this is the case, s/he can be detained for a further period of one year and thereafter for periods of two years at a time (article 21).

3.20.1.4 Request from the nearest relative for discharge

In article 30, relatives are organised in a hierarchy of their degree of closeness to the person as follows:

1. Husband or wife (unless permanently separated)
2. Son or daughter
3. Father
4. Mother
5. Brother or sister
6. Grandparent
7. Grandchild
8. Uncle or aunt
9. Nephew or niece

The nearest relative can make an application for discharge of a person who has been detained in hospital for treatment after having given seventy-two hours' notice in writing to the manager of the hospital. In that time, the responsible medical officer may provide a report to the manager of the hospital that in his/her opinion the person would, if discharged, be likely to act in a way that is dangerous to him/herself or to others. If so, the application for discharge made by the nearest relative would be of no effect and the nearest relative would have to wait six months from the date of the report before making another application (article 29).

3.20.2 Coercive measures

The use of violence to compel another person to do, suffer or omit anything is punishable (article 251 (1) of the Penal Code). Harassment is also considered an offence under article 251A (1). Harassment is defined as alarming another person or causing that person distress (article 251C).

Article 251B covers the threat of violence which is also considered an offence punishable by a prison sentence of 3 to 6 months or a fine of not less than EUR 4,658.75 and not more than EUR 11,646.87 or both a fine and imprisonment.

3.20.3 Mistreatment/abuse

A person who, without intent to kill or to put a person's life in danger, causes harm to the body or health of another person or causes mental derangement to that person, shall be guilty of bodily harm. Such bodily harm may be considered grievous or slight (articles 214 and 215 of the Penal Code).

The punishment for bodily harm is increased by one or two degrees in cases where the person harmed is 60 years old or more or is suffering from a physical or mental infirmity which results in him/her being unable to defend him/herself adequately (article 222A(1)).

Article 339 (1) of the Penal Code provides a list of various acts committed against other people which are considered as contraventions. Those which could be relevant to people with dementia include the following (originally numbering used):

Incidents or cases in which a person:

"(b) without inflicting any wound or blow, threatens others with stones or other hard substances, or throws the same, or takes up any other weapon against any person;

(d) attempts to use force against any person with intent to insult, annoy or hurt such person or others, unless the fact constitutes some other offence under any other provision of this Code;

(e) utters insults or threats not otherwise provided for in this Code, or being provoked, carries his insult beyond the limit warranted by the provocation;

(f) through carelessness or want of caution throws water, or other liquid, or filth upon any person;

(i) frightens or terrifies any other person, in a manner that might cause harm to such person although it be done in jest;

(i) being in duty bound to take care of children, or of other persons incapable of taking care of themselves, neglects to take the necessary care of such children or persons;

(l) pushes against any person in the street with the object of hurting or insulting such person;

(n) annoys, vexes or scoffs at any imbecile, aged, crippled, feeble or deformed person;

(o) even though without the intent of committing another offence, enters into the dwelling-house of another person, against the express warning of such person, or without his knowledge, or under false pretences or by any other deceit."

For those referred to as (d), (e), (l) and (o) proceedings would only be instituted on the complaint of the injured party.

The Domestic Violence Act of 2006 addresses the issue of violence between members of a family or between people sharing the same household. The definition of violence also includes any omission which causes physical or moral harm to the other person. However, this law only concerns the setting up and duties of a special commission to advise the Minister on all aspects of domestic violence.

3.20.4 Driving

Regulation 34 of the Subsidiary Legislation 65.18 on motor vehicles (driving licences) regulations covers various factors which might disqualify a person from obtaining or renewing a driving licence. Under article 9 of regulation 34 it is stated that

“driving licences shall not be issued to, or renewed for, applicants or drivers who suffer from:

- severe mental disturbance, whether congenital or due to disease, trauma or neurosurgical operations;*
- severe mental retardation;*
- severe behavioural problems due to ageing; or personality defects leading to seriously impaired judgment, behaviour or adaptability,*

unless their application is supported by authorised medical opinion and, if necessary, subject to regular medical check-ups.”

It is further stated that the competent medical authority shall give due consideration to the additional risk and dangers involved in the driving of vehicles covered by the definition of this group.

3.21 *Netherlands*

3.21.1 Involuntary internment

The Act of 29 October 1992 (and subsequent amendments)⁵¹ replaced the Act of 27 April 1884 on the State Supervision of the Mentally Ill. It is known as the B.O.P.Z. A new bill (Care and Force) is under preparation at the moment. This bill deals extensively with involuntary care. The B.O.P.Z. applies in case of internment in a nursing home or a psycho-geriatric ward, in general in accommodation where the doors can be locked. In case of internment in a home for the elderly or a pension etc., the B.O.P.Z. does not apply. Involuntary internment in accommodation where the B.O.P.Z. applies can be realised in three ways: by involvement of a court, a mayor or an assessment committee.

3.21.1.1 The conditions for involuntary internment

A court may grant an interim order for a person who is suffering from a disturbance of his/her mental faculties to be admitted to and accommodated in a psychiatric hospital. If the person has already been voluntarily admitted, the order would be to prolong his/her accommodation. The order can only be granted on the basis of two conditions being fulfilled:

- That the disturbance of mental faculties constitutes a danger
- That the danger cannot be averted by the intervention of persons or institutions other than a psychiatric hospital.

However, the above two conditions are not sufficient. An order for involuntary internment is dependent on the fact that the person for whom the measure is intended does not consent to being admitted. An order by the court is also needed if the person himself gives his/her consent, but the guardian or mentor is opposed to internment.

3.21.1.2 The procedure for involuntary internment

A petition for an interim order can be made by the spouse, parents, a blood relation (up to the second degree), a guardian, trustee or mentor of the person concerned. The petition must be made in writing and sent to the Examining Magistrate (public prosecutor) of the competent court, which in most cases is the court in the place of residence of the person concerned. If the petition is clearly unfounded or less than one year has elapsed since a previous request for the same person was rejected and no new facts are stated, the petition may be rejected.

The petition must be accompanied by a declaration made by a psychiatrist who has recently examined the person concerned but who has not been professionally involved in his/her treatment. S/he should nevertheless consult the family doctor and the psychiatrist responsible for the person's treatment. If the person is already in the psychiatric

⁵¹ Act of 29th October 1992 in replacement of the Act of 27th April 1884 Stb. 96 for the Regulation of the State Supervision of the Mentally Ill

hospital on a voluntary basis, the declaration should be made by the medical superintendent of the hospital. The declaration should provide details of the reasons why internment is required.

If a guardian has been appointed for the person, an extract from the register (as defined in article 391 of Book 1 of the Civil Code) must be provided. In the case of a mentor, a copy of the judgement by which mentorship was established and the mentor appointed must be provided.

Before making a decision, the court hears the parties involved, unless s/he considers that the person concerned is not willing to be heard. If s/he does want to be heard but is not in a fit condition to appear in court, the judge and the registrar visit him/her at home or in the psychiatric hospital if s/he is accommodated there. Unless the person objects, the judge orders the legal aid office to appoint a representative for him/her.

The judge can seek the advice of those who presented the petition, the spouse, the person responsible for care, the guardian, trustee, mentor and the institution or psychiatrist treating or accompanying the person. The judge can also arrange for expert examinations and summon the experts and witnesses. The person concerned and his/her legal adviser have the opportunity to make their viewpoint known.

Once a decision has been made, the registrar sends a copy of the judgement to the person involved, his/her legal representative, the spouse, the person responsible for care, the person who made the petition and the examining magistrate. The family doctor is immediately informed if the interim order has been refused. If it has been accepted, s/he is informed of the judgement and receives a copy of the medical declaration.

It is not possible to appeal to a higher court with regard to the decision concerning the granting of an interim order. Once the decision has been made, it must be executed immediately. If more than two weeks have elapsed since the day it was made, it is no longer valid.

3.21.1.3 The duration of involuntary internment

The interim order is valid for a period not exceeding six months. After this time, an order must be made for continued accommodation. The court must be satisfied that the disturbance of the mental faculties of the person concerned will still be present after the current interim order has expired. S/he must also be of the opinion that such disturbance will cause danger to the person involved and that this cannot be averted by any other means than the psychiatric hospital.

A petition for continued internment must be accompanied by a declaration by the medical superintendent of the psychiatric hospital in which the person is accommodated.

The application for granting an order for continued accommodation must be made no later than the sixth or fifth week before the end of the period of validity of the current order. The judge can repeatedly grant an order for continued accommodation. However, after five years of continued accommodation, an order for continued accommodation may be made for a period of maximum 2 years' validity. In case of involuntary admittance to a nursing home, prolongation with a maximum of 5 years is possible (art.17, lid 4 B.O.P.Z).

3.21.1.4 Order for internment by a Mayor

In emergency cases, the mayor may make a custody order for a person over 12 years of age if:

- this person is causing danger,
- the danger to the person involved is believed to be due to a disturbance of the mental faculties,
- the danger is so immediately pressing that it is not possible to delay internment,
- the danger cannot be averted by any person or institutions except a psychiatric hospital.

The mayor may use the services of the police, who must obtain the support of one or more people experienced in the care of mentally disturbed people.

The police may enter a place in which the person is to be found if this is considered to be necessary for the fulfilment of the task. The mayor cannot order that the person be detained unless a psychiatrist, preferably one who is not involved in the person's treatment, has provided a written declaration. If it is not possible to obtain a declaration from a psychiatrist, a doctor may examine the person and make a declaration. On admission to hospital, the mayor shall, if possible, inform the spouse, the legal representatives and the close relatives of the person concerned.

The person who has been interned on the order of the mayor can request the court to award compensation on the grounds that the order made by the mayor was unlawful.

3.21.1.5 Involuntary admittance by an assessment committee

A person over the age of 12, who shows no signs of willingness or resistance in the matter, may be admitted to a care institution on the basis of a statement from a B.O.P.Z. assessment committee. The condition for such admission is that s/he cannot, as a consequence of a disturbance of his/her mental faculties, maintain him/herself outside an institution. According to Blankman, the majority of Alzheimer patients who are involuntarily admitted to a nursing home or psycho-geriatric ward are admitted on this basis. As long as the person neither resists nor agrees with admission, the committee can admit him/her in accordance with the admission criteria. Should the person resist admission, the involvement of a court is needed.

3.21.1.6 The rights of people who have been involuntarily interned

The B.O.P.Z contains a whole chapter (Chapter III) on the rights of patients involuntarily accommodated on the basis of a decision of a Mayor, a court or a B.O.P.Z. assessment committee in a psychiatric hospital. In the B.O.P.Z. 'psychiatric hospital' includes nursing homes and psycho-geriatric wards. The management of a psychiatric hospital is responsible for notifying in writing the spouse, legal representatives and immediate family of the person concerned (the patient) which doctor or other person in the hospital is to have particular responsibility for the patient's treatment. This person must ensure that the patient receives an explanation on this subject on a monthly basis.

3.21.1.7 The right to complain

The patient has the right to lodge a complaint against the hospital and against non-application of an agreed treatment plan. However, if the inspector in charge of the complaint considers that the complainant is clearly inaccessible to reason, s/he may decide not to follow it up.

3.21.1.8 Patient advisors

According to chapter 7 of the B.O.P.Z., the management of psychiatric hospitals belonging to a certain category are obliged to ensure that patients are supported by a patient's "confidant". A patient's confidant is a person who affords patients in a psychiatric hospital advice and support at their request in matters connected with their admission to and accommodation in the hospital. Although this person is employed by the psychiatric hospital, s/he acts independently of the management and hospital staff.

3.21.2 Coercive measures

3.21.2.1 Restriction of personal liberty

Freedom of movement in and around the hospital may be restricted on therapeutic grounds. It can also be restricted if those responsible for the patient's treatment consider that this could have serious negative effects on the patient's state of health or that it is necessary in order to prevent criminal acts or disturbances within the hospital (e.g. disrupting internal regulations). In certain circumstances the right to receive visits and to use the telephone can be limited or denied. Any such restrictions must be reported to the medical superintendent without delay.

3.21.2.2 Restraint and other coercive measures

The administration of treatment against the patient's will is dealt with in the section on "consent to treatment". However, it is interesting to note that article 39 of the B.O.P.Z. allows for the use of coercive measures in certain circumstances. According to this article, certain measures can be taken (other than those which are necessary for carrying out a treatment plan) in order to deal with temporary emergency situations brought about by the patient in the hospital as a consequence of the disturbance of his/her mental faculties. The measures which can be administered are determined by "Orders in Council". According to Blankman, such measures include confinement to one's room, fixation

and forced application of medication or liquid food. The use of such measures may not exceed 7 days and must be recorded.

The medical superintendent must notify the patient's spouse and legal representative. Should they be absent, a member of the immediate family should be contacted, and in any case the inspector.

3.21.3 Driving

A diagnosis of dementia makes a person ineligible to drive a motorized vehicle. In case of doubt or suspicion that a person is in the early stage of dementia, a specialist assessment is advised which includes a driving assessment.

3.22 *Norway*

3.22.1 Involuntary internment

A new law covering the use of compulsory admission, treatment and other forms of coercion was implemented in 2001 in the Mental Health Care Act of 1999.

All institutions, regional mental health care centres and outpatient clinics within mental health care are linked to a supervisory commission.

The supervisory commission is headed by a lawyer and consists in addition of one doctor and two other members. One of the two other members must have a history as a patient or as close relative of a patient, or have represented patient interests in a professional or voluntary capacity.

In addition, a new paragraph in The Patients' Rights Act was implemented in January 2009. The new paragraph deals with the specific term of involuntary internment for the purpose of providing healthcare. The necessity of health care must be evaluated prior to any compulsory measures and the decision must be based solely on the patient's health situation, i.e. not on that of someone else such as the health care provider or the security for other patients.

3.22.1.1 The conditions for involuntary internment

Compulsory admission and treatment requires that patients have a serious mental illness and have been diagnosed by an authorised doctor. In addition, the following criteria must be met:

- There is a possibility of cure or considerable improvement which would not be possible if the patient were not interned.
- The patient represents a considerable danger to him/herself or others.
- Acceptable voluntary solutions, if there are any, have been tried.

3.22.1.2 The procedure for involuntary internment

Involuntary internment requires an examination by an authorised doctor who must evaluate the patient if the terms and conditions are fulfilled. If the patient resists, measures can be taken to oblige the person to allow the authorised doctor to carry out such an evaluation. However, compulsory measures may only be implemented in accordance with a separate special resolution under the provisions of the relevant paragraph and coercion may only be used when deemed strictly necessary.

On the basis of the information provided by the authorised doctor, the responsible mental health professional must ensure that the following conditions have been fulfilled before the person can be admitted for compulsory observation:

- Voluntary measures have been tried but to no avail.
- The person has been examined by two doctors (one of whom should be independent of the institution).
- It is probable that the person satisfies the condition for compulsory mental health care
- The institution is able to offer the kind of treatment and care needed.
- The person has been given the opportunity to express his/her views.
- Even if all conditions are fulfilled, compulsory admittance for observation should only take place if it is considered the best solution for the person concerned.

On the basis of information from the doctor who carried out the initial examination and from the information gained during compulsory observation, as well as consideration of whether the conditions are fulfilled, the responsible mental health professional decides whether the person should be admitted for compulsory mental health care. If this is the case, the person concerned, his/her next-of-kin and the authority which made the request are informed.

3.22.1.3 The duration of involuntary internment

Patients can also be admitted for compulsory observation for up to ten days. Compulsory observation is understood as treatment, admission and other forms of coercion when no consent has been given by the patient. Compulsory observation can be prolonged for a further ten days if necessary.

Compulsory mental care is decided for periods of up to one year at a time.

3.22.1.4 The right to appeal

The supervisory commission is the court of appeal for resolutions related to compulsory mental health care and coercion.

No-one can be held under compulsory mental health care unless the terms of the Mental Health Care Act are fulfilled. The person responsible for a decision to impose compulsory mental health care must continuously assess whether the terms of legislation are fulfilled, and should this not be the case, must pass a resolution of termination (discharge). A patient or his/her relative has the right to request termination of compulsory mental health care at any time.

Resolutions regarding examination and treatment without consent can be appealed to the District Governor. Moreover, the supervisory commission monitors all compulsory treatment in its review of records of compulsory mental health care.

3.22.1.5 Patient advisors

Patient ombudsmen endeavour to promote patients' needs, interests and legal protection in connection with the Health Service, and to improve the quality of the Health Service. Patient ombudsmen are organised federally with an office in every county. The Patient ombudsmen's objectives and responsibilities are embodied in chapter 8 of the Patients' Rights Act.

A patient ombudsman can provide information about a person's rights as a patient or relative/friend. A patient ombudsman can also help provide advice and guidance when certain issues are difficult or incomprehensible. S/he provides support within municipal and regional health care. Patient ombudsmen maintain an autonomous, independent position.

A law codifying and expanding patients' rights was implemented in 1999 in the Patients' Rights Act of 1999. These rights include:

- the right to necessary treatment and care,
- the right to an evaluation of the need for treatment within a maximum of 30 days,
- the right to an individual plan for treatment and care,
- the right to a second opinion,
- the right to choose where to receive treatment.

3.22.2 Coercive measures

The use of coercive measures is not specifically mentioned in existing legislation except for a few examples in the Mental Health Care Act. The focus in legislation, both in the Act of Mental Health Care and the Act of the Patient's Right, is on protective measures for the patient. However, in the guidelines linked to a new paragraph in the Act of Patient's Right there are examples of some coercive measures which can be used, after voluntary solutions and protective measures have been tried.

Section 223 of the General Civil Penal Code deals with the deprivation of liberty. It states that any person who unlawfully deprives another person of his or her liberty or who aids and abets⁵² such deprivation of liberty shall be liable to imprisonment for a term not exceeding five years.

3.22.3 Mistreatment/abuse

According to section 219 of the General Civil Penal Code, any person who by threats, duress, deprivation of liberty, violence or any other wrong grossly or repeatedly mistreats any person in his or her household or in his or her care shall be liable to imprison-

52 to aid and abet means to help someone to do something illegal or wrong

ment for a term not exceeding three years. This also applies to anyone who aids or abets such an offence.

3.22.4 Driving

According to §21 of the Road Traffic Act of 1965:

“No one must drive or attempt to drive a vehicle when s/he is in such a state that s/he cannot be deemed to be capable of driving safely, irrespective of whether this is due to the fact that s/he is under the influence of alcohol or any other intoxicating or narcotic agent, or to the fact that s/he is ill, weak, worn out or tired, or to other circumstances.”

The regulation of driver licence, paragraph 4 in the Road Traffic Act of 1965, states that when a person turns 70 s/he must have a medical examination. If the general practitioner (GP) considers the person incapable of driving safely, the GP informs the Norwegian Board of Health Supervision⁵³ in the county of residence of the person which then will consider the case before forwarding it to the local police.

53 The Norwegian Board of Health is a national supervisory authority with responsibility for general supervision of health and social services. The Institution oversees the population's need for health and social services and those services are run in accordance with adequate professional standards. The Board also collaborates in preventing failures and mistakes within the health care system. Locally, supervision is carried out by the Governmental Regional Board. In matters of health and social affairs, the regional boards report to The Norwegian Board of Health

3.23 *Poland*

3.23.1 Involuntary internment

The provisions of the Mental Health Protection Act of 19 August 1994 (MHPA), amended on December 3, 2010, cover people who are mentally ill (i.e. those who demonstrate mental disorders, those who are mentally retarded and those who demonstrate other disturbances in mental functioning which, according to current medical knowledge, are classified as mental disorders) and who need health services or other forms of assistance or care in order to live in the family or social environment. This law addresses the issue of involuntary internment in a psychiatric institution and involuntary internment in a nursing home. As it is more likely that people with dementia would be admitted into a nursing home, the following section will cover involuntary internment in a nursing home.

3.23.1.1 The conditions for involuntary internment

A person who, due to mental illness or mental retardation, is incapable of looking after his/her own basic needs, who has no possibility of obtaining help from other people and who needs continuous care and nursing services (but not hospital treatment), may be involuntarily interned in a nursing home i.e. without his/her consent or that of his/her guardian (MHPA, article 38).

3.23.1.2 The procedure for involuntary internment

A request may be made to the Guardianship Court for admission to a nursing home without the consent of the person concerned or the guardian:

- by the head of a psychiatric hospital (in the case of a hospitalised person who would not be able to cope alone if discharged but does not need further treatment) or
- by a social welfare agency if the person poses a risk to his/her own life.

The Judge has the right to visit the person in the nursing home at any time to supervise the legality of the admission or residence, to ensure that the person's rights are being respected and to control the conditions of residence therein (art. 43). The actual procedure is defined in a legally binding ordinance.

The Guardianship Court instigates a hearing within 14 days of the request for commitment. The Judge must visit the hospital or nursing home within 48 hours of the provisional commitment and must immediately discharge the person and stop legal proceedings if the measure was clearly unjustified (art. 45). There are no court costs for proceedings before the Guardianship Court for matters relating to involuntary commitment.

If the proceedings continue, the Court must obtain an independent expert opinion from one or more psychiatrists (art. 46). For people being admitted to a nursing home, necessary assistance should be provided by a social welfare agency.

