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Mission Statement
The *Erasmus Law Review* seeks to foster independent critical scholarship as relevant to the discipline of law.
The Board of Editors encourages the submission of legally relevant manuscripts by legal scholars and practitioners as well as those versed in other disciplines relevant to law, such as criminology, sociology, political science and economics.
The *Erasmus Law Review* usually commissions articles around specific themes, although 'calls for papers' on specific topics might be issued occasionally and will be published on the Review's website. All prospective articles are submitted to double-blind peer review (two reviews per article), and final publication is dependent on the outcome of these reviews.

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Nederlands uitgeversverbond
Groep uitgevers voor vak en wetenschap

Introduction

Kristin Henrard*

This issue of *Erasmus Law Review* forms a historic bridge between the review's original format of working exclusively with thematic issues and also having issues on submissions. This particular issue is not entirely 'on submission' and is closer in kind to a previous non-thematic issue (Issue 6(2) of *Erasmus Law Review*), which consisted of articles by promising doctoral students who, after having won an Erasmus School of Law (ESL) Doctoral Research Grant, were granted the opportunity to showcase part of their research. The experience with working occasionally with non-thematic issues has prompted us to open from next year onwards one issue a year for submissions, not only for promising PhD students and other colleagues from ESL, but also for external scholars.

Returning to this particular issue of *Erasmus Law Review*, three PhD students have contributed to it, covering a broad variety of topics, ranging from strategies to outlaw motorcycle gang-related events, variations in workplace violence experienced by emergency responders, to the right to mental health in the digital era.

1. *Teun van Ruitenburg* notes a shift in the security discourse from reactive management of actual events and threats to proactive management based on statistical calculations of risks. In relation to the latter, he zooms in on the distinction between (the criminological rationale of) pre-emption and prevention strategies, while focusing on the current governmental fight against outlaw motorcycle gangs and gang-related crimes. His analysis of three instances where motorcycle events have been prohibited by local governments in the Netherlands reveals the gradual difference between prevention and pre-emption, while problematising the latter as too radical. He calls for more research into pre-emption strategies and their implications and effects.
2. *Lisa van Reemst* seeks to apply victimological theories to workplace violence experienced by emergency responders, in order to identify and categorise possible risk factors. More particularly, criminal opportunity theories and personal vulnerability notions are applied to experiencing workplace violence so as to address the role of situational and victim characteristics. Van Reemst highlights the importance of taking both situational and victim characteristics into account, while also examining the interaction between these two types of characteristics in longitudinal research. The ensuing gain in knowledge on workplace violence could enable the development of effective prevention mechanisms.
3. *Fatemeh Kokabisaghi, Iris Bakx and Blerta Zenelaj* examine under what conditions e-mental healthcare could contribute to the realisation of the highest attainable standard of mental health, having regard to the criteria of Availability, Accessibility, Acceptability and Quality (the AAAQ framework developed by the UN Committee on Economic, Social and Cultural Rights). This is obviously contingent on having an ICT infrastructure worldwide, and fighting digital illiteracy, while guidelines on medical ethics and quality standards need to be respected. The authors also identify a pressing need for further research, particularly in regard to the cultural acceptability of e-mental health care.

We hope that you will enjoy reading this collection of articles, covering a rich variety of topics, straddling various fields of law and adopting a range of different methods.

Kristin Henrard, Editor-in-Chief

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Raising Barriers to 'Outlaw Motorcycle Gang-Related Events'