The court may designate a lawyer for the person concerned by the proceedings even if s/he has not requested one (art. 48).

3.23.1.3 The duration of involuntary internment

There does not seem to be any mention of the duration of involuntary internment in the MHPA. However, article 49 of this act states that detailed regulations for matters concerning nursing homes (e.g. admission and discharge) are issued in the form of a legally binding ordinance from the Minister of Labour and Social Policy in consultation with the Minister of Health and Social Welfare and the Minister of Justice (art. 49).

3.23.1.4 The right to appeal and suspension of the ruling

The person who has been involuntarily admitted into a nursing home, his/her guardian, *de facto* guardian, spouse, blood relative or sibling may appeal to the Guardianship Court against the court decision.

3.23.1.5 Patient advisors

The Guardianship Court designates a keeper who is responsible for assisting a person who has been involuntarily interned throughout his/her stay in the nursing home.

3.23.2 Coercive measures

3.23.2.1 Restriction of personal liberty

Deprivation of liberty is covered by article 189 of the Penal Code which states that depriving a human being of their liberty shall result in imprisonment for a term of between 3 months and 5 years. If the deprivation of liberty was for more than 7 days or involved particular torment, the sentence would be for between 1 and 10 years.

Isolation is included in the definition of physical restraint. Please see below for details.

3.23.2.2 Restraint and other coercive measures

According to article 18 of the MHPA, amended by The Act on Changes in the Act on Mental Health Protection, which defines in detail the kinds of coercive measures, as well as changes added by The Act on Medical Activity of April 15, 2011 concerning direct coercion, physical restraint of people with mental disorders may only be applied if a person represents a risk to his/her own life or health, or that of other people, threatens public safety or violently damages or destroys surrounding objects (or if warranted by special regulations of the MHPA). If necessary, the doctor may request the assistance of the police and the fire brigade. Direct coercion is used when it is necessary for the conduct of indispensable medical activity aimed at the removal of the causes of admission to hospital without the person's consent. It may be also used in order to prevent the person's unlawful departure from the hospital.

The Resolution of the Minister of Health and Social Welfare of August 23, 1995 on the manner of applying direct coercion described when and how such measures could be

used. The Act on Medical Activity of April 15, 2011, in Article 139, provides more changes in article 18 of the MHPA. Physical restraint includes holding down, coerced administration of medication, compulsory medication, immobilisation and isolation, which cannot last longer than four hours. In case of need, a doctor, upon a personal examination of the patient, may prolong the immobilisation for further six-hour periods. The decision to apply physical restraint must be made by a doctor who should also determine the manner of physical restraint used and supervise its implementation. In psychiatric hospitals and nursing homes, a nurse may take this decision in the absence of a doctor and then notify the doctor. In life threatening situations, when the person needs immediate treatment, a person responsible for the work of a medical rescue team (a paramedic) may take this decision. After ordering direct coercion, a card detailing the use of such measures should be filled out, providing the reasons for its use, the kind used and the duration of immobilisation or isolation. The card is added to the patient's medical documentation. The least inconvenient measure possible should be chosen and during the use of direct coercion special care and consideration for the person's good should be exercised.

Direct coercion can be used no longer than necessary to obtain a medical result, and in cases where it is difficult to obtain, only for the time needed to transport the patient to hospital. The transport of the patient under coercive measure must be carried out in the presence of the medical rescue team.

The person for whom the measure is intended must be informed beforehand. The method causing least personal discomfort should be selected and care must be taken to safeguard the wellbeing of the person concerned

Justification for the use of restraint by a doctor employed in a health facility must be assessed within 3 days by the head of that facility or by a psychiatric specialist authorised by the local authorities if applied by any other doctor.

Articles 190 and 191 of the Penal Code address the issue of threats with or without the intent to compel the threatened person to behave in a certain way or refrain from certain behaviour.

3.23.3 Mistreatment/abuse

The Penal Code covers various forms of physical abuse. Articles 156 and 157 deal with grievous bodily harm and bodily injury/impairment to health respectively.

Dangerous neglect is covered by article 160 of the Penal Code which states that whoever exposes a human being to an immediate danger of loss of life, a serious bodily injury or seriously endanger his/her health may be sentenced to up to 3 years' imprisonment. If the perpetrator is responsible for the care of the person who was exposed to such danger, s/he may be imprisoned for between 3 months and 5 years.

The Act on Social Welfare of March 2004 provides that persons living in nursing homes should be granted human rights, especially right to dignity, liberty, intimacy and safety. The Act gives detailed description of services which nursing homes should provide and what kind of training and skills the staff of a nursing home should have. However, there are still incidences reported in the media of mistreatment and abuse of the elderly in nursing homes. More and more such institutions appoint special Ombudsmen to work in nursing homes, safeguarding patients' rights. They are employed by the Office of Patients' Rights Spokesman of the Ministry of Health.

3.23.4 Driving

In Poland, driving licences are usually issued for an unlimited period of time. If a person commits a driving offence, they might lose their driving licence and to get it back a medical examination is needed. There are no specific regulations for healthcare professionals concerning the procedure to follow when patients are found to have a condition which might have an adverse effect on their ability to drive (Kloszewska and Kwiecińska, 1997). In a Resolution of the Minister of Health and Social Welfare of April 15, 2011, changing the previous provisions in the Resolution on Medical Examinations of People applying for a driving licence, two diseases are mentioned (epilepsy and diabetes), which the doctors entitled to issue certificates about the health conditions of applicants, should take into account, before giving their decision about the person's ability to drive.

3.23.5 References

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3.24 Portugal

3.24.1 Involuntary internment

The right to personal liberty is guaranteed by article 27 of the Constitution. This right is frequently violated as many elderly people are interned in nursing homes and residential care homes without their formal agreement. Portuguese legislation (Decreto-Lei nº 64/2007) imposes formal contracts and stipulates that only the client or his/her legal representative can sign these contracts (so as to make involuntary internment difficult). However, it remains a cultural practice and relatives still violate this legal measure. So people are attending nursing homes or day care centres without their consent or even against their will. It is against the fundamental rights stated in the Portuguese Constitution and in International Conventions that are in force in Portugal.

The involuntary internment of people with dementia is much better regulated and is covered by the Law on Mental Health No. 36/98 of 24 July 1998.

3.24.1.1 The conditions for involuntary internment

Clause 12 of the above-mentioned law lays down the following conditions for involuntary internment:

1. The person suffering from a serious psychological illness who, as a result of the illness, threatens the judicial property of significant value, either belonging to him/her or others, of a personal or equity nature, and who refuses to submit himself/herself to the necessary medical treatment, can be interned in a suitable establishment.
2. The person suffering from a serious mental illness who does not possess the necessary judgement to evaluate the meaning and extent of consent, and for whom absence of treatment causes acute deterioration of his/her state, may also be interned.

Involuntary internment, according to clause 8, should only be used if it can be justified as proportional to the potential danger that non-internment would entail and if it is the only way to ensure that the person will receive the necessary treatment. If possible, it should be substituted by outpatient treatment.

3.24.1.2 The procedure for involuntary internment

The legal representative, any person with the legal right to request restraint, the public health authorities and the Public Prosecutor all have the right to apply for internment. In addition, whenever a doctor, in the course of an examination or visit, finds that either of the above conditions has been fulfilled, s/he may contact the relevant public health authority in order to request compulsory internment. The clinical director of a psychiatric institution can also request the forced internment of a voluntary patient (clause 13).

The application should simply be addressed in writing to the competent court. There are no special formalities to respect concerning the writing of the application but it should contain a description of the facts on which the application is based and wherever possible, it should include information which might assist the judge in his/her decision, e.g. clinical, psychiatric and psychosocial reports. The judge then notifies the person concerned, informing him/her of the relevant rights and rules of court procedure. A counsel for defence is appointed and the person's spouse is informed (clause 14-15).

A clinical-psychiatric evaluation is carried out by the psychiatric services in the area where the person lives. A report must be produced within 7 days and submitted to the Court. If there is any disagreement amongst the psychiatrists, each must present his/her report and the judge may then decide to arrange for another clinical-psychiatric evaluation to be carried out by other psychiatrists (clause 17).

On receipt of the clinical-psychiatric report, the judge arranges for a hearing. The presence of other people may be requested, in particular a doctor and psychiatrists in order to lend additional support. The whole process may take several days and the decision to intern the person must be based on specific clinical justification, including a clinical diagnosis and relevant reasons. A joint session is then held. The internee's counsel for defence and the Public Prosecution Service must be present at this session. Having heard all the relevant parties the judge then either declares that a decision has been made immediately or will be made within 5 days. The decision must include details of the person to be interned, clinical reasons, the clinical diagnosis and where relevant the reasons for internment. Notification of the decision is given to the Public Prosecution Service, the internee, the counsel for the defence and the applicant. Arrangements can then be made to transport the internee to the relevant place of internment. The place of internment must be as near as possible to the internee's home. The location of this place must be communicated to the internee's counsel for the defence, the relative living closest to the internee, the person who lives with him/her as a spouse or a person in whom the internee trusts (clause 18-21).

A person who is incapacitated can be interned, but whenever this occurs, a certificate must be obtained from the competent court that certain provisions of the Law on Mental Health have been respected. These clauses deal with the possibility of organising outpatient treatment wherever possible, the termination of internment when the conditions for it are no longer valid and the regulated review of the need for internment (clause 29).

3.24.1.3 The duration of involuntary internment

As stated above, internment may be terminated if the conditions which led to it are no longer valid.

3.24.1.4 The right to appeal

Once a person has been interned, s/he has certain rights in addition to those of general patients. These include the right to be informed and, wherever necessary, to receive clari-

fication on his/her rights, to be represented by a counsel for defence, to appeal against the internment decision, to send and receive correspondence, to be present at any proceedings which directly concern him/her and to communicate with a special committee.

3.24.1.5 Patient advisors

The above-mentioned committee is established in accordance with clause 38 of the Law on Mental Health No. 36/98 of 24 July 1998. It is made up of psychiatrists, jurists, a representative of an association of relatives and mental health users and other mental health experts nominated by the Ministries of Justice and Health. The committee is responsible for visiting establishments, communicating directly with the internees, dealing with their complaints and correcting any violations of the law on internment.

3.24.2 Coercive measures

3.24.2.1 Restriction of personal liberty

It is illegal to deprive someone of his/her personal liberty according to Article 27 of the Constitution. It is further stated in paragraph 2 of article 27:

"No-one shall be deprived of his or her liberty, in whole or in part, unless as the consequence of a sentence of imprisonment imposed by a court convicting him or her of an offence punishable by law, or as the consequence of a security measure judicially ordered."

3.24.2.2 Restraint and other coercive measures

The Law on Mental Health No. 36/98 of 24 July 1998 contains a clause which covers the rights and duties of the people who have recourse to mental health care (not only those who have been interned). According to clause 5, it is illegal to subject a person to electroconvulsive therapy without his/her consent. However, if it is judged that a person is incapable of evaluating the meaning or extent of consent to the above, the decision can be taken by his/her legal representative.

There is an administrative regulation, binding all the National Health System professionals ("Circular Normativa Nº: 08/DSPSM/DSPCS de 25/05/07) that specifies the conditions under which a physical restraint measure is acceptable (only as an exception, in very severe situations threatening the person's integrity and under a medical prescription. A nurse can only decide about this in very special cases. All physical restraint measures have to be registered and duly justified.

3.24.3 Mistreatment/abuse

Clause 5 of the Law on Mental Health No. 36/98 of 24 July 1998 states that users of mental health services should be able to enjoy decent living conditions, hygiene, food, safety, respect and privacy in internment and residential accommodation. Furthermore, they should be allowed to communicate with the outside world and receive visits from family members, friends and legal representatives (albeit within the limitations imposed by the

services and the nature of the illness). Finally, it is stated that treatment and protection should be given to the patient in a way which respects his/her individuality and dignity.

The new Code of Medical Ethics of 2009 also addresses the issue of abuse. Article 52 recognises the particular need to care for children, the elderly and people who are dependent, particularly when they are mistreated by their families. Article 53 mentions the special need to protect victims of abuse and denounce such acts (Guimaraes, 2008).

Article 152.º - A of the Portuguese Criminal Code states that if a person, having under his/her responsibility a minor or someone who is especially weak because of his/her age, handicap, disease or pregnancy, mistreats that person, physically or psychologically, including physical punishments, deprivation of freedom, sexual offences or cruel treatments, s/he will be punished with a prison sentence of one to five years.

This penalty may be increased to between two and eight years in case of a severe offence against physical integrity, or to between three and ten years if the mistreatment results in the death of the victim.

3.24.4 Driving

The Physical, Mental and Psychological Condition of Drivers is now governed by the “Decreto-Lei nº 313/2009” of 27.10. in which Article 18, nº 1, states that people who are found to have serious cognitive impairments (linked to attention, perception and memory) in the relevant clinical examinations will not be granted a driving licence or be able to renew an existing licence.

According to article 18, nº 2, an application from any person presenting the following symptoms must also be rejected:

- Behaviour which reveals mental deterioration, mental weakness or low resistance to a processing overload,
- Psychotic or para-psychotic behaviour,
- Clear emotional instability,
- Cyclical syndromes,
- Aggressiveness and impulsiveness or irritability of an explosive nature,
- Acute agitated behaviour,
- Depressive or antisocial behaviour.

Article 13º of the same decree covers the medical professionals’ duty to report people who are unfit to drive to the relevant authorities. It states that medical professionals who, in the course of their clinical activity, treat drivers with chronic or progressive illness or handicap, or identify psychiatric disorders which might affect the patient’s ability

to drive safely must communicate this to the Health Authority and provide the Health Authority with a detailed confidential clinical report.

3.24.5 References

Firmino, H., Silva Carvalho, P. and Cerejeira, J. (2008), Practice of competence assessment in dementia: Portugal. Ed. Gabriela Stoppe (2008), *Competence assessment in dementia*, Springer Wien New York.

Guimaraes, P. (2008), Personal communication

3.25 *Romania*

3.25.1 **Involuntary internment**

Involuntary internment is covered by the Law on Mental Health and Protection of People with Mental Disorders (No. 487) which was adopted by the Senate on 27 June 2002. The procedure for involuntary internment is only applied when all attempts to admit the person on a voluntary basis have failed. If applied, the person can only be admitted involuntarily to a psychiatric hospital that is equipped to provide professional/specialist care in specific conditions.

3.25.1.1 **The conditions for involuntary internment**

A person can be involuntarily admitted if a competent psychiatrist decides that s/he is suffering from a mental disorder and considers that because of that mental disorder there is an imminent danger of the person harming him/herself or other people. Another justifiable reason for involuntary internment is that a person may have a severe mental disorder and impaired judgement, and that failure to admit or detain that person is likely to lead to a serious deterioration of his/her condition or would hinder the administration of appropriate treatment (article 45).

3.25.1.2 **The procedure for involuntary internment**

The people who can request the involuntary internment of a person with a mental disorder are:

- The family doctor providing healthcare for the person concerned,
- The psychiatric specialist providing healthcare for the person concerned,
- The person's family,
- Representatives of the competent local public administration services,
- Representatives of the police, the gendarmerie, the prosecutor's office or the fire brigade.

The person making the request must provide reasons, sign the declaration, provide details of his/her identity, explain the circumstances surrounding the request and provide details of the identity and medical history of the person concerned (article 47).

The person is usually transported to the psychiatric hospital by the ambulance services. If the person seems to be quite dangerous, the assistance of the police, the gendarmerie or firemen may be requested. During this process, all possible safety measures must be taken to ensure that the physical integrity and dignity of the person are respected (article 48).

The person is then examined by a psychiatrist with the aim of determining whether involuntary admission is necessary. The person must be informed immediately of any decision

to submit him/her for psychiatric treatment and his/her personal or legal representative must be informed within 72 hours (article 49). If it is not known whether the person has a personal or legal representative or their address is not known, the doctor⁵⁴ must notify the guardianship authorities (article 50). If s/he considers that there is no justification for the involuntary internment of the person, s/he will not detain the person and will register this decision, along with the reasons for it, in the medical records (article 51).

Once the doctor (psychiatrist?) has made a decision to involuntarily intern a person, this decision must be confirmed within 72 hours by a commission made up of 3 members appointed by the director of the hospital, namely 2 psychiatrists (preferably other than the one who admitted the person for the initial examination) and a doctor of another specialty or a representative of civil society. This commission is responsible for examining the person within 15 days and whenever the doctor responsible for their care requests it. The commission must notify the patient and his/her personal or legal representative of their decision and record it in the person's medical file (article 52).

Within 24 hours of making a decision to involuntarily intern the person, the commission must inform the prosecutor's office which then reviews the decision. In order to do this, the commission must provide the prosecutor's office with the person's medical file and relevant documents. If the prosecutor's office is of the opinion that the internment is unjustified, it will order a new psychiatric examination to be carried out by another medical-judicial commission (article 53).

3.25.1.3 The duration of involuntary internment

There is no mention in the law about an initial duration of the involuntary internment. It is simply stated in article 56 that when the conditions leading to the decision to admit a person involuntarily are no longer met, and this is confirmed by the psychiatrist taking care of the person, the commission reviewing the procedure will, after having examined the person, release him/her. The patient can then either leave the institution immediately or, if s/he so wishes, can request the continuation of treatment based on his/her written consent (article 56).

3.25.1.4 The right to appeal

The person or his/her personal or legal representative can appeal to a competent judicial body against a decision for involuntary internment. During the process, the judge hears the person (provided that the person's condition permits this). If this is not possible, the judge will visit the person in the unit where s/he is being detained in order to conduct the hearing. The case will be dealt with urgently (article 54).

3.25.1.5 Patient advisors

The personal advisor mentioned several times in connection with the process of involuntary internment is defined in the Law on Mental Health and Protection of People with

⁵⁴ The person referred to in the English translation of the law is "the doctor" but it seems from the context that this means the psychiatrist who examines the person to determine whether or not to involuntarily intern him/her.

Mental Disorders of 2002 as a person, other than the legal representative, nominated by a person with mental disorder, who agrees to represent the interests of the person concerned.

3.25.2 Coercive measures

3.25.2.1 Restriction of personal liberty

The illegal deprivation of a person's freedom shall be punished by a prison sentence of between 3 and 10 years (article 201 (1) of the Criminal Code).

According to the Law on Mental Health and Protection of People with Mental Disorders of 2002,

"The care and treatment of people with mental disorders must be carried out in the least restrictive environment, with the least restrictive procedures that respect, to the extent possible, the person's physical and psychical integrity and meet, at the same time, his or her health needs, as well as the necessity of ensuring the physical safety of others." (article 26)

3.25.2.2 Restraint and other coercive measures

According to article 210 (1) of the Criminal Code a person who threatens someone else with the commission of an offence or a damaging act will be imprisoned for 6 months to 1 year or fined if the threat is considered to have alarmed the latter. The sanction cannot, however, exceed that which would have been applied had the offence or damage been committed.

Blackmail is covered by article 211 (1) of the Criminal Code which states that the coercion of a person by violence or threat to give, do, not do or suffer something, if the act is committed in order to obtain an unlawful benefit shall be punished by a prison sentence of between 1 and 5 years. If the blackmail is linked to a real or imagined act, which if revealed would compromise the person, the sentence would be between 2 and 7 years (article 211 (2)).

3.25.3 Mistreatment/abuse

Article 26 of the Law on Mental Health and protection of people with disabilities of 2002 states that a person suffering from mental disability has to be protected from harm caused by the unjustified administration of medicines or certain diagnostic or treatment procedures, against ill treatment caused by other patients, by personnel or other persons or any other actions causing physical or mental suffering.

The issue of neglect is covered in the Criminal Code. Article 198 states that the act of abandoning, sending away or leaving helpless a child or a person who is unable to look after themselves by a person who is responsible for their supervision or care thereby placing that person's life, health or corporal integrity in imminent danger, shall be pun-

ished by a prison sentence of between 1 and 3 years or a fine. If, however, the person responsible for the other person's care or supervision voluntarily resumes such care or supervision after the incident of neglect has occurred, s/he shall not be punished.

Article 200 foresees a sentence of between 1 and 6 months or a fine for failure to notify the authorities about a person who has been abandoned or is lost, who needs help, whose life, health or corporal integrity is in jeopardy and who lacks the power to save him/herself.

Chapter III of the Criminal Code contains several articles on the topic of violence and neglect. Article 185 states that hitting or any other act of violence causing physical suffering shall be punished by imprisonment of between 1 month and 3 months or a fine. This is followed by a series of articles which describe to what extent this punishment is increased in line with the severity of the possible resulting injury (e.g. resulting in the need for medical care for up to 20 days, up to 60 days or more than 60 days) and based on whether the act was committed by a family member.

Article 189 states that with the exception of grievous bodily harm and acts resulting in a person's death, acts resulting in the need for between 10 and 60 days' medical care, which were committed by negligence, shall be punished by imprisonment of 1 to 3 months or by a fine.

3.25.4 Driving

Romanians over the age of 65 must have a health check every year in order to keep their driving licences. Every month, doctors must inform the police of all new diagnoses of mental disorder thus creating a dilemma for doctors who must choose between the desire to protect the general public from accidents caused by people with mental disorders and their ethical obligation to respect confidentiality (Tătaru, 2008).

3.25.5 Reference

Tătaru, N. (2008), Practice of competence assessment in dementia: Romania. Ed. Gabriela Stoppe (2008), *Competence assessment in dementia*, Springer Wien New York.

3.26 *Slovakia*

3.26.1 **Involuntary internment**

3.26.1.1 **The reasons for involuntary internment**

According to §6 of Act No. 576 on Healthcare, health-related services and on the amendment and supplementing of certain laws of 22 September 2004 (HHS), inpatient care can be provided without informed consent if:

1. the person has a mental illness or symptoms of a mental defect AND
2. poses a threat to him/herself or to his/her environment, OR
3. there is a risk of serious deterioration of his/her state of health.

3.26.1.2 **The procedure for involuntary internment**

If a patient is admitted to hospital for inpatient care without his/her informed consent, the healthcare provider must notify a court covering the territory of the inpatient health-care facility within 24 hours. The court then rules on the legitimacy of the reasons for taking the person into inpatient care. Until the Court has made a decision, only life-saving medical care or measures to protect the person's surroundings are permitted (§9 (4)).

3.26.1.3 **Duration of involuntary internment**

As soon as the reasons for involuntary admission cease to exist, either the patient must be released or s/he (or his/her legal representative/tutor) must consent to the further provision of healthcare (§9 (5)). In the case of a person who is unable to consent, their legal representative must be notified before they are released.

3.27 Slovenia

3.27.1 Involuntary internment

Involuntary internment is covered by the Law on Non-Contentious Procedure (Official Gazette of the Republic of Slovenia, No. 30/86-ZNP) (the LNCP). Article 49 of the more recent Law on Medical Activity (Official Gazette of the Republic of Slovenia, No. 9/92, 37/95 and 8/96-ZZDej) also deals with involuntary internment. However, the two laws are not in complete accordance with each other, especially with regard to the conditions for involuntary admission.

3.27.1.1 The conditions for involuntary internment

Under article 70 of the LNCP, a person can be involuntarily admitted to a mental institution or other institution (e.g. a social care institution) by a court of law on the following grounds:

- S/he is suffering from a mental disorder or mental illness AND
- S/he presents a serious danger to the life or health of him/herself or that of other people OR
- S/he represents a serious danger to the property of him/herself or that of other people.

The Law on Medical Activity does not stipulate that admission to hospital must be urgently necessary to prevent causing harm or damage.

3.27.1.2 The procedure for involuntary internment

The courts must be informed within 48 hours of the involuntary internment in the closed section of a mental health institute. Information must be provided about the interned person, his/her medical condition, the reasons for internment and who brought the person to the mental health institution (LNCP, art. 71). Such notification is only necessary in the case of people who are detained in a closed department without their consent and does not cover voluntary hospitalisation even in a closed department.

The court then immediately informs the social welfare office, the mental health institution and a spouse or next of kin that a court procedure has been started.

Within 3 days, the court visits the person who has been interned and interrogates him/her (unless this would be damaging to the latter due to his/her medical condition). Doctors involved in the course of treatment and other people who can give information about the person's mental condition are interrogated. The person is also examined by a psychiatrist from another mental health institute. (LNCP, art. 74 and art. 75)

On the basis of this information, the court decides whether to prolong the internment or dismiss the person from the institution. This must be done within 30 days of notification

that a person has been detained against his/her will. During this time, the mental institution can move the person to an open ward or dismiss him/her if it feels that the reasons for internment are no longer valid (LNCP, art.76).

The Human Rights Ombudsman points out that deadlines are often not respected and that there are considerable inadequacies regarding the hearing and decision-making process. For example, despite the fact that detention is only admissible in cases where the person, due to his/her mental state, represents a danger to him/herself or others, the court often decides simply on the basis of the opinion an expert witness who confirms the person's mental state and not the danger (and hence urgent need for hospitalisation). Although the detained person is briefly questioned by the court, in practice, this has little influence on the decision.

3.27.1.3 Duration of involuntary internment

If, on the basis of the evidence given, the court decides to further retain the person in the institution against that person's will, it defines the period of involuntary internment which cannot be longer than 1 year.

If the institution judges that further treatment will be necessary, it must request a prolongation of the involuntary commitment at least 15 or 30 days before the initial period of involuntary internment expires (LNCP, art. 79).

3.27.1.4 The right to appeal and suspension of the ruling

The interned person, his/her patient advocate or guardian, the social welfare office, a spouse or relative and the mental health institution can appeal against the internment decision. This must be done within 3 days of the court decision (LNCP, art. 77).

3.27.2 Coercive measures

3.27.2.1 Deprivation of liberty

Article 143 of the Penal Code deals with false imprisonment. It states:

- (1) Whoever unlawfully incarcerates another person or keeps him/her incarcerated or otherwise deprives him/her of the freedom of movement shall be sentenced to imprisonment for not more than one year.*
- (2) If the offence under the preceding paragraph is committed by an official through the abuse of office or of official authority, such an official shall be sentenced to imprisonment for not more than three years.*
- (3) Any attempt to commit the offence under the first paragraph of the present article shall be punished.*
- (4) Whoever either deprives another person unlawfully of his/her liberty for a period exceeding one week or acts so in an aggravated manner shall be sentenced to imprisonment for not less than six months and not more than five years.*

3.27.2.2 Restraint and other coercive measures

According to the Human Rights Ombudsman of the Republic of Slovenia (2007), the conditions governing the implementation of restraint in psychiatric hospitals (e.g. straitjackets, isolation and bed straps) are not regulated by law and there is therefore no court supervision of such measures. Nevertheless, the use of forcible protective measures and restrictions should be used for the shortest possible time, under supervision and be recorded in the patient's medical file.

3.27.3 Mistreatment/abuse

3.27.3.1 Mistreatment and abuse within the family

The Family Violence Prevention Act (ZPND) of 2008 covers various forms of violence inflicted by one family member against another. Family violence is the term used to refer to any form of physical, sexual, psychological or economic violence exerted by one family member against another irrespective of age, sex or any other personal circumstances of the victim or the perpetrator of the violence (article 3). Detailed definitions of the types of violence are provided. They focus on the results of the various acts of violence such as pain, fear, shame, feelings of inferiority, endangerment and anguish. Economic violence is defined as:

...undue control or setting of restrictions of any family member concerning disposing with one's income or in other words managing the financial assets with which the family member disposes or manages and it can also mean undue restricting of disposing or managing the common financial assets of family members.”(Article 3 (6))

The provisions of the act also cover “disregard” which is defined as a form of violence in which a person does not provide due care to the family member who is in need of it due to illness, disability, old age, developmental or any other personal circumstances.

Article 4 states that special care must be taken when considering violence and providing aid for older and disabled people as well as for people who, due to personal circumstance, are not capable of taking care of themselves. According to article 2 of this act, such people do not have to be related to the perpetrators of the violence as the definition of family member includes “persons living in a common household”.

The act gives victims of violence the right to have an assistant to protect their integrity and represent them in all violence-related proceedings as well as a legal representative. The victim's assistant can be any adult person who is not considered to be the perpetrator of the violence. Measure can also be taken to remove the perpetrator of the violence from the home or to enable the victim to safely gather the belongings they need for their basic vital needs.

3.27.3.2 General provisions relating to mistreatment or abuse

Articles 133 to 135 of the Penal Code deal with actual, aggravated and grievous bodily harm.

Whoever violates the physical or mental integrity of another by maltreating him/her shall be punished by a fine or a prison sentence of up to six months. Prosecution is only initiated if a complaint of mistreatment is filed (article 146 of the Penal Code).

It is considered a crime, under the Penal Code, to expose another person to danger. Article 138 states:

Whoever leaves another person helpless and in a life-threatening situation which s/he himself has caused shall be sentenced to imprisonment for not more than two years.

Similarly:

Whoever abandons a person who has been entrusted to him/her or whom s/he is bound to take care of in circumstances which endanger the life or health of the entrusted person shall be sentenced to imprisonment for not more than two years (article 139)

3.28 Sweden

3.28.1 Involuntary internment

The 1966 Compulsory Mental Care (Certain Cases) Act was replaced by:

- The Compulsory Mental Care Act (SFS 1991:1128)
- The Forensic Mental Care Act (SFS 1991:1129)

The care of people suffering from mental disorders is covered by the general provisions of the Health and Medical Service Act (SFS 1982:763). The Compulsory Mental Care Act covers mental care combined with custodial and other coercive measures. The Forensic Mental Care Act applies in cases which are not covered by the Compulsory Mental Care Act such as people who have been ordered by court to receive mental care or who have been arrested, remanded in custody or admitted to a unit for forensic psychiatric examination or to a correctional institution.

In the introduction to the English translation of this law, the Ministry of Health and Social Affairs (1993) described the objectives of this legislation as follows:

"The new legislation has the effect of strengthening legal safeguards for patients and augmenting judicial control. In addition, it makes better provisions for the protection, laid down by the Constitution Act, against deprivation of liberty and forcible bodily interference, and it brings the rules on compulsory mental care into line with the 1983 recommendations of the Ministerial Committee of the Council of Europe.

The new legislation is intended as a more adequate response than LSPV⁵⁵ to the development of psychiatry during the past decade in favour of close restrictions on coercive care.

Mental care shall as far as possible be provided on a voluntary basis. Compulsory mental care is only to be resorted to when there is no possibility of care on a voluntary basis.

The purpose of compulsory care shall be for the patients to become capable of voluntary participation in continuing care."

55 The 1966 Compulsory Mental Care Certain Cases Act

3.28.1.1 The conditions for involuntary internment

Under the Compulsory Mental Care Act (SFS 1991:1128) a person can be interned if:

S/he is suffering from a serious mental disturbance and on account of his/her mental state and his/her personal circumstances, the patient generally has an absolute need of mental care which cannot be provided for in any other way than the admission of the patient to a medical institution for qualified psychiatric all day care, and

S/he objects to such care, as is referred to above or, on account of his/her mental state, is manifestly incapable of expressing his/her consent to care.

It is stated that when appraising the need for care under this paragraph, it should be considered whether the patient constitutes a danger to the safety or physical or mental health of another person.

3.28.1.2 The procedure for involuntary internment

On the basis of a special medical examination conducted by an authorised doctor, a medical certificate (care certificate) must be issued and forwarded without delay to the medical institution where the question of involuntary internment is to be considered. The examination must only be performed if there is reasonable cause for doing so. The certificate should show that there is reason to suppose that the above-mentioned pre-conditions have been fulfilled. It should also include an account of the nature of the mental disturbance and any other circumstances which necessitate care.

An admission order is then issued and within four days the patient is taken to the care institution, where it must be decided within 24 hours whether s/he is to be admitted against his/her will. During this time, the doctors on duty have the right to prevent the patient from leaving the hospital.

A chief medical doctor in a mental care unit decides on compulsory admission. This cannot be the same doctor who issued the care certificate.

A patient who is in voluntary care can be admitted into compulsory care by the chief medical doctor if the conditions have been fulfilled and it is feared that the patient on account of his/her mental disturbance may inflict serious injury upon him/herself or some other person. For such decisions, a care certificate must be issued by another doctor. In such cases, the chief medical doctor must apply to the county administrative court within four days requesting permission for the continuation of compulsory care.

3.28.1.3 The duration of involuntary internment

If the internment lasts for more than four weeks, the chief medical doctor must apply to the county administrative court for permission to extend the internment. An account of the care and treatment needed must be appended to the application. If the application is granted the internment may be extended by four months. Afterwards, if internment is

still necessary, a further period of six months can be granted and this is renewable. If the court rejects the application, compulsory care must cease immediately.

3.28.1.4 The right to appeal

The patient may appeal to the county administrative court against the decision of chief medical doctor's order for compulsory care. Before the court hears the appeal, a statement is requested from the chief medical doctor on the circumstances which led to the compulsory care and details of the support and treatment which was planned for the patient. Unless further investigation is required, the case should be tried within eight days of the appeal.

3.28.1.5 Patient advisors

Under paragraph 30 of the Compulsory Mental Care Act (SFS 1991:1128) a patient advisor (known as a supporting person) shall be appointed at the request of the patient. A patient adviser can be appointed in other circumstances if the patient does not object. The appointment of the supporting person is governed by the provisions of the Act on Patients' Committees (SFS 1998:1656).

The role of the supporting person is to support the patient in personal matters for as long as s/he is receiving compulsory care. The supporting person is entitled to visit the patient in the institution. S/he cannot improperly divulge or utilise matters coming to his/her knowledge in the course of the assignment and relating to the patient's health status or personal circumstances in general.

3.28.2 Coercive measures

3.28.2.1 The restriction of personal liberty

Paragraph 20 of the Compulsory Mental Care Act (SFS 1991:1128) deals with isolation. A patient may not be isolated from other patients unless this is necessary. This could be due to aggressive or disruptive behaviour which seriously impedes the care of other patients. An isolation order can be made for up to eight hours and can be prolonged for a further eight hours. Under special circumstances the duration of eight hours can be extended. As with restraint, an isolation order can only be made by the chief medical doctor and isolation for more than 8 hours must be notified to the National Board of Health and Welfare without delay.

The National Board of Health and Welfare previously issued general guidelines on "the use of protective measures for people with dementia in special accommodation for service and care" (SOSFS 1992:17 and 1997:16). According to these guidelines, a person with dementia cannot be locked up to prevent him/her from leaving a building. However, the installation of a device which makes it difficult to open a door is permitted as it is intended to delay and not prevent the person from leaving. Similarly, an alarm system can be installed, but if the alarm goes off staff must merely try to persuade the person

to return to his/her room. The general guidelines were recently cancelled. However, the National Board of Health and Welfare gives the same advice.

3.28.2.2 Restraint and other coercive measures

The use of coercive measures is covered by the Compulsory Mental Care Act (SFS 1991:1128). In paragraph 19 of this act, it is stated that if there is immediate danger of a patient seriously injuring him/herself or another person, the patient may be briefly constrained by means of a belt or similar device. The order for restraint must be made by the chief medical doctor. Care personnel must be present during the period for which the patient is kept under restraint. This period can be prolonged if necessary, but in such cases the National Board of Health and Welfare should be informed without delay.

3.28.2.3 The need for sufficient personnel

To avoid coercive measures, it is necessary to have sufficient personnel in dementia care. After a successful campaign by Demensförbundet (The National Dementia Association) the Swedish Parliament has requested guidelines on the number of personnel in nursing homes for people with dementia. The Government has entrusted the National Board of Health and Welfare to elaborate such guidelines. Demensförbundet would like recommendations on minimum staffing levels, preferably covered by law. However, there is strong opposition to minimum levels from the organisation representing counties and municipalities. In this connection, it is important to have trained personnel, adapted premises and principals who are present.

3.28.2.4 Controversial proposals

A controversial commission has presented proposals regarding coercive and protective measures. According to Demensförbundet and others, the proposals of the commission undermine the civil rights of people with dementia and their relatives/carers. The proposals are currently being discussed by the Government. Demensförbundet has directly pointed out to the minister responsible the negative consequences of the proposals of the commission.

3.28.3 Mistreatment/abuse

The Health and Medical Personnel Act (SFS 1998:531) has been replaced by the new Patient's Safety Act (SFS 2010: 659). In accordance with the act, the National Board of Health and Welfare takes the appropriate measures to deal with situations in which the care provided does not satisfy the criteria for good care and the safety of patients.

Abuse is covered by the Social Services Act (SFS 2001:453). Chapter 14, paragraph 3 states:

"Every person, active in the social services, who observes or becomes aware of serious abuse or of an obvious risk of abuse with regard to activities against or which may be against individuals within the social services, shall report the matter immediately to the social welfare committee."

The above provisions also apply to professionals in private practice of a similar kind. The report shall be submitted to the party responsible for the activity.

3.28.4 Driving

In Sweden, driving licences are granted for life. The renewal procedure is a mere formality involving a change of photograph every ten years. However, a medical examination is required for the renewal of driving licence for heavy vehicles after the age of 45.

Under the 1998 Driving Licence Act (SFS 1998:488), doctors are obliged to report patients who are obviously unfit to drive. Chapter 10 paragraph 2 states:

"If a doctor, when examining a driving licence holder, concludes that this person is obviously medically unfit to hold a licence, the doctor shall report this to the Swedish Transport Agency. Before reporting, the doctor shall inform the licence holder. There is no obligation to report if there is reason to believe that the licence holder will conform to the doctor's instructions to refrain from driving a vehicle for which a licence is required."

There are regulations and guidelines for the practical application of this in the statutes of the Swedish Transport Agency (TSFS 2010:125). Chapter 10 in these statutes covers dementia and other cognitive disorders.

According to the statutes of the Swedish Transport Agency, dementia constitutes an obstacle for the possession of a driving licence. When dementia is considered mild, possession of a licence for a normal car and motorcycle can be granted.

In the "general advice" section, it is stated that dementia should be considered mild if the patient, despite a notably deteriorated ability to function professionally and socially, nevertheless can lead an independent life with a relatively sound sense of judgement.

It is also stated that dementia is determined either on the basis of a diagnosis made according to conventional medical practice, or on an assessment, based on the information available, that the criteria for such a diagnosis have been fulfilled. Such criteria are those which are specified in a criteria-based system for the classification of diagnoses, e.g. Diagnostic and Statistical Manual of Mental Disorders (DSM) or the international Classification of Diseases (ICD).

In the case of mild dementia, a certificate should be prescribed by a doctor and a review carried out at appropriate intervals to determine whether the person should be allowed to have a driving licence.

3.29 Switzerland

3.29.1 Involuntary internment

Involuntary internment is covered by article 397a-f of the Civil Code (part of the guardianship measures). In the revised law on guardianship measures (*droit de la protection de l'adulte*) which was adopted by the Parliament in December 2008 and comes into force on 1 January 2013, it is covered by the articles 426 to 439 of the Civil Code. There have been some amendments of the terms, the procedure and competences.

3.29.1.1 The conditions for involuntary internment

According to article 397a, a person can be placed or retained in an appropriate establishment against his/her will if due to a mental disorder, weakness of the mind (*"faiblesse d'esprit"*), alcoholism, drug addiction or serious neglect the necessary personal assistance cannot be provided in any other way. The burden of the individual on his/her entourage can also be taken into consideration.

There is no definition of what is an appropriate establishment. According to one part of the doctrine the involuntary admission of people with dementia into residential care has to respect the rules governing involuntary internment. Others say that in this case, this person must have a guardian (i.e. a *tuteur ou curateur*) who decides for him or her. The new law uses the term institution, which also means residential care. There should no longer be any doubt about the applicability of the rules of involuntary internment.

3.29.1.2 The procedure for involuntary internment

Involuntary internment is determined by cantonal law. The new law stipulates more regulations at federal (Confederation) level. The decision regarding internment is taken by a tutelary authority in the place of residence of the person concerned or in case of emergency by a tutelary authority in the place where the person is currently staying. In case of emergency or mental disorder, the cantons can appoint other appropriate authorities (i.e. doctors) to take care of the involuntary placement (art. 397b). According to the new law, the Cantons can appoint doctors to order involuntary internment but only for less than 6 weeks (new art. 429 of the Civil Code).

The tutelary authorities of the place where the person is situated and other offices designated by cantonal law must inform the tutelary authorities of the person's place of residence whenever a person who has been declared legally incompetent is placed or retained in an establishment (art. 397c).

The person for whom the measure is intended must be informed of the reasons for the measure and informed in writing of the possibility to appeal to a judge against being retained or the rejection of a request for liberation. Decisions concerning adults with mental disorders can only be taken after experts have been consulted. If expert opinions

were already requested during the first court hearing, the higher courts are not obliged to obtain them again (art. 397e).

Judges follow a simple and rapid procedure. If necessary, they provide the person for whom the measure is intended with legal assistance. This person must also be heard by the judge (*le juge de première instance*) (art. 397f).

3.29.1.3 The duration of involuntary internment

The person who has been placed or retained against his/her will must be released as soon as the reasons for placement/retention cease to exist (art. 397a).

If the decision for placement or retention in an establishment was made by a tutelary authority, that authority can end the measure. In other cases, the decision to end involuntary placement/retention is made by the establishment (art. 397b).

3.29.1.4 The right to appeal and suspension of the ruling

The person concerned or a person who is close to him/her can appeal to the judge within 10 days after having being informed of the decision (art. 397d).

3.29.2 Coercive measures

In the new law on guardianship measures there are rules at confederation level covering the deprivation of liberty. Until now, there have only been cantonal laws regulating these measures (e.g. in the Canton of Bern) which nevertheless respect limits stipulated in the Swiss Constitution. There are also guidelines written by the Swiss Academy of Medical Sciences (www.samw.ch).

In the new law on guardianship, coercive measures (measures restricting liberty/mobility) are covered by art. 383 to 385 of the Civil Code. It concerns people who stay for a long period of time in "*Wohn- oder Pflegeeinrichtungen*" (i.e. in medico-social establishments or homes).

The term "*limitation de la liberté de mouvement*" (measures restricting liberty/mobility) is broad and concerns also locking doors, electronic surveillance, bed rails to prevent falls etc. The use of sedation is not covered by this law as that would be covered by rules governing the use of medication.