Underlining the Difference between Pre-Emption and Prevention

Teun van Ruitenburg*

Abstract

Fighting outlaw motorcycle gangs is currently one of the top priorities of many governments around the world. This is due to the notion that outlaw motorcycle gangs do not consist solely of motorcycle enthusiasts. Numerous cases reveal that these clubs, or at least their members, are involved in (organised) crime. In order to tackle these clubs, the former Dutch Minister of Security and Justice announced a whole-of-government strategy towards outlaw motorcycle gangs in 2012. As part of this effort, authorities such as the Dutch National Police, the Public Prosecution Service, the Dutch Tax Authority and local governments aim to cooperate in order to disrupt and restrict outlaw motorcycle gangs by means of Criminal, Administrative and Civil Law. Part of this strategy is to hinder club-related events. This article discusses the latter strategy in light of the distinction between prevention and pre-emption. As the latter two concepts are often used interchangeably, this article attempts to use a more strict division between prevention and pre-emption. Thereby, it becomes apparent that outlaw motorcycle gangs are to some extent governed through uncertainty. The author suggests that maintaining the 'prevention–pre-emption distinction' can offer an interesting and valuable point of departure for analysing today's crime policies.

Keywords: Prevention, pre-crime, pre-emption, risk, outlaw motorcycle gangs

1 Introduction

In 2014, a local Harley-Davidson club in the Netherlands was planning – as it aims to do every year – to organise a motorcycle fair from 11 April until 13 April. Because this motorcycle fair has always taken place without any problems, the mayor of the municipality of 'Laarbeek' initially issued a permit based on which the club was allowed to organise this event yet again. However, the municipality withdrew the assigned permit on the advice of the Dutch National Police as the latter expressed considerable concerns with regard to possible public order and safety disturbances.[1] This was especially the case because the Dutch National Police feared an escalation of violence between warring outlaw motorcycle gangs (henceforth OMGs).[2] This incident was not an isolated case as a second motorcycle fair 'Motorcycle-day Zilst' in another municipality was also cancelled by the local government for similar reasons. The event, scheduled for 20 April 2014, was to be organised for the first time by 'Harley-Davidson Club de Kempen'.[3] Furthermore, the 'Harley-day', in the village of Valkenswaard, and the motorcycle event 'American Day Uitgeest', both scheduled for 26 April 2014, also did not take place. It seems that these withdrawals of permits were not unique for this period of time, as the local government of the small village of Cuijk had also prohibited the gathering of several international OMGs in May 2013. On this occasion, members of the Dutch Veterans MC were planning to organise a three-day event called the 'Brothers in Arms Run'. However, the municipality of Cuijk decided not to provide the required permit for the event, fearing possible public disorder. Moreover, the Mayor of Cuijk argued that prohibiting the event would be in line with the Dutch nationwide policy to

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1. *See* <https://extranet.laarbeek.nl/actueel/nieuws_3139/item/vergunning-motorbeurs-aarle-rixtel-ingetrokken_12617.html> (last visited 3 August 2015).
2. In academic literature but also in various policy documents, different 'labels' are being used to refer to outlaw motorcycle gangs. Some authors refer to these clubs as '1%-Motorcycle Clubs' or '1%-MCs', while others prefer to use the term 'outlaw motorcycle clubs' (*see*, for example, A. Blokland, M. Soudijn & E. Teng, 'Wij zijn geen padvinders. Een verkennend onderzoek naar de criminele carrieres van leden van 1%-motorclubs', 56 *Tijdschrift voor Criminologie* 3 (2014). A. Veno and J. van den Eynde, 'Moral Panic Neutralization Project: A Media-based Intervention', 17 *Journal of Community & Applied Social Psychology* 490 (2007). The Dutch Government, however, currently maintains the term 'Outlaw Motorcycle Gangs'. Note that this article is not about OMGs itself, but about the Dutch approach towards clubs that are labeled as 'outlaw motorcycle gangs'. In March 2014, the Dutch National Police documented fifteen 'outlaw motorcycle gangs', such as the Hells Angels MC, Satudarah MC, Veterans MC and No Surrender MC. For a complete overview of the listed OMGs in the Netherlands in April 2014, *see* Politie Landelijk Eenheid, *Outlawbikers in Nederland* (2014), at 19. For the sake of convenience and because I am taking the approach of the Dutch Government as the point of departure for this article, I chose to use the term 'outlaw motorcycle gang' in accordance with the Dutch Government.
3. *See* <www.omroepbrabant.nl/?news/208924962/Motordag+Zilst+in+Veldhoven+ook+afgelast+om+onrust+motorwereld.aspx> (last visited 3 august 2015).