According to article 383 of the new law, a person's freedom of movement can only be restricted if less restrictive measures have failed or seem insufficient and provided that this restriction serves to prevent a serious danger or threat to the life or physical integrity of the person concerned or of a third party. Such measures can also be used in order to stop a disruption to community life. The person concerned must be informed beforehand of the nature of the measure, the reasons for its use, its probable duration and the

name of the person who will be responsible for his/her care during its use. The measure must be stopped as soon as possible and its continued use assessed at regular intervals.

Article 384 of the new law stipulates that a protocol must be established in which the name of the person who ordered the measure is indicated as well as the purpose, type and duration of the measure.

According to article 385 of the new law, the person concerned or somebody who has his/her close interests at heart, can at any time make a written appeal against the measure to the authorities for the protection of the adult of the institution concerned. If the said authority finds that the measure does not correspond to the law, it may lift the measure or order another measure.

3.29.3 Mistreatment/abuse

3.29.3.1 Physical abuse

There are several articles in the Swiss Penal Code of 21 December 1937 RS 311.0 which address the issue of abuse.

Article 122 of the Penal Code covers serious bodily harm whereby a person intentionally injures a person to the extent that that person's life is in danger. It also includes intentional actions which result in serious harm to the victim's bodily integrity or his/her physical or mental health.

Article 123 covers other harm to a person's physical integrity or health. It is further stated that the sentence would be more severe in cases where the victim was unable to defend him/herself (e.g. a child for whom the person was responsible) and/or where the perpetrator was the victim's spouse or partner. Presumably, this would also apply in the case of a person with dementia for whom the spouse was the guardian.

Assault which does not result in bodily harm or damage to the victim's health may result in a fine if reported (art.1263). Legal proceedings may be taken automatically if the perpetrator is the victim's spouse or partner.

3.29.3.2 Neglect/negligence

Physical harm or damage to a person's health caused by another person's negligence may be punished by a fine and up to 3 years' imprisonment if reported. If the damage/harm is severe, legal proceedings are automatically taken (art. 125).

Endangering someone's life or health is covered by article 1274 of the Penal Code. It states that anyone who, whilst being responsible for the care of another person who cannot protect him/herself, puts that person's life in danger, seriously endangers his/her health or abandons him/her to such a risk, can be sentenced to five or more years'

imprisonment or a fine. If a person unscrupulously endangers another person's life, the possible sentence is the same but it is covered by article 1294.

3.29.4 Driving

There are no specific rules for people with dementia with regard to driving. All drivers over 70 years old have to have a check every two years. If a doctor has doubts about a person's capacity, s/he has to inform the administration. Then the driver has to take a test. However, there are no common rules for this test that are applicable in all Cantons.

The legal basis for this can be found in the Federal Law on Road Traffic of 19 December 1958 RS 741.01 (article 14.4 was introduced in 1975) and in the *"Ordonnance du 27 octobre 1976 réglant l'admission des personnes et des véhicules à la circulation routière (Ordonnance réglant l'admission à la circulation routière, OAC"*.

Art. 14 par. 4: Any doctor can report to the medical surveillance authorities, as well as the authorities responsible for issuing and withdrawing driving licences, any person who is not capable of safely driving a motorised vehicle due to a physical or mental illness or infirmity or due to drug addiction.

According to article 16c, it is considered an offence for a person to drive a motorised vehicle if s/he is incapable of driving because of drugs, medication or other reasons. Article 16d further states that a driving licence can be withdrawn for an indefinite period of time if a person, due to his/her mental or physical aptitudes, is unable or no longer able to drive a vehicle safely.

Article 271 (lit. b of the OAC) further states that the subsequent medical control carried out by a "médecin-conseil"⁵⁶ concerns people over the age of 70 and those who have been seriously injured in an accident or who are suffering from a serious illness.

⁵⁶ This is a doctor who is employed by the State and has certain powers of supervision/control which include that related to the assessment of driving capacity. However, it can also be the family doctor, which can be a problem because of their long-lasting relation.

3.30 Turkey

3.30.1 Involuntary internment

3.30.1.1 The conditions for involuntary internment

The similarity, under the Turkish Civil Code (*Türk Medeni Kanunu* = TMK, No. 4721, dated 22.11.2001), between the conditions for the appointment of a guardian (Arts. 405, 406) and the conditions for involuntary internment (TMK Art. 432) is fairly apparent. However, one does not necessarily need to have a guardian appointed before s/he can be involuntarily interned.⁵⁷ Still, in most cases, it is hard to deny the need for a guardian in cases where a person is being interned.

Involuntary internment as a protective measure was not specifically covered by the former Turkish Civil Code (*Türk Kanunu Medenisi*), No. 473 which had remained in force from 1926 to the end of 2001. It was finally introduced by the new TMK, No. 4721, dated 22.11.2001 which entered into force on 01.01.2002. As the source of inspiration, the Turkish Legislator cited selected amendments made in the Swiss Civil Code (*Zivilgesetzbuch* = ZGB Arts. 397a – 397f, 405a)⁵⁸ which had entered into force in Switzerland on 01.01.1981. Applicable provisions of the Civil Codes of Switzerland and Turkey were drafted to cover common legal issues of a wide-ranging group of people who need special attendance. Therefore, the relevant Code provisions (which are cited in this paper) do not only apply to those suffering from various types of mental disorder, but also to addicts of alcohol/illegal drugs, patients with highly dangerous infectious diseases and vagabonds (*serseri*). In other words, the same Code provisions are more or less also applicable to other persons in this wide-ranging group.

On 22.02.1983, two years after the said 1981 amendments in the Swiss ZGB, the Council of Europe Committee of Ministers adopted a Recommendation: R (83) 2 (=R (83) 2), concerning the legal protection of persons suffering from mental disorder placed as involuntary patients, which also covers related issues in detail. Although no direct reference has been made to R (83) 2 in the legislative commentary of TMK, the earlier Swiss ZGB articles and accordingly certain TMK articles contain provisions compatible or comparable with R (83) 2, yet not in every aspect. (Some of these shall briefly be mentioned below.)

The conditions for involuntary internment as a protective measure within the scope of TMK Art. 432, in particular those pertaining to dementia, may be summarised as follows:

1. The grounds for the involuntary internment of a person are to be prescribed and listed by Law and include *inter alia*, mental illness (*akıl hastalığı*) and mental weakness (*akıl zayıflığı*).

⁵⁷ Compare with R (83) 2 (Council of Europe, Committee of Ministers) Art. 9, see also this paper p.1 par. 3.

"The placement, by itself, cannot constitute by operation of law, a reason for the restriction of the legal capacity of the patient. However, the authority deciding a placement should see, if necessary, that adequate measures are taken in order to protect the material interests of the patient"

⁵⁸ However, the specific Art 314a of the Swiss ZGB regarding involuntary internment of a minor under parental power (*velayet*) for his/her own protection was not adopted in Turkey. For related issues, see TMK Art. 347.

Naturally, the involuntary internment of a person is only possible as an exception to the constitutional rule. In line with Article 5(1)(e)⁵⁹ of the Convention for the Protection of Human Rights and Fundamental Freedoms (as amended), to which Turkey is a party, Art. 19 of the 1982 Turkish Constitution (= *Anayasa*, as amended) provides that “Everyone has the right to liberty and security of person. [...] No one shall be deprived of his/her liberty except in the following cases where procedure and conditions are prescribed by law: [...] execution of measures taken in conformity with the relevant legal provision for the treatment, education or correction in institutions of a person of unsound mind [...] when such [here listed] persons constitute a danger to the public.” The “grounds” are limited to those listed in the Constitution and their scope cannot be expanded by analogy.^{60 61}

It may be helpful here to consider the definition of the terms “mental illness” and “mental weakness” as used in the Turkish legal context. “Although TMK refers to “mental illness” in various provisions, there is no definition of mental illness in TMK. Not every mental disorder which may be defined as a mental illness by medical science is to be understood as a mental illness in the meaning of TMK. What is legally relevant within the meaning of TMK is the issue of the existence or the non-existence of the power of judgement at a given time when a person enters into a legal transaction or is involved in a legal act. Not all mental illnesses result in the lack of the power of judgement of the person with the mental illness. It is also crucial to determine whether the lack of power of judgement was permanent or temporary, and if temporary, to also determine when it started.

Mental weakness (*akıl zayıflığı*) as referred to but not defined in TMK, is not a kind or degree of mental illness; but rather a different mental disorder which a person may be born with or may develop later in life.⁶² It may contain elements of insufficiency, underdevelopment, standstill or reduction of mental functions. Dementia is an example of this. Even if medical science may label some of these cases as mental illness, from a legal perspective, they are treated as mental weaknesses. Most people with mental weaknesses retain their power of judgement. However, from a legal perspective, a person with a mental illness does not have power of judgement. As this power is not always lost forever and may come and go in some cases, it is important to examine its existence at the time of the person’s action in question.”⁶³

Because of its severe consequences for any individual, the involuntary internment of such persons necessitates a complete medical examination by an official medical

59 “Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law: [...] the lawful detention of persons for the prevention [...] of persons of unsound mind, [...]”

60 Kocaaga, Köksal, Koruma Amacıyla Özgürlüğün Kısıtlanması [An article], Gazi Üniversitesi Hukuk Fakültesi Dergisi, Ankara, 2006, c. X, s.1, 2, p. 38

61 Kiliçoğlu, Ahmet, Medeni Kanunumuzun Aile-Miras ve Eşya Hukuku’nda Getirdiği Yenilikler, Ankara, 2004, p. 162

62 Zevkililer, Aydın, Kişiler Hukuku, Ankara, 1981, p. 58 et seq.,

63 Özsunay, Murat, Legal Capacity and Proxy Decision Making in Dementia – National Reports – Turkey, Dementia in Europe Yearbook 2010, p. 181, 3.28.2 Definitions and use of terms

committee.⁶⁴ Comprehensive neurological, psychiatric, neuropsychiatric examinations and tests must be carried out.⁶⁵

2. Moreover, any existing ground for the involuntary internment of a person should also pose danger for the society in a given case.

In other words, “danger for society” is an additional requirement to be considered in each case.⁶⁶

3. Only adults (*ergin*) can be involuntarily interned for one of the grounds listed under TMK Art. 432.

Children are excluded from the scope of this Art.⁶⁷

4. The involuntary internment of such a person is permitted only when his/her personal protection cannot be provided for in any other (more suitable) method.

For example, an aggressive yet wealthy person with mental illness may be confined to his/her own house, provided that medical treatment by private doctors is possible and all costs can be covered by his/her own assets. In such a case, the need for “an institution” cannot be established.⁶⁸

5. On the other hand, the burden inflicted upon their entourage/environment by such relatively dangerous persons is also to be taken into account.

Society is generally expected to tolerate such persons to a certain extent. Such a person can involuntarily be interned, as the last resort, only when the burden for his/her entourage/environment becomes too great in a given case.

6. The sole purpose of involuntary internment is to treat, educate or correct such a person.

If these purposes can be effectively achieved only in an institution, it is necessary that such an institution is appropriately established before someone can be put into it. *Ratio legis* of involuntary internment is not solely isolating the person from his/her environment for the sake of his/her entourage/environment, but to help him/her, generally speaking, to improve him/herself.

At this point, rough comparisons in three issues may be made between R (83) 2 and the Turkish Regulation of Patients’ Rights (*Hasta Hakları Yönetmeliği* = HHY) of 01.08.1998 drafted by the Ministry of Health (*Sağlık Bakanlığı*):

The right to be treated under the same ethical and scientific conditions as any other sick person and under comparable environmental conditions roughly corresponds to the right to equal treatment without discrimination under HHY Art. 5/c.

64 Özsunay, Murat, *ibid.* p. 182, 3.28.3 Proxy decision making, 3.28.3.1 Guardianship, 3.28.3.1.1 Conditions for the appointment of a guardian, par. 1

65 Compare with R (83) 2, Art. 2 which also reads “Difficulty in adapting to moral, social, political or other values, in itself, should not be considered a mental disorder”.

66 Compare with R. (83) 2, Art. 3

67 For interment of minors see TMK md. 446

68 Kiliçoğlu, Ahmet, *ibid.* p. 41

The right to informed consent to indispensable but risky medical treatments, involving consultation with the patient's legal representative, if any under R. (83) 2, Art. 5/2 corresponds to the less detailed HHY Art. 22.

Finally, the right to be protected from clinical trials of products and therapies not having a psychiatric therapeutic purpose on persons suffering from mental disorder, subject to placement under R. (83) 2, Art. 5/3, is comparable to HHK Art. 32/1,2. The latter forbids all research-oriented medical experiments, without the permission of the Ministry and the informed consent of the volunteer-patient.

7. Such a person is to be placed in an appropriate institution regardless of his/her will in this respect.

Note that the issue of the institution's "appropriateness" was covered above.

8. So long as the above conditions are met or prevail, a person who has originally been admitted into an appropriate institution at his/her own request may be detained (*alikoyma*) in that institution in spite of his/her subsequent request (free will) to be released.⁶⁹

3.30.1.2 The procedure for involuntary internment

The authority to decide on involuntary interment and detention lies within the jurisdiction of the guardianship authority (Civil Court of Peace = *Sulh Hukuk Mahkemesi*) at the concerned person's place of the residence (TMK Art. 19) or -in cases of emergency- at the place he/she happens to be at such time. The same authority, i.e. Court, is also authorised to decide on the release of the interned person from the institution (TMK Art. 433). TMK does not grant authority to doctors themselves, even in cases of emergency, to involuntarily intern a patient.⁷⁰

If such a decision is taken by a competent Civil Court of Peace at a place other than the interned or detained person's place of residence, the Civil Court of Peace at the former place or others authorised by special laws (under TMK m. 405/II, administrative authorities, public notaries, courts and public registration clerks)⁷¹ are to notify the Court at the place of said person's residence.⁷²

The decisions regarding involuntary internment or detention of a person are taken under the Code of Civil Procedure (*Hukuk Muhakemeleri Kanunu*, No. 6100 = HMK, in force since 01.10.2011)⁷³, in simplified (*basit*) trial procedure (TMK Art. 437/I), provided that the following are observed (TMK Art. 436/I):

1. The person who may eventually be interned or detained shall be heard by the judge (TMK Art. 437/III)⁷⁴; if s/he has a guardian, the judge should also hear the guardian

69 Compare with R (83) 2, Art. 1/2, 3

70 Compare with R. (83) 2, Art. 4/1 for a different approach.

71 Özsunay, Murat, *ibid* p. 183, 3.28.3 Proxy decision making, 3.28.3.1 Guardianship, 3.28.3.1.1 Conditions for the appointment of a guardian, par. 2

72 Kocaaga, Köksal, *ibid* p. 45

73 Compare with R (83) 2, Art. 1/1

74 Compare with R. (83) 2, Art. 4/3

(TMK Art. 403). If needed, the person shall be granted legal assistance i.e. access to the services of an appointed attorney at law whose fees are paid by the State (TMK Art. 437/II, HMK Articles 334-340). Furthermore, at the time the judge finally gives a decision, he/she shall inform the person about the reasons of the decision and remind him/her in writing that s/he can raise an objection against it before the supervisory authority⁷⁵, i.e. before the Civil Court of General Jurisdiction.⁷⁶

Due to the “danger for society” aspect of internment, any concerned person may initiate this procedure. Likewise, public servants who in the course of their duties discover the existence of one of the grounds for involuntary internment are to notify the situation to competent guardianship authority at once (TMK Art. 432).⁷⁷ TMK does not specifically list doctors among those who are obliged to notify.⁷⁸ Art. 26 of the Ethical Rules for Doctors, issued by the Turkish Union of Doctors (*Türk Tabipler Birliği*)⁷⁹ in short, requires a doctor in exceptional emergency cases to act in his/her own discretion. However, this discretion solely granted for the interest of the patient and not the interest of society. Therefore, it cannot be easily said that a doctor, even in emergency cases, should notify the authorities for the involuntary interment of a patient. On the other hand, doctors and medical staff are expected to notify competent authorities if they find out, in the course of their duties, that a crime may have been committed. Failure to do so is a crime under the Turkish Penal Code⁸⁰ (Art. 280).

2. The person who has been interned in an institution shall be immediately informed in writing that he/she can raise an objection, at latest within ten days, before the supervisory authority (Civil Court of General Jurisdiction) against the detainment decision or the denial of the request for release from the institution.
3. All requests which require a decision of the Court shall be forwarded to the competent judge without delay.
4. The guardianship authority, i.e. Civil Court of Peace, or judge which had previously decided for the detention may in the light of the given circumstances postpone the execution of the decision (TMK Art. 436/I/4).⁸¹
5. A decision about persons suffering from *inter alia*, mental illness and mental weakness can be given only after the report of an official medical committee has duly been obtained.⁸² The supervisory authority (Civil Court of General Jurisdiction) may waive this requirement where the guardianship authority (Civil Court of Peace) has previously applied to an expert-witness.

75 Özsunay, Murat, *ibid* p. 183, 3.28.3.1.2 How guardianship is arranged, p. 185, 3.28.3.1.5 Measures to protect the ward from misuse of power, par. 1

76 Compare with R. (83) 2, Art. 4/2

77 Kocaaga, Köksal, *ibid* p. 43

78 Compare with R. (83) 2, Art. 4/2

79 http://www.ttb.org.tr/mevzuat/index.php?option=com_content&task=view&id=65&Itemid=31

80 For other crimes see also 1.1.3 Mistreatment/abuse

81 Adopted from Swiss ZGB Art. 397e(4), however the wording in Turkish is imprecise.

82 Compare with R. (83) 2, Art. 4/1

3.30.1.3 Duration of involuntary internment

The involuntarily interned person is to be released from the institution as soon as his/her condition permits this (TMK Art. 432/III)⁸³. The request for release may be made by the interned person as well as by the administrators of the institution if they see this fit.⁸⁴

3.30.1.4 The right to appeal

The person who has been interned or others close to him/her may raise an objection, within ten days starting from the date of notification, against this decision before the supervisory authority. The same right to objection may be invoked against the denial of the request for release from the institution (TMK Art. 435).

3.30.2 Coercive measures

The specific rights of those who are placed as involuntary patients prescribed under Art. 6 of R (83) 2 (see above), in particular the right "to communicate with any appropriate authority, the person mentioned in Art. 4 of R (83) 2 and a lawyer, and to send any letter unopened" are not exactly added to the text of relevant Turkish Codes. Nevertheless, Articles 5/d and 39 of the Turkish HHY (see above) refer to the inalienability of "personal rights" and "respect to humanitarian values" as well as the patient's right to invoke these rights. These Turkish principles may be considered to roughly correspond and cover the said specific rights of the Recommendation including its Art. 10 which requires respect of the patient's "dignity".

3.30.3 Mistreatment/abuse

Perpetrators of various acts constituting mistreatment and abuse of relatively weaker persons, such as those suffering from dementia, are punished by law, mainly the Turkish Penal Code (*Türk Ceza Kanunu* = TCK, No. 5237 of 26.09.2004).

Any person who performs acts which are bound to cause torment to another person shall be sentenced to a penalty of imprisonment for a term of two to five years. If such an act is committed against a person who is *inter alia* physically or mentally incapable of defending him / herself, the imprisonment term shall be three to eight years (TCK Art. 96.).

Any person, holding the duty of protection or observation of an individual who is unable to care for him/herself due to age or illness, who abandons such person by leaving him/her by him/herself shall be sentenced to a penalty of imprisonment for a term of three months to two years. (TCK Art. 97/1). The penalty shall be increased if the victim suffers an illness, injury or death as a consequence of the abandonment (TCK Art. 97/2).

Any person who fails under the given circumstances to adequately assist an individual who is unable to care for him/herself due to age, illness, injury or any other reason, or

⁸³ Compare with R. (83) 2, Art. 8/1,2

⁸⁴ Kocaaga, Köksal, *ibid* p. 53

who fails to notify at once the competent authorities of these circumstances shall be sentenced to a penalty of imprisonment for a term of up to one year or to a judicial fine (TPC Art. 98/1). If the victim dies as a result of such failure, a penalty of imprisonment for a term of one to three years shall be imposed (TCK Art. 98/2).

Any person who unlawfully deprives a person from exercising his/her right to go to or to remain in a particular place shall be sentenced to a penalty of imprisonment for a term of one to five years (TCK Art. 109/1). The use of force, threats and deception increases the imprisonment term i.e. two to seven years (TCK Art. 109/2). The term shall be doubled when committed against *inter alia* individuals who are incapable of defending themselves physically or mentally (TCK Art. 109/3/f).

On the other hand, society is protected against any acts committed by those suffering from mental illness. This may also pertain to any harmful acts of those suffering from dementia insofar as a given severe case of dementia can be indentified as mental illness. Any person who neglects his/her duty to care for or look after a person suffering from a mental illness in such a way as to create a danger to the life, health or property of others shall be sentenced to a penalty of imprisonment for a term of up to six months or to a judicial fine.

3.30.4 Driving

A person who applies for a driving licence is required *inter alia*, to submit a medical report, given upon an examination of a practitioner or expert doctor, which confirms that s/he is fit to drive⁸⁵. The relevant Regulation lists a number of medical conditions which adversely affect the fitness of a person, including "mental illness" (*ruh hastaligi*) in the form of severe mental illness, mental deficiency, dementia/senility (*demans = bunama*), behavioural disorder due to old age, personality disorder, severe behavioural disorder. If the examining doctor observes such a condition, the person is sent to an appropriate expert doctor for an adequate examination of this condition. This second-level medical report shall be decisive. Such persons shall be denied a driving licence⁸⁶.

If any of these listed perilous medical conditions come about after a person has already been issued a driving licence and its results are coincidentally observed by the traffic police, the person shall be sent to a medical examination which shall be carried out by the medical board. If the said medical board finds that the driver has subsequently lost his/her fitness to drive, the driver's licence shall be withdrawn, until the person can - if at all - recover⁸⁷.

85 Law on Highway Traffic (*Karayollari Trafik Kanunu*), No. 2918 of 13/10/1983 as amended, Art. 41/c

86 Regulation on the required medical conditions and examinations of prospective drivers and drivers (*Sürücü Adayları ve Sürücülerde Aranacak Sağlık Şartları ile Muayenelerine Dair Yönetmelik*) of 26.9.2006/26301, Arts. 4/2/(I), 9/1/a

87 Law on Highway Traffic, No. 2918 of 13/10/1983 as amended, Art. 45

3.30.5 Acknowledgement

Mr Murat R. Özsunay, M.C.J., Attorney at Law, Bars of Istanbul & Frankfurt, was the author of the above text on the legal situation in Turkey.

3.31 United Kingdom - England

3.31.1 Involuntary internment

3.31.1.1 The conditions for involuntary internment

The Mental Health Act 2007 contains details of the procedure for the admission and compulsory detention of a person in a hospital. However, this does not mean that compulsory detention is the only possibility. Section 131 states:

"Nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or mental nursing home in pursuance of arrangements made in that behalf and without any application, order or direction rendering him liable to be detained under this Act, or from remaining in any hospital or mental nursing home in pursuance of such arrangements after he⁸⁸ has ceased to be so liable to be detained."

Consequently, if it is possible for a person to be admitted on a voluntary or informal basis, this should be considered before resorting to compulsory detention. In fact, involuntary internment should only be considered as a last resort. If a mentally incapable person does not object to entering hospital and receiving care or treatment, admission should be informal. In this case, the doctor in charge of the mentally incapacitated person is responsible for deciding on admission. S/he should make this decision on the basis of what is in the patient's best interests and is justifiable according to the common law doctrine of necessity⁸⁹.

In addition to this the Mental Health Act will introduce the Deprivation of Liberty safeguards by amending the Mental Capacity Act England and Wales in April 2009. The safeguards will provide a structure for health professionals when deciding whether detention of an adult in a hospital or care home is in their best interests. The adult will be able to appeal against the decision once it has been made.

3.31.1.2 The conditions for admission to hospital for assessment

Under section 2 of the Mental Health Act 2007, a person can be admitted to hospital and detained there for not more than 28 days if the following conditions are fulfilled:

"he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and

he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons."

88 The use of "he" reflects the actual wording of the legal text. Here and in the rest of this report, it should also be understood to refer to "she".

89 For more info on this issue, please refer to: R v Bournewood Community and Mental Health NHS Trust ex parte L (1998 3 All ER 289) and section 3 for details about the doctrine of necessity.

3.31.1.3 The conditions for admission to hospital for treatment

The person may be further detained subject to the provisions for admission for treatment. An application for admission for treatment may be made (under section 3 of the Mental Health Act 2007) if the following conditions are fulfilled:

“he is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and

in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition; and

it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section.”

3.31.1.4 The procedure for admission and involuntary internment

According to the Mental Health Act of 1983, in order to have a person admitted to and detained in hospital for assessment, the application must be supported by two written recommendations made by two registered medical practitioners each including a statement that the conditions for admission have been fulfilled. An application for admission for treatment must also be founded on two written recommendations from registered medical practitioners. They must include details of the mental illness or disorder the person is suffering from (both agreeing on one form of disorder even if additional disorders are not mentioned by both) and an explanation of why other methods of dealing with the patient are not being used or are not appropriate, if available. The 2007 Act extends the list of people who can be called upon to decide whether someone ought to be sectioned.

An application for admission must be submitted to the managers of the hospital to which admission is sought. This may be made either by the nearest relative of the patient or by someone from the list of approved health professionals. The applicant must have seen the person within the last 14 days. Before or within a reasonable time after the application has been made, the applicant must inform the person who appears to be the nearest relative of the patient that an application has been made or is due to be made. If this person objects to admission, the application cannot go ahead. On the other hand, it is the duty of the health professionals to make an application for admission to hospital if a person seems to be in need of it and to make sure that detention in a hospital seems to be the most appropriate way of providing the care and medical treatment the patient needs. However, if the nearest relative objects, the application cannot be made.

3.31.1.5 The duration of involuntary internment

Once admitted, a person can be detained for a period not exceeding 6 months. This can be prolonged by a further 6 months. However, within two months of admission, the responsible medical officer must review the patient's case and discharge him/her unless the conditions for admission for treatment (mentioned earlier) are fulfilled. The 2007

Act abolishes the 'treatability test' and introduces a new 'appropriate medical treatment' test. Consequently, it will not be possible for patients to be compulsorily detained or their detention continued unless medical treatment which is appropriate to the patient's mental disorder and all other circumstances of the case is available to that patient.

3.31.1.6 Emergency admission and short-term detention

In cases of emergency, an application can be made either by a health professional on the approved list or the nearest relative of the patient. It must be stated in the application that it is of urgent necessity for the patient to be admitted and detained in hospital and that making the normal application would involve undesirable delay. The patient can be admitted into hospital for 72 hours in order to allow enough time for the second medical recommendation to be obtained.

A patient who is receiving treatment for mental disorder on an in-patient basis can be prevented from leaving a hospital if it appears to a nurse that s/he is suffering from a mental disorder to such a degree that it is necessary for his/her health or safety or for the protection of others that s/he be restrained and that it is not practicable to find a medical practitioner for the purpose of furnishing a report. In this case, the nurse must make a record of this measure being applied and can then detain the patient in the hospital for a period of six hours. The nurse must then make a report to the managers of the hospital.

According to section 136, if a constable finds in a public place a person who seems to be suffering from mental disorder and in need of immediate care or control, s/he may take the necessary steps to remove that person to a safe place if this would be in the interests of that person or for the protection of other people. Once removed, the person can be detained for a period of 72 hours, during which time s/he may be examined by a registered medical practitioner and interviewed by an approved social worker with a view to making the necessary arrangements for treatment or care.

Section 152 of the Housing Act 1996 states that the High Court or a county court may, on application by a local authority, grant an injunction prohibiting a person from engaging in threatening behaviour or conduct causing a nuisance or annoyance to other residents. If there is reason to believe that the person is suffering from mental illness or severe mental impairment, the judge may remand the accused person to a hospital for a report on his/her mental condition under section 25 of the Mental Health Act 1983.

3.31.2 Coercive measures

Section 6 of the Mental Capacity Act 2005 defines restraint as the use of force or the threat to use force where a person with incapacity resists, and any restriction of liberty or movement whether or not the person with incapacity resists. A person may legitimately use restraint only if s/he reasonably believes that it is necessary to prevent harm to the person with incapacity and provided that the restraint used is proportionate to the likelihood and seriousness of the harm.

3.31.3 Mistreatment/abuse

3.31.3.1 Ill-treatment and neglect

Part IX of the Mental Health Act 2007 deals with offences including abuse. Paragraph 127 states that it is an offence for any person who is an officer, manager or member of staff employed in a hospital or mental nursing home to ill-treat or wilfully to neglect a patient who is receiving treatment for mental disorder as either an in-patient or out-patient. It is also an offence for any individual to ill-treat or wilfully neglect a mentally disordered patient who is subject to guardianship under the 2007 Act or is otherwise in the individual's custody or care.

In 1995 the General Medical Council, which is the statutory body for doctors, stated that doctors should disclose information to the relevant people if they believe that a patient is a victim of neglect or physical or sexual abuse. If the patient does not consent to disclosure of the information, the information should only be disclosed if the doctor considers that it would be in the best interests of the patient.

The Mental Capacity Act 2005 made it a criminal offence to ill treat or neglect a person who lacks capacity, with a maximum sentence of five years or a fine.

3.31.3.2 Warrant to search and remove

According to section 135 of the Mental Health Act 2007, a justice of the peace can issue a warrant to search for and remove a person believed to be suffering from a mental disorder from a place if s/he is of the opinion that this person is being ill-treated, neglected or not kept under proper control or alternatively, if the person seems to be unable to care for him/herself and is living alone. The warrant may be issued on the basis of information provided on oath by an approved social worker. A constable, who is named in the warrant, may enter into any building where the person is believed to be residing using force if necessary.

3.31.3.3 Harassment and causing fear of violence

Under the Protection from Harassment Act 1997, it is an offence for a person to pursue a course of conduct which amounts to harassment of another and which s/he knows or ought to know amounts to harassment. It is considered that a person "ought to know" that a particular action amounts to harassment if a reasonable person in possession of the same information would think that the course of conduct (an act committed on at least two occasions) amounted to harassment of another. Conviction of such an offence may lead to a claim for compensation and in certain cases an injunction to restrain the accused. Conduct is understood to include speech.

It is also an offence under this act to behave in such a way as to cause another person to fear, on at least two occasions, that violence will be used against him/her. As with harassment such behaviour is judged on the basis of how another person with the same information would view it.

3.31.4 Driving

3.31.4.1 General provisions

The Road Traffic Act 1991 contains a few articles relating to offences involving driving when unfit to do so, e.g.:

A person who causes the death of another person by driving a mechanically propelled vehicle dangerously on a road or other public place is guilty of an offence.

A person who drives a mechanically propelled vehicle dangerously on a road or other public place is guilty of an offence.

If a person drives a mechanically propelled vehicle on a road or other public place without due care and attention, or without reasonable consideration for other persons using the road or place, he (or she) is guilty of an offence.

According to the provisions of this act, a person is regarded as driving dangerously if the way s/he drives falls far below what would be expected of a competent and careful driver and it would be obvious to a competent and careful driver that driving in that way would be dangerous.

Section 93 of the Road Traffic Act of 1988 deals with the withdrawal of driving licences. This states that the Secretary of State can serve a notice in writing and revoke a driver's licence at any time if s/he is satisfied on inquiry that the licence holder is suffering from a relevant disability. Under the previous section of this act "relevant disability" is defined as any prescribed disability as well as any other disability likely to cause the driving of a vehicle by the person in question to be a source of danger to the public.

3.31.4.2 Obligations concerning licensing requirements and insurance

Once a person who holds a current driving licence is diagnosed as suffering from dementia, s/he is legally obliged to inform the Driver and Vehicle Licensing Authority (DVLA). The same applies if s/he wishes to obtain a new licence. Failure to report the diagnosis to the DVLA is a criminal offence punishable by a fine of up to £1,000.

It is a criminal offence to drive without at least third party car insurance. A person who has received a diagnosis of dementia must inform his/her insurance company, as failure to do so jeopardises the validity of the car insurance.

3.31.4.3 Carrying on driving once a diagnosis of dementia has been made

A person with dementia who decides to continue driving should contact the DVLA and request a medical investigation. The DVLA then sends a questionnaire to the person requesting permission to obtain reports from his/her doctor and specialists. A formal driving assessment may also be required. If on the basis of the medical information, the

DVLA decides that the person should be allowed to continue driving, it issues a licence, which is valid for a period of one year.

If a person who has been diagnosed as having dementia fails to report the diagnosis and also carries on driving against the advice of his/her doctor, that doctor may inform the DVLA if there is a significant deterioration in the person's condition. Other people, such as a family member, a neighbour or a police officer, who are concerned about a person's ability to drive, may also contact the DVLA and ask them to make a medical investigation.

3.32 United Kingdom - Scotland

3.32.1 Involuntary internment

Mental Health (Care and Treatment) (Scotland) Act 2003

The Act was designed to modernise and improve the use of compulsory measures in mental health care. It reflects the general move over the last two decades towards care and treatment in the community rather than in hospitals or other residential settings. The title reflects the philosophy of the legislation with the focus on 'care' and 'treatment'. In basic terms, the Act provides for the protection of people with a mental disorder in a hospital or community setting.

It contains mechanisms for dealing with offenders who have a mental disorder and so interacts with the criminal justice system.

The Act covers individuals who are defined as having a 'mental disorder'. The term includes mental illness, personality disorder and learning disability. The majority of cases involving compulsory measures have been in relation to people diagnosed with a mental illness. However, the Mental Welfare Commission for Scotland monitors the use of compulsory measures and has found increasing use of emergency or short-term measures being used for people aged over 75 years with a diagnosis of dementia.

Detention (Involuntary internment)

The Act deals with several forms of compulsion in relation to a person with mental disorder where:

There is a significant risk to the person's health, safety or welfare or the safety of any other person (what is a significant risk is a question of judgement for health and social care professionals. The tribunal will test this assessment during an appeal or on an application for a compulsory treatment order).

Treatment is available to prevent the person's condition from deteriorating or to relieve its symptoms or effects.

Compulsory admission is necessary because the person will not agree to admission and/or treatment; and

The person's ability to make decisions about the provision of medical treatment is significantly impaired because of mental disorder.

Types of order

Emergency Detention (72 hours)

Short-term Detention (28 days and can be extended)

Compulsory Treatment Order (6 months – can be extended)

Mental Health Tribunals

The Act introduced a new system of mental health tribunals with a number of functions, including considering applications for orders and appeals against orders.

Emergency detention

This is detention in a psychiatric hospital for up to 72 hours if necessary. It does not authorise any medical treatment. In an emergency, common law powers might be used. A registered medical practitioner can sign an emergency detention certificate if s/he believes that a person's ability to make decisions about medical treatment is significantly impaired because of mental disorder. This authorises the removal of the individual to a specific hospital. Before signing the certificate the medical practitioner must be satisfied that:

There is an urgent need to detain the person in hospital to access the medical treatment s/he needs.

If the person was not detained, there would be a significant risk to his or her health, safety, or welfare or the safety of another person, and

Any delay caused by starting the short-term detention procedure is undesirable.

If any treatment is needed the short-term detention procedure must generally be used.

Short-term detention

This may be used where it is necessary to detain an individual with mental disorder who cannot be treated voluntarily and without the treatment the person would be at risk of significant harm. To obtain a certificate the approved medical practitioner must consult and gain the approval of a Mental Health Officer whatever the circumstances.

Compulsory Treatment Order

Compulsory Treatment Orders (CTOs) are granted by the Mental Health Tribunal. They last for 6 months, can be extended by the responsible medical officer for a further six months and then extended annually. The Tribunal reviews them at least every two years. Therefore, they can restrict or deprive liberty for long periods of time. The Mental Welfare Commission for Scotland looks at how these orders are used for people of different ages and genders to see if there are any trends. Over recent years, the number of new orders has come down. The use of CTOs for people aged 65 and over has increased for people with dementia in recent years.

'De facto detention'

Practitioners must be careful that they are not using excessive coercion to prevent people from leaving hospital when they wish to. They must take care to document situations where they have concerns if an informal patient wishes to leave. The Tribunal can, under section 291 of the 2003 Act, order that an informal patient is being unlawfully detained. People with dementia pose a difficult problem. The Tribunal has ruled that a person with

dementia is unlawfully detained in a general hospital when prevented from leaving. It can be appropriate to redirect someone and dissuade him/her from leaving but repeatedly thwarting a determined effort to leave is likely to represent a significant deprivation of liberty, and the patient should be formally detained.

Adults with Incapacity (Scotland) Act 2000

Scottish incapacity laws were reformed with the introduction of the Adults with Incapacity (Scotland) Act in 2000. This Act covers people with a mental disorder who lack some or all capacity to make decisions or act in their own interests. It recognises that capacity is not all or nothing but is 'decision specific'. The Act introduced a number of measures to authorise someone else to make decisions on behalf of the person with incapacity, on the basis of a set of principles on the face of the Act. These are fundamental. Any action or decision:

Must benefit the person,

Must be the least restrictive of the person's liberty in order to gain that benefit,

Must take account of the person's past and present wishes (s/he must be given assisted to communicate by whatever means is appropriate to the individual),

Must follow consultation with relevant others as far as practicable,

Must encourage and support the person to maintain existing skills and develop new skills.

The individual may, whilst competent, appoint one or more persons to act their financial (continuing) and or welfare attorney. This must be registered with the Office of the Public Guardian. It does not allow the attorney, to detain the grantor in a psychiatric hospital. If the person refuses to comply with the attorney, the attorney has no compulsory powers to detain. Where there is concern for the person's safety, the attorney can apply to the court for a welfare guardianship order. Powers can be granted to allow the guardian to decide on the accommodation of the person and other powers such as who they can consort with. Where the welfare guardian has powers over accommodation s/he is able to restrict the freedom of the person by placing them in a care home against their will. However, whether this amounts to deprivation of liberty under the European Court of Human Rights ruling will depend on a number of other circumstances and the accumulative impact of which would need to be considered (Patrick and Smith, 2009; Mental Welfare Commission for Scotland, 2011). With regard to the issue of non-compliance, if the person on guardianship, for example, runs away, the guardian can apply to the Court under s70 for an order to require the person to return.

Because there is no automatic review of welfare guardianship orders there is concern that the Adults with Incapacity (Scotland) Act 2000 may not be compliant with the European Convention on Human Rights. The Act states that the order should be for a standard 3 years but can be more or less at the discretion of the Court. However, there has been a practice of orders being granted for indefinite periods and this has given rise to

concern in relation to certain groups. However, for people with dementia, who have a progressive brain disorder, an indefinite order may be deemed appropriate.

The Scottish Law Commission is currently undertaking a review of the Adults with Incapacity (Scotland) Act 2000 in relation to deprivation of liberty issues. It has established an advisory group of key stakeholders, including Alzheimer Scotland, and will be reporting in due course.

3.32.2 Driving

The Road Traffic Act of 1991 contains a few articles relating to offences involving driving when unfit to do so, e.g.:

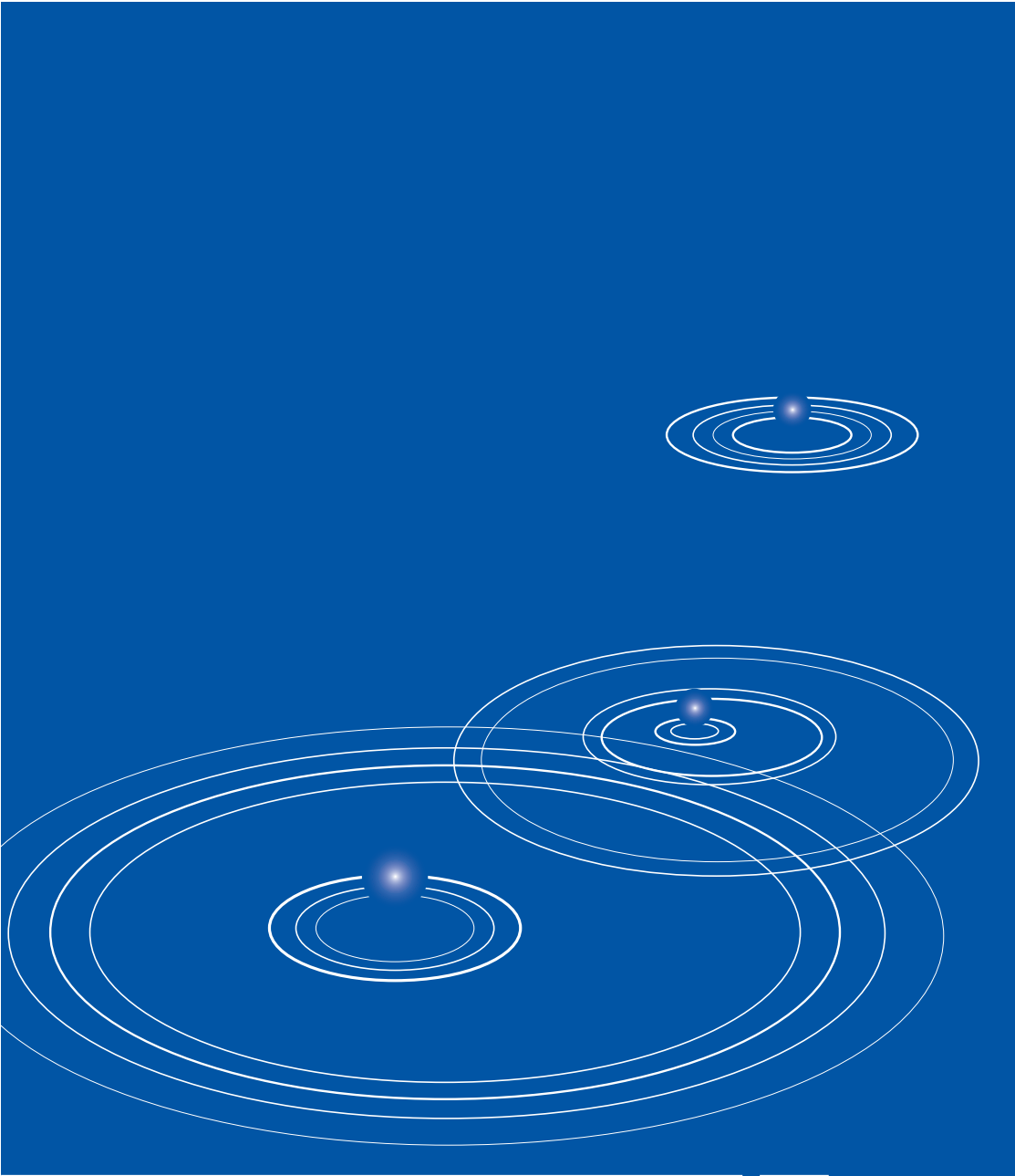
- A person who causes the death of another person by driving a mechanically propelled vehicle dangerously on a road or other public place is guilty of an offence.
- A person who drives a mechanically propelled vehicle dangerously on a road or other public place is guilty of an offence.
- If a person drives a mechanically propelled vehicle on a road or other public place without due care and attention, or without reasonable consideration for other persons using the road or place, he (or she) is guilty of an offence.
- According to the provisions of this act, a person is regarded as driving dangerously if the way s/he drives falls far below what would be expected of a competent and careful driver and it would be obvious to a competent and careful driver that driving in that way would be dangerous.

A person who has been diagnosed with dementia must inform the Driver and Vehicle Licensing Authority (DVLA). Failure to do could lead to a fine of up to £1,000. Moreover, a person who had an accident but did not previously inform the DVLA of his/her dementia might not be covered by his/her insurance company. Once the DVLA has been informed of that someone has dementia, they send a questionnaire to the person and request a medical report. A driving assessment may also be required. The Medical Advisers at the DVLA then decide whether the person can continue driving (Alzheimer Scotland, 2003).

3.32.3 References

Patrick, H. and Smith, N. (2009), *Adult Protection and the Law in Scotland*, Bloomsbury Professional.

Mental Welfare Commission for Scotland Annual Report 2010 – 2011 www.mwscot.org.uk



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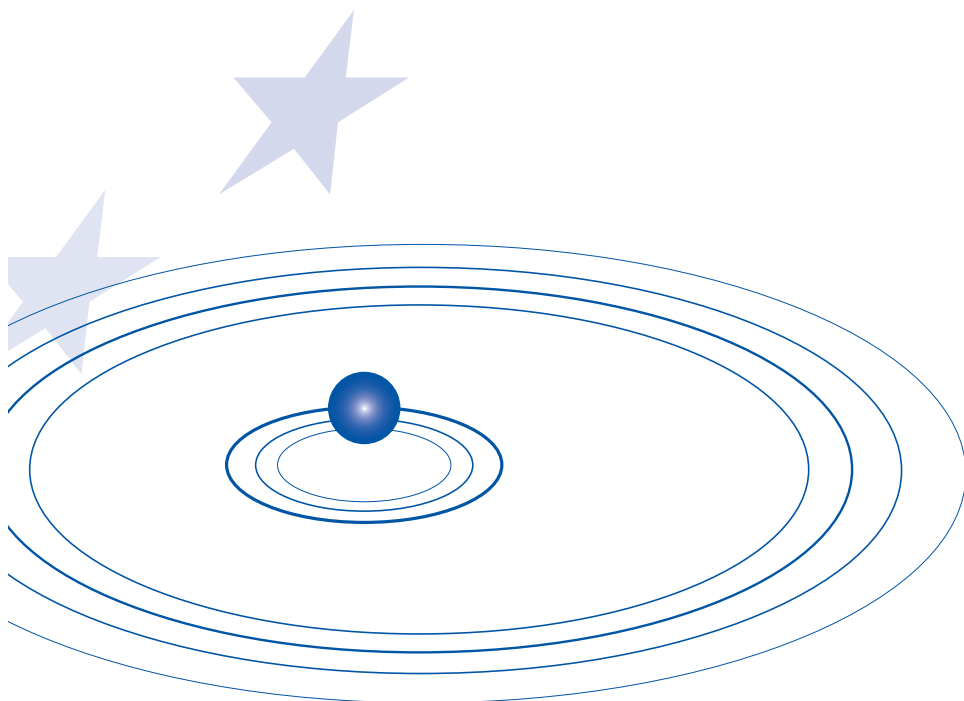
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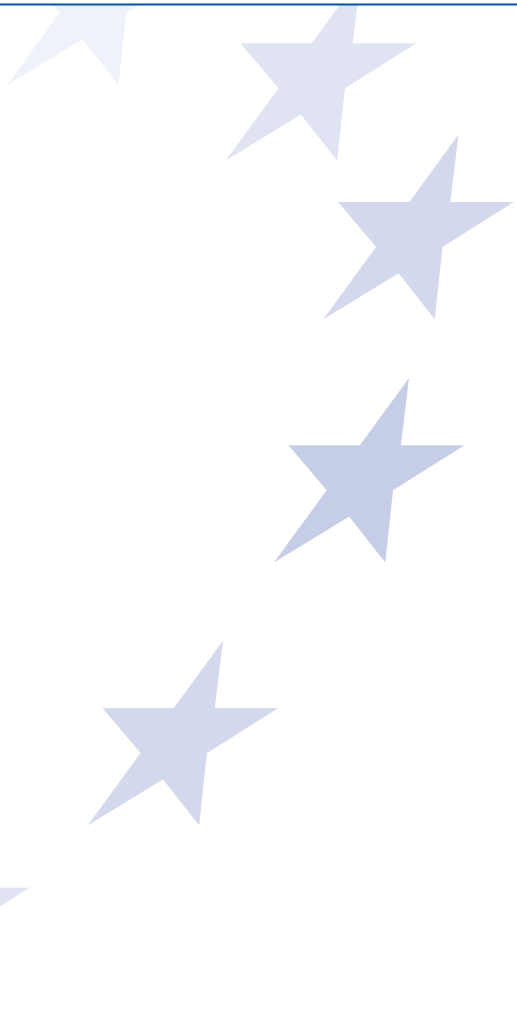
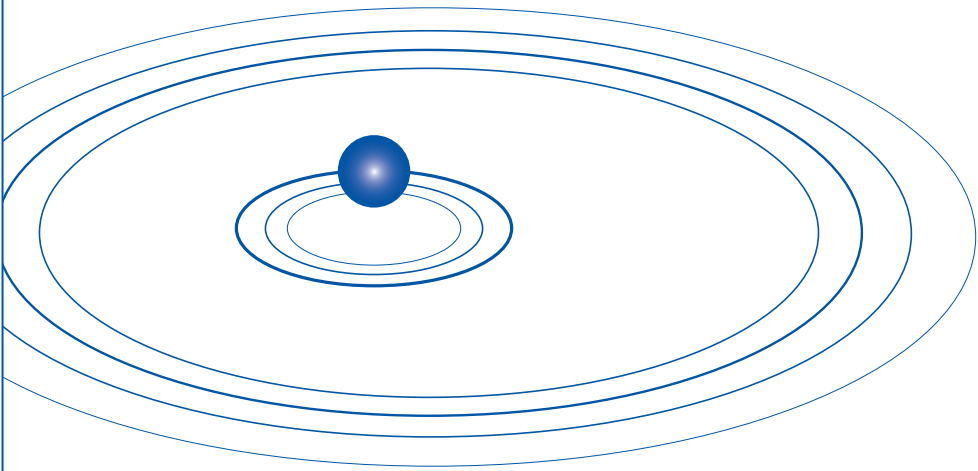


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Annual Report 2010

1.1 Preface



I took over as Chairperson of Alzheimer Europe in October 2010 and the majority of activities which are described in this Annual Report were undertaken by my predecessor Maurice O'Connell. It is therefore natural that I start my introduction by singling out Maurice and thanking him for his clear leadership over the past six years. The width and depth of activities highlighted in our Annual Report are a clear testament to how much Alzheimer Europe has grown under his direction.

2010 constituted the 20th anniversary of Alzheimer Europe and we celebrated this during our very successful conference in Luxembourg held under the motto "Facing dementia together". Our 20th anniversary was also an ideal opportunity to reflect on our past achievements and the future direction of our organisation. In our membership satisfaction survey, it was encouraging to see the overwhelming vote of confidence we received from our member organisations who rated all our past activities very highly and who gave us their support for the future strategic direction of Alzheimer Europe.

Our policy of involving people with dementia in our activities also made a qualitative jump last year. We were able to make clear recommendations on how to better involve people with dementia in our conferences through the introduction of a bursary system and by ensuring people with dementia are actively involved as speakers. In addition, we involved people with dementia in all working groups set up by the organisation. Last but not least, we were able to reach a decision on how to involve people with dementia in our governance through the development of a European Working Group of People with Dementia and the nomination by that group of a representative on our Board. These decisions will need to be followed up by a statutory reform in 2011, but the way ahead is now clear.

Other highlights in 2010 were our projects in the ethical and legal field. We continued with the activities of the European Dementia Ethics Network and provide a comprehensive overview and discussions of the ethical issues related to assistive technologies. In addition we covered the laws in 30 European countries in the field of legal capacity and proxy decision making. I am proud to say that Alzheimer Europe has become a reference in this important field.

We also continued our campaign to make dementia a European priority and I am truly astounded by the progress we have been able to achieve since the adoption of our Paris Declaration in 2006 which marked the start of our campaign asking for:

1. the development of dementia strategies,
2. greater investment in dementia research and
3. better collaboration and exchange of best practices between European countries.

In all of these three areas, we saw progress. At the end of 2011, there were dementia strategies in place in England, France, the Netherlands, Scotland, Sweden and Wales. Additional countries had started with the development of such strategies, including Belgium, Cyprus, the Czech Republic, Denmark, Finland, Ireland, Italy, Luxembourg and Malta. Thanks to the launch of the Joint Programming Initiative on Neurodegenerative Diseases in 2011 we should see greater support for research on a European level and a better coordination of national research efforts. Last, but not least, ALCOVE, the Joint Action on Dementia will bring together experts and representatives of health ministries to improve early diagnosis, limit the use of anti-psychotics and exchange good practices in the fields of epidemiological research, care and rights of people with dementia. Alzheimer Europe will be happy to collaborate with these initiatives.

We continued to find supporters of our campaign in the European Parliament and many members of the European Alzheimer's Alliance either supported our European campaign or collaborated with our national member organisations. The lunch debates we organised in the European Parliament were well attended and I would like to thank Dagmar Roth-Behrendt, MEP (Germany) and Nessa Childers, MEP (Ireland) for graciously agreeing to host these events. We highlighted these policy developments in our Dementia in Europe Magazine which has become an essential tool for our continued campaign. The number of policy makers willing to contribute or to be interviewed for our magazines continues to grow from one year to the next.

In 2010, we also started our "Value of Knowing" survey. Together with the Harvard School of Public Health and the Alzheimer's associations in France, Germany, Poland, Spain and the US and thanks to an educational grant by Bayer Healthcare, we developed a survey on the public perceptions of the value of diagnosis, which will also aim at providing a more accurate picture of the public's familiarity, understanding and knowledge of Alzheimer's disease.

We were also asked to provide the carers' and patients' perspective in PharmaCog and DECIDE, two EU financed research projects. In both these projects, AE will contribute to the ethical discussions and support the dissemination of the research results to the general public and the carer and patient community.

This impressive list of activities would not have been possible without our small but highly dedicated team at Alzheimer Europe. My heartfelt thanks for their contributions go to our Executive Director, Jean Georges and his colleagues Annette Dumas, Julie Fraser, Dianne Gove, Gwladys Guillory and Grazia Tomasini. Similarly, the Board of Alzheimer Europe was instrumental in providing guidance and monitoring the various activities of the organisation. I was particularly happy to see that our meetings continued in the same team spirit as before.

Thanks to the support of the European Commission and the operating grant provided for our activities, the financial year was less challenging than previous years. We are deeply

grateful for this recognition and absolutely vital support. In addition, my thanks go to the Luxembourg Alzheimer's association who seconded Jean Georges to our organisation and provided our rent free offices.

I am deeply grateful for the additional support of our various funders from the public sector (German Ministry of Health), foundations (Fondation Médéric Alzheimer, Fondation Roi Baudouin) and the corporate sector (Bayer Healthcare, Elan, GlaxoSmithKline, Janssen-Cilag, Lilly, Lundbeck, Mazars, Novartis, Nutricia and Pfizer).

Heike von Lützu-Hohlbein
Chairperson

1.2 *Executive summary*

In 2010, Alzheimer Europe

- Continued with the development of the European Dementia Ethics Network bringing together European experts in the field of dementia ethics and carried out an in-depth literature review on the ethical implications of the use of assistive technologies in home and institutional settings,
- Published its position and guidelines on the ethical use of assistive technology for/by people with dementia,
- Carried out an inventory of national legislations on proxy-decision making and legal capacity,
- Dedicated its 2010 Dementia in Europe Yearbook to the subject of proxy decision making and legal capacity and included descriptive national reports on the legislation in place in 29 European countries,
- Carried out a survey of its members on the involvement of people with dementia and approved recommendations on how to better involve people with dementia in activities, projects, conferences, as well as the governance of the organisation,
- Greatly expanded its coverage of scientific and policy developments in the framework of its Dementia Observatory and included 474 news articles in its monthly e-mail newsletter,
- Further developed its website which attracted over 160,000 visitors,
- Organised its 20th Anniversary Conference in Luxembourg under the theme “Facing dementia together” which was attended by over 300 delegates from 34 countries,
- Elected a new Board with Heike von Lützu-Hohlbein (Germany) as Chairperson, Iva Holmerová (Czech Republic) as Vice-Chairperson, Maria do Rosário Zincke dos Reis (Portugal) as Honorary Treasurer and Sigurd Sparr (Norway) as Honorary Secretary,
- Carried out a survey of its members which highlighted a very high degree of satisfaction of its members with the organisation’s past activities and strategic direction,^
- Developed a new strategic plan focusing on the key objectives of making dementia a European priority, supporting policy with facts, basing actions on ethical principles and building a stronger organisation,
- Welcomed Alzheimer Uniti from Italy as a new provisional member,
- Continued its collaboration with a number of European networks in the dementia field and supported the development of a European Memory Clinics Association,
- Collaborated with the European Patients’ Forum on general patient issues such as cross-border health care,
- Supported the activities of the Alliance for MRI,

- Strengthened its contacts with AGE, the European Platform for elderly people,
- Received an operating grant for its activities from the EU public health programme,
- Continued the development of the European Alzheimer's Alliance which grew to 50 Members of the European Parliament from 17 Member States,
- Organised two lunch debates in the European Parliament which were hosted by Dagmar Roth-Behrendt, MEP (Germany) and Nessa Childers, MEP (Ireland),
- Focused on the development and implementation of national dementia strategies and dedicated a section of its website to the presentation of these strategies,
- Published two editions of its "Dementia in Europe Magazine" which carried interviews from a variety of national and European policy makers,
- Produced a special anniversary supplement to its magazine highlighting the key events and achievements of the past 20 years,
- Closely collaborated with Members of the European Parliament on their own initiative report on a European Alzheimer's Initiative,
- Developed contacts with the Joint Programming Initiative on neurodegenerative diseases,
- Actively contributed to the Spanish Presidency Conference "Mental Health and Well-being of Older People" and to the Belgian Presidency Conference "Improving the quality of life of people with dementia – a challenge for European society",
- Continued its collaboration with the European Medicines Agency and participated in expert meetings on familial neurodegenerative diseases and on the use of biomarkers in dementia,
- Participated as a full partner in the PharmaCog ("Prediction of cognitive properties of new drug candidates for neurodegenerative diseases in early clinical development") project by taking part in ethical discussions and by disseminating information on the project's progress,
- Was invited to join the Decide ("Diagnostic Enhancement of Confidence by an International Distributed Environment") Consortium where it will represent the views of people with dementia and their carers,
- Developed a survey on the perceptions and attitudes of the general public in 5 countries (France, Germany, Poland, Spain and the US) about Alzheimer's disease and their views on the value of a diagnosis thanks to an educational grant by Bayer Healthcare,
- Published the third edition of the "*Guide des aidants*," the French Care Manual,
- Submitted its recommendations on end-of-life care and the findings of its EuroCoDe project on the socio-economic impact of dementia for peer review resulting in the publication of the recommendations in the Journal of Nutrition, Health & Aging and of the EuroCoDe findings in the International Journal of Geriatric Psychiatry.

1.3 *AE Core Activities*

In 2010, Alzheimer Europe received the support of the European Commission. The following core activities of Alzheimer Europe were funded thanks to an operating grant to Alzheimer Europe in the framework of the Public Health Programme.

1.3.1 **European Dementia Ethics Network**

The launch phase of the European Dementia Ethics Network was successfully completed in 2009 with the support of the German Health Ministry and the organisation had created a European Dementia Ethics Steering Committee and developed a section of its website dedicated to dementia ethics. The implementation phase of the network was successfully started in 2010.

In 2010, the Steering Committee was comprised of the following experts:

- François Blanchard (France)
- Alain Franco (France)
- Jean Georges (Alzheimer Europe)
- Cees Hertogh (Netherlands)
- Iva Holmerová (Czech Republic)
- Sabine Jansen (Germany)
- Kati Juva (Finland)
- Mary Marshall (United Kingdom)
- Celso Pontes (Portugal)
- Michael Schmieder (Switzerland) and
- Sigurd Sparr (Norway).

In addition, representatives from the German Ministry of Health and national representatives from Belgium and Luxembourg (Magda Aelvoet, Christian Berringer, Malou Kapgen, Cornelia Reitberger and Matthias von Schwanenflügel) attended and supported the meetings of the ethics network.

The aim of the network was to carry out an in-depth literature search on identified priority areas and develop a report with the findings. In 2010, the network paid particular attention to the ethical implications of the use of assistive technologies in home and institutional settings. A working group was set up comprised of a person with dementia, a carer, representatives of Alzheimer associations and researchers and ethicists with an interest in the field. The working group was made up of the following experts:

- Dianne Gove (Alzheimer Europe)
- Inger Hagen (Norway)

- Sirkkaliissa Heimonen (Finland)
- Stefánia Kapronczay (Hungary)
- Heike von Lützu-Hohlbein (Germany)
- James and Maureen McKillop (United Kingdom - Scotland)
- Maria McManus (United Kingdom – Northern Ireland)
- Alistair Niemeijer (Netherlands)
- Päivi Topo (Finland) and
- Luiza Spiru (Romania)

Alzheimer Europe organised two meetings of the Dementia Ethics Steering Committee and the working group on assistive technologies.

The work resulted in a report which presents the position of Alzheimer Europe and guidelines on the ethical use of assistive technology for/by people with dementia and proposes an ethical framework for decision making. A brief overview is provided of the three main issues of importance, namely dementia, assistive technology and ethics. This is followed by a discussion of the various ethical issues linked to the use of assistive technology which addresses not only possible disadvantages and ethical dilemmas but also looks at the positive implications of the use of assistive technology and how it can contribute towards respecting certain ethical principles with regard to people with dementia.

1.3.2 Legal Rights Project

In 1998, Alzheimer Europe had dedicated a project to an inventory of legislation affecting people with dementia. The successful Lawnet project resulted in the development of national reports for the 15 Member States of the European Union.

In 2009, Alzheimer Europe decided to embark on a three-year project to update the national reports to include all legislative reforms which had been undertaken since the earlier Lawnet project and to develop national reports for those countries that had joined the European Union, as well as other countries covered by the organisation (Iceland, Norway, Switzerland and Turkey).

As a start, the organisation focused on biomedical issues (including consent to treatment, the right to information, advance directives and end-of-life questions) in 2009. In 2010, Alzheimer Europe developed national reports on the issues of proxy decision making (e.g. guardianship measures and continuing powers of attorney) and various forms of legal capacity (e.g. relating to marriage, making a will or a contract, voting, civil liability and criminal responsibility).

Alzheimer Europe was able to count on the active contributions of several legal experts from its member organisations, as well as a number of independent lawyers and legal experts. In addition, Alzheimer Europe received the support of Fondation Médéric Alzheimer for the development of the 29 national reports which were published in the 2010 edition of the organisation's Dementia in Europe Yearbook.

1.3.3 Involving people with dementia

Alzheimer Europe carried out a survey of its member organisations in which it enquired about how best to involve people with dementia in future activities. Three key recommendations of the Alzheimer Europe Board (the involvement of people with dementia in project working groups, the inclusion of people with dementia as speakers at conferences and the setting up of a bursary system for people with dementia for AE conferences) all received the overwhelming support of the members of Alzheimer Europe and will be formalised in the framework of a forthcoming review of the organisation's statutes.

However, Alzheimer Europe did not await the conclusions of the survey to fully involve people with dementia in its activities. James McKillop participated in the working group on assistive technologies set up in the framework of the Dementia Ethics Network and was invited as a keynote speaker at the organisation's Annual Conference in Luxembourg. In order to encourage the participation of people with dementia in AE activities further, a bursary system was created which covered the costs for people with dementia from different European countries to attend the conference. In addition, a section of the organisation's Dementia in Europe Magazine was dedicated to presenting personal accounts by people with dementia and their carers.

The survey of members also proposed different models for involving people with dementia in the decision making process of the organisation and a majority of members expressed their support for the establishment of a European Advisory Group of people with dementia who would elect a person with dementia to the Board of Alzheimer Europe. The terms of reference of this advisory group and the election procedure will be further clarified in 2011.

1.3.4 European Dementia Observatory

In the past years, Alzheimer Europe has greatly improved the information it provides to its members and external stakeholders on key developments. As a long-term objective, Alzheimer Europe would like to set up a European Dementia Observatory where all relevant developments in the dementia field would be monitored and reported on.

In 2010, the monthly e-mail newsletters contained information on the latest activities of Alzheimer Europe and those of the European Alzheimer's Alliance and its member organisations, as well as information on interesting policy initiatives both on a national

and European level. Alzheimer Europe also covered research developments in its monthly newsletter.

A total of 474 articles were featured in 2010 in Alzheimer Europe's monthly e-mail newsletters and these articles can be broken down as follows:

Subject	Number of Articles
Activities and projects of Alzheimer Europe	28
European policy developments in the field of dementia	54
National policy developments	27
Activities and projects of AE member organisations	93
Scientific developments	202
Dementia in Society	35
New resources and publications	35

The information was also included on the Alzheimer Europe website which continued to receive a significant number of visitors throughout the year.

Month	Visitors
January 2010	12,003
February 2010	12,723
March 2010	15,419
April 2010	13,071
May 2010	12,645
June 2010	12,757
July 2010	12,114
August 2010	12,623
September 2010	15,996
October 2010	16,364
November 2010	16,068
December 2010	12,459
Total:	164,242

1.3.5 20th Alzheimer Europe Conference in Luxembourg

In 2010, Alzheimer Europe celebrated its 20th anniversary and therefore chose to organise its Annual Conference in Luxembourg, where the organisation's secretariat has been established since 1996.

Under the theme “Facing dementia together”, Alzheimer Europe and Association Luxembourg Alzheimer focused on the importance of partnerships which are necessary to improve the quality of life of people with dementia and their carers.

The conference was held under the Patronage of H.R.H. the Grand Duchess of Luxembourg and a number of high level national (Minister of Health Mars di Bartolomeo, Minister for Family and Integration Marie-Josée Jacobs, Minister for the Economy Jeannot Krecké) and European representatives (European Commission Director for Public Health Andrzej Rys) attended the conference.

Over 300 delegates from 34 countries attended the conference and listened to the keynote speakers who came from a variety of backgrounds and included:

- Philippe Amouyel (France)
- Dieter Ferring (Luxembourg)
- Dianne Gove (Alzheimer Europe)
- Iva Holmerová (Czech Republic)
- Julian Hughes (United Kingdom)
- Maria Isaac (European Medicines Agency)
- Christina Kuhn (Germany)
- Heike von Lützu-Hohlbein (Germany)
- Gráinne McGettrick (Ireland)
- James and Maureen McKillop (United Kingdom-Scotland)
- Antoni Montserrat (European Commission)
- Kaisu Pitkälä (Finland)
- Gerrit Rauws (Belgium)
- Bengt Winblad (Sweden)

A total of 97 presentations were made during the conference with parallel sessions being dedicated to a wide variety of subjects, such as:

- Assistive technologies and design
- Education and training
- Innovative care services and approaches
- International dimension of dementia
- National dementia strategies
- Non-pharmacological approaches

- Nursing home care
- Organisation and financing of care
- Perceptions of dementia
- Relationships, communication and sexuality
- Rights and ethics
- Screening, diagnosing and treating dementia
- Successful campaigning
- Supporting and involving people with dementia.

Alzheimer Europe asked participants to evaluate different aspects of the conference and a total of 57 delegates returned the evaluation forms. The different plenary sessions were all judged highly with between 68.75% and 84.09% of delegates rating the four plenary sessions as “good” or “very good” and only between 2.04% and 8.33% rating the plenary sessions as “poor”. Similarly, 78.18% of delegates felt that the choice of topics for parallel sessions had been “good” or “very good”. Of the various aspects of the conference, the time left for discussion amongst conference delegates was the only area rated as “poor” by 26.79% of delegates and Alzheimer Europe will ensure the possibilities for dialogue will be enhanced at future conferences. Asked whether delegates would recommend an Alzheimer Europe Conference to friends and colleagues, 90.57% replied positively and 9.43% negatively.

The Annual General Meeting of Alzheimer Europe also took place in the framework of the 20th Alzheimer Europe Conference in Luxembourg. At the meeting, the member organisations adopted the annual report and financial accounts and approved the work plan and budget for 2011. In addition, the members elected a new Board:

- Heike von Lützau-Hohlbein (Germany) as Chairperson
- Iva Holmerová (Czech Republic) as Vice-Chairperson
- Maria do Rosário Zincke dos Reis (Portugal) as Honorary Treasurer
- Sigurd Sparr (Norway) as Honorary Secretary
- Sabine Henry (Belgium), Liane Kadusch-Roth (Luxembourg), Patrick Maugard (France), Maurice O’Connell (Ireland), Sirpa Pietikäinen (Finland), Alicja Sadowska (Poland), Charles Scerri (Malta) and Henry Simmons (United Kingdom-Scotland) as members of the Board

1.4 *Organisational issues*

1.4.1 **Membership satisfaction survey and new strategic plan**

After the successful implementation of its 2003-2006 Business Plan and its 2006-2010 Strategic Plan, Alzheimer Europe felt it important to assess the views of its membership on past activities and projects before developing a new Strategic plan.

85% of the member organisations of Alzheimer Europe participated in a survey to assess the satisfaction of members with past activities. The responses were overwhelmingly positive and all past activities were rated as “Excellent” or “Good” by over 70% of AE’s members. A number of activities scored even higher and the following activities were all rated as “Excellent and “Good” by over 90% of the membership:

- The Paris Declaration on the political priorities of the European Alzheimer movement,
- Alzheimer Europe’s campaign to make dementia a European priority,
- The organisation’s communication tools including the monthly e-mail newsletter, the Dementia in Europe magazines and the website,
- The inventory of legislation on healthcare decision making by people with dementia,
- The comparison of social support systems as part of the EuroCoDe project,
- The report and position on advance directives,
- The recommendations and report on end-of-life care for people with dementia.

For the development of its strategic plan, Alzheimer Europe opted for continuity in light of the positive feedback on its past activities. For the period 2011-2015, the organisation identified the following key strategic objectives:

1. Making dementia a European priority,
2. Supporting policy with facts,
3. Basing our actions on ethical principles and
4. Building a stronger organisation.

The new strategic plan was presented at the Annual General Meeting in Luxembourg and welcomed by the members with a view of adopting the document in 2011.

1.4.2 **Membership development**

After the acceptance of Alzheimer associations from Croatia, Estonia and Slovenia as members in 2009, Alzheimer Europe now covers the vast majority of Member States of the European Union (with the exception of Hungary, Latvia and Lithuania).

At the same time, Alzheimer Europe established informal contacts with associations in Hungary, Latvia and Lithuania and involved them where possible in its projects and activities.

In 2010, Alzheimer Europe also welcomed the Italian association “Alzheimer Uniti” as a provisional member.

1.4.3 Strategic partnerships

As in previous years, Alzheimer Europe continued its collaboration with a number of other key European organisations with an interest in dementia, such as the European Alzheimer’s Disease Consortium, the European Federation of Neurological Societies, the European Association of Geriatric Psychiatry, the European Union Geriatric Medicine Society, the Interdem network, the European Association for Palliative Care and the International Association of Gerontology – European Region. Alzheimer Europe also collaborated in the development and setting up of the European Memory Clinics Association (EMCA).

As a member of the European Patients’ Forum (EPF), Alzheimer Europe contributed to European discussions on general health and patient related issues such as cross-border health-care or the legislation on information to patients. Alzheimer Europe also participated in an EPF seminar on health technology assessment and EPF’s General Assembly.

Alzheimer Europe also continued its involvement with the Alliance for MRI which was created to address the concerns raised by the impact of a European Directive on the use of MRI for clinical and research purposes and participated in a meeting of the Alliance with members of the Cabinet of EU Health Commissioner John Dalli. The campaign of the Alliance contributed to the European Commission re-examining the directive.

In 2010, Alzheimer Europe also strengthened the contacts with AGE, the European Platform for elderly people with the two organisations collaborating on the preparatory meetings of the Presidency Conferences on Mental Health and Dementia and exchanging information on their respective activities.

1.4.4 Fundraising

In 2010, Alzheimer Europe was able to count on the support of the European Commission which provided an operating grant for Alzheimer Europe’s activities in the framework of the EU public health programme.

In addition, Alzheimer Europe was able to rely on a number of additional income categories, such as membership dues and other contributions from member organisations, direct payments from individuals such as conference registration fees and publication

sales, support from foundations and from corporate sponsors in line with the organisation's guidelines.

Alzheimer Europe continues to disclose all sources of funding in a transparent fashion in line with the guidelines for organisations accredited by the European Medicines Agency.

1.5 *European Public Affairs Activities*

1.5.1 **European Alzheimer's Alliance**

Alzheimer Europe continued its close contacts with Members of the European Parliament. The number of MEPs who joined the European Alzheimer's Alliance grew from 41 to 50 by the end of 2010 representing 17 Member States of the European Union and all of the seven political groups in the European Parliament.

In 2010, Alzheimer Europe organised two successful lunch debates in the European Parliament.

- On 22 June, Dagmar Roth-Behrendt, MEP (Germany) hosted a lunch debate entitled "Alzheimer's disease and dementia as a national priority: contrasting approaches by France and the UK" at which Florence Lustman, coordinator of the French Alzheimer's Plan and Andrew Ketteringham, Director of External Affairs of the UK Alzheimer's Society presented the dementia strategies of their respective countries.
- Nessa Childers, MEP (Ireland) hosted a lunch debate on 7 December which was dedicated to the Joint Programming Initiative on research in neurodegenerative diseases at which Pieter Jelle Visser, a Dutch researcher and member of the Joint Programming Initiative, as well as Elmar Nimmesgern from the Research Directorate General of the European Commission presented the progress of this initiative.

A number of Alliance members also supported Alzheimer Europe's work by contributing to the organisation's publications such as the Dementia in Europe magazine. This was the case of the Alliance Chair Françoise Grossetête (France) and Vice-Chairs Frieda Brepoels (Belgium), Brian Crowley (Ireland) and Dagmar Roth-Behrendt (Germany). In addition, Sirpa Pietikäinen (Finland) and Astrid Lulling (Luxembourg) gave interviews on the key challenges faced by people with dementia and their carers in their countries.

1.5.2 **Policy Watch and "Dementia in Europe Magazine"**

A clear focus of Alzheimer Europe's work in 2010 was on European and national policy developments in the field of Alzheimer's disease and other related dementias.

Alzheimer Europe dedicated a new section of its website to national dementia plans and included information on existing dementia strategies or Alzheimer plans in countries such as France, the Netherlands, Norway and the United Kingdom (England and Scotland), as well as information on campaigns and plans in countries such as Cyprus, Finland, Malta and Portugal.

Alzheimer Europe published two editions of the "Dementia in Europe Magazine" which included a variety of articles on policy developments, as well as interviews with European and national policy makers including EU Health Commissioner John Dalli. Alzheimer

Europe also included detailed information on its various projects and meetings, such as the European Parliament lunch debates and Annual Conference of the organisation. In addition, the magazine featured a section on “Living with dementia” where people with dementia and carers provided insightful accounts of their own experiences of dementia.

As part of its 20th anniversary celebration, Alzheimer Europe published a special supplement to the magazine which highlighted a number of key events, meetings, projects and achievements of the past 20 years.

1.5.3 Making dementia a European priority

1.5.3.1 European Alzheimer’s Initiative

Following the adoption by the European Commission of a European initiative on Alzheimer’s disease and other dementias in 2009, the European Parliament decided to write an own-initiative report and appointed Marisa Marias, MEP (Portugal) as rapporteur of this report.

This provided an ideal opportunity for Alzheimer Europe to meet with Members of the European Parliament to present the views of the organisation.

Alzheimer Europe prepared a position paper which was supportive of the Commission’s focus on four key areas:

- Public health: prevention and early diagnosis of dementia,
- Research: enhanced cooperation between Member States and improved epidemiological data collection,
- Social affairs: exchange of best practices on early interventions and social care,
- Legal issues: Patient rights and autonomy.

Alzheimer Europe was invited to present its views at a hearing organised by the Public Health Committee of the European Parliament in October 2010. Thanks to the support of the active Members of the European Alzheimer’s Alliance, the report adopted by the Committee in December 2010 took account of a number of amendments suggested by Alzheimer Europe.

1.5.3.2 Joint Programming on Alzheimer’s disease

Alzheimer Europe welcomed the launch of the Joint Programming Initiative on Alzheimer’s disease and neurodegenerative diseases in 2010. The organisation was able to involve Professor Philippe Amouyel, the chair of the Management Board in a number of its activities and to establish close contacts with the initiative.

In particular, Philippe Amouyel gave an in-depth interview on the initiative in Alzheimer Europe's Dementia in Europe Magazine and provided a progress report at the 20th Alzheimer Europe Conference in Luxembourg.

One of Alzheimer Europe's lunch debates in the European Parliament was also dedicated to a presentation of the plans of the Joint Programming Initiative in 2011.

1.5.3.3 EU Presidency activities

As in previous years, Alzheimer Europe was successful in collaborating with the Presidencies of the European Union.

Alzheimer Europe was invited on the preparatory committee for a Spanish Presidency Conference on Mental Health of elderly people which was organised in the framework of the European Pact for Mental Health. In addition, AE took an active part in the conference on 28 and 29 June in Madrid, Spain and was asked to chair the workshop on informal carers.

Alzheimer Europe also collaborated with the Belgian Presidency and participated in the preparatory meetings for the Belgian Presidency Conference on the societal aspects of dementia. To support the preparations, Alzheimer Europe partnered in the development of a survey aimed at identifying examples of best practices with regard to the involvement of people with dementia as citizens and ensured the participation of national Alzheimer associations in the data collection.

Representatives of the Alzheimer Europe Board and member organisations took an active part in the Belgian Presidency Conference entitled "Improving the quality of life of people with dementia. A challenge for European society" and organised on 25 and 26 November 2010.

1.5.3.4 European Medicines Agency

Alzheimer Europe continued its collaboration with the European Medicines Agency in 2010. As an accredited patient organisation, Alzheimer Europe was able to participate in a stakeholder meeting on new dementia developments organised on 11 January 2010 at which experts discussed the latest developments as to potential biomarkers for the diagnosis of Alzheimer's disease and the assessment of disease progression.

An additional expert meeting on familial neurodegenerative diseases took place on 8 November and was also attended by Alzheimer Europe.

Finally, as in previous years, Alzheimer Europe staff took place in the plenary meeting for all patient organisations accredited at the European Medicines Agency and the training session on the review of product information.

1.6 *Other activities and projects*

1.6.1 **PharmaCog**

PharmaCog, short for “Prediction of cognitive properties of new drug candidates for neurodegenerative diseases in early clinical development” is a project which started its work on 1 January 2010 thanks to significant funding from the Innovative Medicines Initiative. The aims of the project are to:

- Validate the tools necessary to streamline Alzheimer’s disease drug discovery,
- Set the standard for European drug discovery providing optimised and validated protocols,
- Provide the infrastructure to sustain world class drug discovery in Europe and
- Disseminate the results obtained from health professionals to patients.

Alzheimer Europe represents the interests of people with dementia and their carers in this consortium and helps with the dissemination of the research results to a lay audience. In 2010, the organisation developed a section of its Internet site dedicated to the PharmaCog project, provided progress reports of the project in its newsletter and magazine and organised a symposium with project leaders in the framework of the Annual Conference in Luxembourg.

1.6.2 **Decide project**

In 2010, Alzheimer Europe was also invited to join the consortium of a project funded through the Seventh Framework Programme of the European Union (FP7). The aim of DECIDE (Diagnostic Enhancement of Confidence by an International Distributed Environment) is to design, implement, and validate a GRID-based e-Infrastructure. Over this e-Infrastructure, a service will be provided for the computer-aided extraction of diagnostic markers for Alzheimer’s disease and schizophrenia from medical images.

The project started on 1 September 2010 and Alzheimer Europe will help with the dissemination of research results to the patient and carer community.

1.6.3 **Value of diagnosis**

With the support of an educational grant of €310,000 from Bayer Healthcare, Alzheimer Europe developed a survey to investigate the differences in public perception and awareness of Alzheimer’s disease in a number of European countries (France, Germany, Poland and Spain) and to identify the views of the general public on the value of a diagnosis of Alzheimer’s disease.

In 2010, Alzheimer Europe set up a working group with representatives of the US Alzheimer's association and Alzheimer organisations from the participating European countries, as well as researchers and policy makers with an interest in this field. The survey was agreed upon by the end of 2010 and the field work of the survey will start in 2011.

1.6.4 AE Publications

In collaboration with France Alzheimer, Alzheimer Europe published a revised edition of the successful *"Guide des aidants"*. For this third edition of the French version of the Care Manual, 5,000 copies were published which will be distributed through the network of the French Alzheimer association and its local member organisations.

The key recommendations of Alzheimer Europe's project on end-of-life care were published in the Journal of Nutrition, Health & Aging.

The findings of the working group on the cost of dementia of the Commission financed "European Collaboration on Dementia – EuroCoDe" project were published in the peer reviewed journal, the International Journal of Geriatric Psychiatry.

1.7 *Annex: Meetings attended by AE representatives*

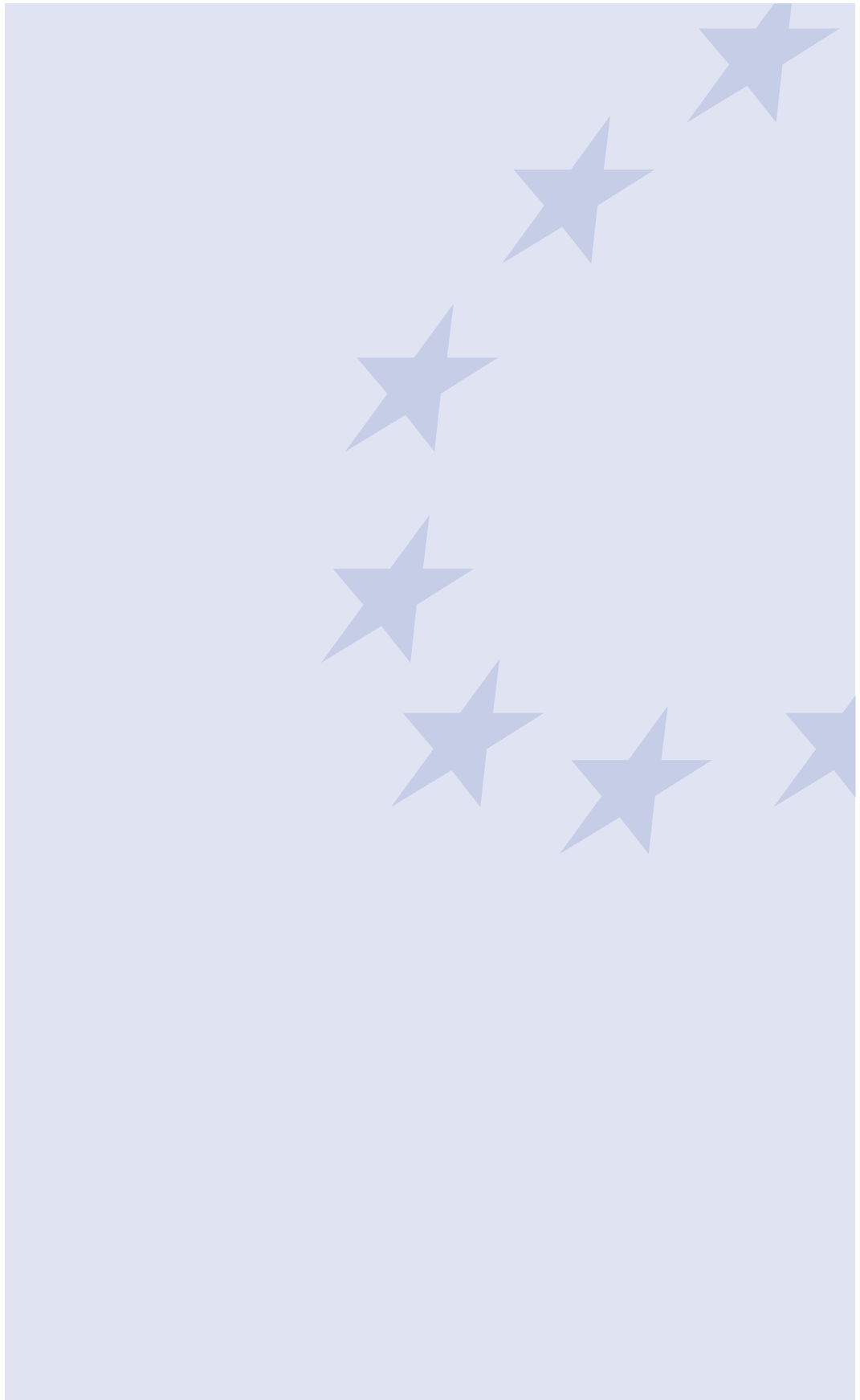
Date	Meeting	Location
7 January	Meeting with Alzheimer's Society	London, United Kingdom
11 January	EMA Workshop on "New developments in dementia of Alzheimer's type"	London, United Kingdom
12 January	Health Consumer Powerhouse meeting "How to cure the EU Patient Information Gap"	Brussels, Belgium
12 January	Hearing of Commissioner-designate Viviane Reding	Brussels, Belgium
18 January	Meeting with Association Luxembourg Alzheimer	Luxembourg, Luxembourg
19 January	Launch of RightTimePlaceCare project	Brussels, Belgium
20 January	Meeting with EFPIA representatives	Brussels, Belgium
4 February	EFPIA think tank	Brussels, Belgium
18 February	Meeting with Association Luxembourg Alzheimer and Université de Luxembourg	Luxembourg, Luxembourg
23 February	European Parliament Carers Interest Group	Brussels, Belgium
25 February	Meeting with Foundation Compassion Alzheimer Bulgaria	Luxembourg, Luxembourg
2 March	Family Platform Info Day in European Parliament	Brussels, Belgium
3 March	Eurofound Seminar "Company strategies in Europe: Flexibility and social dialogue"	Brussels, Belgium
8 March	AE Working group on the ethical implications of assistive technologies	Brussels, Belgium
9 March	Steering Committee of the European Dementia Ethics Network	Brussels, Belgium
10-12 March	Alzheimer's Disease International Conference	Thessaloniki, Greece
23 March	Meeting with Novartis	Geneva, Switzerland
31 March	Meeting with International Longevity Centre	Brussels, Belgium
7 April	Meeting with Luxembourg-Congrès	Luxembourg, Luxembourg

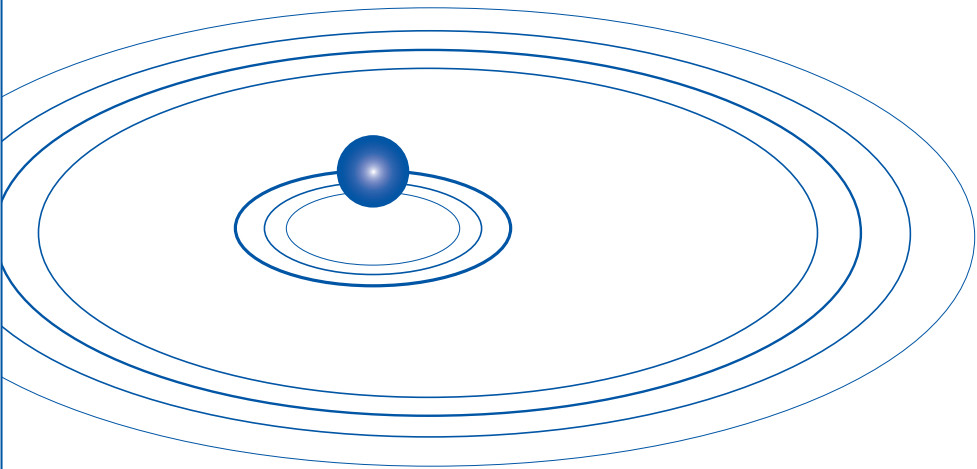
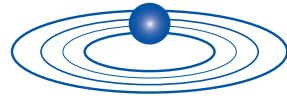
Date	Meeting	Location
12 April	Meeting with Antoniya Parvanova, MEP (Bulgaria)	Brussels, Belgium
26 April	AE Board meeting	Brussels, Belgium
27 April	EFPIA think tank	Brussels, Belgium
27 April	European Parliament Employment and Social Affairs Committee	Brussels, Belgium
27-28 April	EFGCP Workshop "Ethical challenges in clinical research at both end of life"	Antwerp, Belgium
28 April	European Parliament Mental Health Interest Group	Brussels, Belgium
28 April	European Parliament Industry Committee	Brussels, Belgium
28 April	European Parliament Internal Market Committee	Brussels, Belgium
4 May	Belgian Presidency Expert meeting on dementia	Brussels, Belgium
4 May	European Parliament Environment and Health Committee	Brussels, Belgium
5 May	Recognition Meeting	Berlin, Germany
6 May	Patients' Rights Day in European Parliament	Brussels, Belgium
11 May	STOA Meeting on Ageing Research	Brussels, Belgium
13 May	Meeting with Pfizer	Luxembourg, Luxembourg
18 May	European Patients' Forum Seminar on Health Technology Assessment	Brussels, Belgium
19 May	General Assembly of European Patients' Forum	Brussels, Belgium
25 May	Meeting with European Patients' Forum	Brussels, Belgium
3 June	Meeting with Elena Oana Antonescu, MEP (Romania)	Brussels, Belgium
3 June	Meeting with Emilia Romana, European Parliament	Brussels, Belgium
8-9 June	100 Year Anniversary Meeting of Karolinska Institutet	Stockholm, Sweden
11 June	Meeting with Marisa Matias, MEP (Portugal)	Brussels, Belgium
12 June	European Memory Clinics Association	Basel, Switzerland
21 June	AE Board	Brussels, Belgium

Date	Meeting	Location
22 June	European Parliament lunch-debate: "Alzheimer's disease and dementia as a national priority"	Brussels, Belgium
22 June	European Parliament Women's Committee	Brussels, Belgium
23 June	University of Maastricht debate on health literacy	Brussels, Belgium
28-29 June	Spanish Presidency Conference on the mental health of elderly people	Madrid, Spain
7 July	European Commission seminar on Ageing and Women's Health	Brussels, Belgium
8 July	Meeting with Alliance for MRI and Cabinet of EU Health Commissioner	Brussels, Belgium
1 September	Parliament Magazine reception	Brussels, Belgium
3 September	Meeting with AGE	Brussels, Belgium
6 September	Strategy meeting of AE Board	Brussels, Belgium
14 September	Meeting with Servier	Brussels, Belgium
16 September	Annual Conference on Ligue Alzheimer	Louvain-la-Neuve, Belgium
22 September	AE Working group on the ethical implications of assistive technologies	Berlin, Germany
22 September	Steering Committee of the European Dementia Ethics Network	Berlin, Germany
22 September	EFPIA Think tank	Brussels, Belgium
28 September	European Parliament Carers Interest Group	Brussels, Belgium
30 September	AE Board meeting	Luxembourg, Luxembourg
30 September	AE Annual General Meeting	Luxembourg, Luxembourg
1 October	Meeting with Nutricia	Luxembourg, Luxembourg
1-2 October	20th Alzheimer Europe Conference	Luxembourg, Luxembourg
5-9 October	European Health Forum "Health in Europe, ready for the future"	Hof Badgastein, Austria
10 October	Alzheimer Café Day of Ligue Alzheimer	Brussels, Belgium

Date	Meeting	Location
11 October	European Commission workshop “Healthy ageing, adaptation of health systems”	Brussels, Belgium
13 October	Meeting with Servier	Brussels, Belgium
13 October	Meeting with Bristol-Myers-Squibb	Brussels, Belgium
13 October	Meeting with Alzheimer’s Society (UK)	Brussels, Belgium
20 October	Meeting with office of Marina Yannakoudakis, MEP (United Kingdom)	Brussels, Belgium
25 October	Meeting with office of Nessa Childers, MEP (Ireland)	Brussels, Belgium
26 October	Meeting with Lilly	Brussels, Belgium
27 October	United Nations Human Rights Office Seminar on “Human rights of persons in institutional care”	Brussels, Belgium
28 October	European Parliament Committee on Public Health Hearing on Alzheimer’s disease	Brussels, Belgium
28 October	Meeting with office of Glenys Willmott, MEP (United Kingdom)	Brussels, Belgium
3-4 November	Steering Committee of “Value of Diagnosis” project	London, United Kingdom
8 November	EMA Expert meeting on familial neuro- degenerative diseases	London, United Kingdom
15 November	Meeting with Pfizer	Brussels, Belgium
16 November	International Longevity Centre meeting in European Parliament	Brussels, Belgium
17 November	AGE Conference on elderly abuse	Brussels, Belgium
18 November	EFPIA Think tank	Brussels, Belgium
24 November	Meeting with AGE	Brussels, Belgium
25-26 November	EU Presidency Conference “Improving the quality of life of people with dementia: A challenge for European society”	Brussels, Belgium
29-30 November	EMA meetings with patient organisations	London, United Kingdom
30 November	European Parliament Environment and Public Health Committee	Brussels, Belgium

Date	Meeting	Location
30 November	Council of Europe seminar on decision making regarding medical treatment in end-of-life situations	Strasbourg, France
6 December	AE Board meeting	Brussels, Belgium
7 December	European Parliament lunch-debate: "The Joint Programming of Research in neurodegenerative diseases"	Brussels, Belgium
8 December	Meeting with Sanofi-Aventis	Brussels, Belgium
8-11 December	APFADA Conference: Alzheimer's disease: towards an integrated policy"	Lisbon, Portugal





Financial Report

2.1 Report of the Réviseur d'entreprises agréé



To the Board of Directors
ALZHEIMER EUROPE
Association sans but lucratif

R.C.S. Luxembourg F2773

145, Route de Thionville
L - 2611 Luxembourg

REPORT OF THE REVISEUR D'ENTREPRISES AGREE

Following our appointment by the General Meeting of the Board of Directors dated September 30, 2010, we have audited the accompanying annual accounts of **ALZHEIMER EUROPE**, which comprise the balance sheet as at December 31, 2010 and the profit and loss account for the year then ended, and a summary of significant accounting policies and other explanatory information.

Responsibility of the Board of directors for the annual accounts

The Board of Directors is responsible for the preparation and fair presentation of these annual accounts in accordance with Luxembourg legal and regulatory requirements relating to the preparation of the annual accounts; and for such internal control as the Board of Directors determines is necessary to enable the preparation of annual accounts that are free from material misstatement, whether due to fraud or error.

Responsibility of the réviseur d'entreprises agréé

Our responsibility is to express an opinion on these annual accounts based on our audit. We conducted our audit in accordance with International Standards on Auditing as adopted for Luxembourg by the Commission de Surveillance du Secteur Financier. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the annual accounts are free from material misstatement.

MAZARS - RÉVISEURS D'ENTREPRISES, EXPERTS COMPTABLES ET FISCAUX
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An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the annual accounts. The procedures selected depend on the réviseur d'entreprises agréé's judgement, including the assessment of the risks of material misstatement of the annual accounts, whether due to fraud or error. In making those risk assessments, the réviseur d'entreprises agréé considers internal control relevant to the entity's preparation and fair presentation of the annual accounts in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Board of Directors, as well as evaluating the overall presentation of the annual accounts.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the annual accounts give a true and fair view of the financial position of **ALZHEIMER EUROPE** as of December 31, 2010, and of the results of its operations for the year then ended in accordance with Luxembourg legal and regulatory requirements relating to the preparation of the annual accounts.

Luxembourg, March 14, 2011

For MAZARS, Cabinet de révision agréé


Philippe SLENDZAK
Partner

Appendix:

- balance sheet as of December 31, 2010
- profit and loss account for the year ended December 31, 2010

2.2 Balance sheet as of December 31, 2010

ALZHEIMER EUROPE Association sans but lucratif R.C.S. Luxembourg F2773		
<u>Balance sheet as of December 31, 2010</u>		
	<u>2010</u> <u>EUR</u>	<u>2009</u> <u>EUR</u>
ASSETS		
Current assets		
Debtor EU Commission - Eurocode	-	174.745
Debtor EU Commission	100.000	-
Other debtors	26.843	67.963
Cash at bank and on deposit	527.841	136.470
	<u>654.684</u>	<u>379.178</u>
Accruals	4.826	7.687
	<u> </u>	<u> </u>
Total Assets	<u><u>659.510</u></u>	<u><u>386.865</u></u>
LIABILITIES		
Capital and reserves		
Results brought forward	162.675	145.088
Result of the year	6.525	17.587
	<u>169.200</u>	<u>162.675</u>
Creditors		
Amounts owed to credit institutions	-	990
Payments received on account - Other	388.985	22.919
Trade creditors	55.743	36.655
Creditors - Eurocode partners	-	131.352
Other liabilities	45.582	32.274
	<u>490.310</u>	<u>224.190</u>
	<u> </u>	<u> </u>
Total Liabilities	<u><u>659.510</u></u>	<u><u>386.865</u></u>

2.3 Profit and loss account – Year ended December 31, 2010

ALZHEIMER EUROPE Association sans but lucratif R.C.S. Luxembourg F2773 Profit and loss account year ended December 31, 2010		
	<u>2010</u> <u>EUR</u>	<u>2009</u> <u>EUR</u>
Other operating income		
Sponsorship	582.459	356.483
Sponsorship received on account	-302.552	-22.919
EU Subsidy	250.000	-
Co-financing in kind	138.680	108.463
Membership fees	53.150	46.500
Donations	263	630
Publication sales and royalties	12.240	2.572
Project participation and other subsidies	59.320	70.222
Other operating income	23.973	15.004
AE Conference registration fees	65.700	91.875
Unpayable debts	4	-
External charges		
External experts	-340.578	-218.041
Publication and information material	-91.626	-59.478
Travel expenses	-47.598	-24.285
Communication costs	-20.688	-35.502
Accommodation expenses	-127.997	-82.768
Office rent and associated costs	-25.011	-26.105
Office stationary and related costs	-2.366	-2.838
Leasing	-13.069	-17.708
Membership fees	-1.120	-220
Other costs	-2.282	-2.404
Irrecoverable debt	-	-6.275
Staff costs		
Wages and salaries	-160.569	-136.739
Social security costs	-44.834	-37.873
Interest receivable and similar income	3.081	1.144
Interest payable and similar charges	-2.055	-2.151
	<u>6.525</u>	<u>17.587</u>

2.4 *Annex: Breakdown of 2010 Income*

2.4.1 Introduction

In 2010, Alzheimer Europe had an audited income of EUR 1,188,868.67 of which EUR 641,024.92 (53.92%) were for the organisation's core activities (including the organisation's Dementia Ethics Network and Annual Conference), EUR 237,843.75 (20.01%) were for the organisation's public affairs activities and EUR 310,000 (26.08%) for the organisation's "Value of diagnosis" project.

2.4.2 Funding of core activities

In 2010, the core funding of Alzheimer Europe (EUR 641,024.92) was composed as follows:

- EUR 304,012.74 (47.43%) from public funding,
- EUR 181,029.77 (28.24%) from member organisations,
- EUR 78,203.28 (12.20%) from individuals,
- EUR 39,329.54 (6.14%) from corporate sources,
- EUR 26,800 (4.18%) from foundations and other non-profit organisations,
- EUR 8,568.93 (1.34%) from other sources and
- EUR 3,080.66 (0.48%) from bank interest and similar.

2.4.2.1 Public funding

In 2010, the breakdown of public funding totalling EUR 304,012.74 can be broken down as follows:

- Alzheimer Europe received EUR 250,000 as an operating grant from the European Commission and EUR 21,192 for its participation in the PharmaCog project
- EUR 13,692.95 was received from the Social Security administration in Luxembourg,
- EUR 10,350 from Luxembourg Congrès as a contribution to the rent of the conference centre for the 20th AE Conference in Luxembourg and
- EUR 8,777.79 from the German Ministry of Health to cover the expenditure of some of the running costs of the European Dementia Ethics Network.

2.4.2.2 Funding from member organisations

In 2010, the EUR 181,029.77 funding from member organisations can be broken down as follows:

- EUR 93,045.53 from the Luxembourg member organisation through the secondment of the AE Executive Director,

- EUR 53,150 in membership fees,
- EUR 12,000 from the Luxembourg member organisation by providing the offices of Alzheimer Europe free of rent,
- EUR 6,134.24 in co-financing from member organisations covering the travel expenses of AE Board members to attend Board meetings,
- EUR 17,700 in co-financing from Board members and representatives of member organisations in time donated to the organisation (at EUR 300 per day).

2.4.2.3 Individuals

In 2010, AE received EUR 78,203.28 from individuals which can be broken down as follows:

- EUR 65,700 in conference registrations,
- EUR 12,240.10 in publication sales and
- EUR 263.18 in donations.

2.4.2.4 Corporate support

In 2010, Alzheimer Europe received EUR 39,329.54 from corporate sources as core-funding which can be broken down as follows:

- EUR 10,867.36 from Elan as support to the Alzheimer Europe Conference in Luxembourg,
- EUR 10,000 from Pfizer as support to the Alzheimer Europe Conference in Luxembourg,
- EUR 7,500 from Nutricia as support to the Alzheimer Europe Conference in Luxembourg,
- EUR 5,000 from Novartis as support to the Alzheimer Europe Conference in Brussels,
- EUR 3,000 from Mazars which carried out the audit of the organisation's accounts free of charge and
- Huntsworth Health contributed EUR 2,962.18 in travel support and honoraria.

2.4.2.5 Foundations and organisations

The EUR 26,800 which Alzheimer Europe received in 2010 from foundations and other non-profit organisations can be broken down as follows:

- EUR 5,000 from Fondation Médéric Alzheimer and Fondation Roi Baudouin to support the Alzheimer Europe Conference in Brussels,
- EUR 9,000 from Fondation Médéric Alzheimer to support the legal rights project of Alzheimer Europe,
- EUR 7,800 in co-financing from foundations and other in time donated to AE (at EUR 300 per day).

2.4.2.6 Bank interest and similar

In 2010, Alzheimer Europe had an income of EUR 3,080.66 from bank interest and similar income.

2.4.2.7 Other income

In 2010, EUR 8,568.93 came from other sources not mentioned above.

2.4.3 Funding of public affairs activities

In 2010, Alzheimer Europe received EUR 237,843.75 for its public affairs activities, of which

- EUR 213,210.37 (89.64%) came from corporate sponsors,
- EUR 22,918.74 (9.64%) from reserves brought forward from the financial year 2009,
- EUR 1,012.80 (0.43%) from other income and
- EUR 701.84 (0.30%) from public sources.

2.4.3.1 Corporate support

The corporate support received by Alzheimer Europe for its public affairs activities can be broken down as follows:

- Pfizer, Janssen-Cilag and Novartis each contributed EUR 40,000 as a gold sponsor,
- GlaxoSmithKline contributed EUR 35,638 as a gold sponsor,
- Lundbeck and Lilly contributed EUR 20,000 each as silver sponsors,
- Elan contributed EUR 10,072.37 as a bronze sponsor and
- Nutricia provided EUR 7,500 in support.

2.4.3.2 Reserves

In 2010, Alzheimer Europe was able to contribute EUR 22,918.74 of its own reserves to its public affairs activities which came from income received on account in 2009.

2.4.3.3 Public funding

In 2010, EUR 701.84 was received from the Social Security administration in Luxembourg,

2.4.3.4 Other income

In 2010, EUR 1,012.80 came from sources not included above.

2.4.4 Funding of “Value of knowing”-project

In 2010, AE received an educational grant of EUR 310,000 from Bayer Healthcare for its “Value of knowing” project.

2.4.5 Overall funding

The following table lists all sources of income received in 2010. In line with the policy of the European Medicines Agency on transparency requirements for accredited patients' organisations, this is presented in total amounts as well as in terms of percentages of the overall income of the organisation.

Funding source	Funding received (2010)	As % of AE income (2010)
Bayer Healthcare	310,000.00	26.08%
Pfizer	50,000.00	4.21%
Novartis	45,000.00	3.79%
Janssen	40,000.00	3.36%
GSK	35,638.00	3.00%
Elan	20,939.73	1.76%
Lundbeck	20,000.00	1.68%
Lilly	20,000.00	1.68%
Nutricia	15,000.00	1.26%
<i>Sub-total: Pharmaceutical funding</i>	<i>556,577.73</i>	<i>46.82%</i>
Mazars	3,000.00	0.25%
Huntsworth Health	2,962.18	0.25%
<i>Sub-total: Other corporate sources</i>	<i>5,962.18</i>	<i>0.50%</i>
Total: Corporate funding	562,539.91	47.32%
European Commission	271,192.00	22.81%
Social Security and Tax administrations	14,394.79	1.21%
Luxembourg Congrès	10,350.00	0.87%
German Ministry of Health	8,777.79	0.74%
Total: Public funding	304,714.58	25.63%
Association Luxembourg Alzheimer	104,045.53	8.75%
Other member organisations	76,984.24	6.48%
Total: Member organisations	181,029.77	15.23%
Individuals (Conference fees, donations, registration fees)	78,203.28	6.58%
Total: Individuals	78,203.28	6.58%
Fondation Médéric Alzheimer	14,000.00	1.18%
Fondation Roi Baudouin	5,000.00	0.42%
Other organisations	7,800.00	0.66%
Total: Foundations and organisations	26,800.00	2.25%

Reserves	22,918.74	1.93%
Total: Reserves	22,918.74	1.93%
Bank interest and similar	3,080.66	0.26%
Total: Bank interest and similar	3,080.66	0.26%
Other income	9,581.73	0.81%
Total: Other income	9,581.73	0.81%
Total Income	1,188,868.67	100.00%

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