fight OMGs.[4] Indeed, the former Dutch Minister of Security and Justice, Mr. Opstelten, argued that it is important to make a clear statement that the so-called 'outlaw motorcycle gangs' are not to be 'facilitated' in the Netherlands.[5]

The latter statement – considering the literature on the linkage between OMGs and (organised) crime – clearly did not appear out of thin air. According to many researchers, law enforcement agencies and the Dutch Ministry of Security and Justice, it seems reasonable to assert that OMGs are involved in (organised) crime.[6] At the same time, researchers argue that it would be unjust to presume OMGs to be criminal enterprises by definition.[7] Research shows that there are important differences among OMGs concerning the number of convictions of OMG members, as well as the nature and seriousness of the committed crimes.[8] The Dutch National Police seems to agree with this view, stating that it is not self-evident that every 'outlaw biker' is criminally active by definition.[9]

More generally, OMGs have been a foremost priority on the political agendas of many countries around the world. For instance, having its roots in California (1948), the arrival of the Hells Angels MC in Canada led to numerous gang-related incidents in the 1990s (also known as the Quebec biker war), which urged the Canadian Government to begin what Katz described as an '… all out crackdown to rid society of the Outlaw Motorcycle Gang problem…'.[10] The Nordic countries have equally been startled by a 'biker war' between the Hells Angels and the Bandidos. The 'Great Nordic Biker War' in 1990s included numerous murders and attempted murders across Denmark, Norway, Finland and Sweden, which led to a strong focus on OMGs. For instance, in Denmark a law was passed in 1996 that enabled the police to ban members of the Hells Angels MC from certain locations (*e.g.* a clubhouse).[11] Moreover, the German city of Hamburg first banned the Hells Angels in 1983 ('vereinsverbot'), which also made it possible to ban Hells Angels-related symbols.[12] Both the Canadian and the Australian Governments also adopted an anti-associations legislative model aimed at criminalising associations between members of OMGs and, consequently, to disrupt the OMGs as a whole.[13]

At the same time, however, there has also been a critical debate on how OMGs are being approached. That is, some measures have provoked concern because they tend to forestall risks or crimes that have not yet taken place. In this respect, Ayling has described the approach towards OMGs, or 'bikies' in Australia as a 'pre-emptive strike'. The author has argued that this 'strike' aims to *pre-empt* and not necessarily to *prevent* crime.[14] In line with this argument, some authors have stressed that contemporary society is to some extent using pre-emptive strategies – which is different from prevention – to deal with risks, dangers and uncertainties.[15] Although Tulich stated that '… prevention and pre-emption are conceptually distinct …', the distinction between pre-emption and prevention is not always clear.[16]

The distinction between the concepts of pre-emption and prevention is the focus of this article. To lift a corner of the veil, the deployment of 'preventive' strategies to inhibit a particular danger from happening is preceded by a more balanced risk assessment, while still accepting a certain amount of exposure to the danger. Pre-emption goes a step further by taking matters into its own hands. That is, by not accepting any risk of danger, pre-emptive strategies aim to take full control over a 'risky situation' as though it were certain that the feared danger will actually unfold.

The general aim of this article is to further illustrate how the underlying (criminological) rationale of pre-emptive strategies differs from the rationale of crime prevention strategies. This is done in light of the recent discussion on the 'pre-emptive approach' towards OMGs in Australia, the growing worldwide attention towards OMGs and the more stringent focus on OMG-related activities in general. Specifically, I focus on three instances where motorcycle events have been cancelled by a local government in the Netherlands. I make use of the jurisprudence related to the three preliminary proceedings at the Administrative Court. Although this article focuses on the attempt to control the problem of OMGs, it is clear that the discussion can be placed within a much wider security discourse that is '…

4. *See* <www.bndestem.nl/algemeen/binnenland/feest-motorclub-veterans-mag-doorgaan-1.3808222> (last visited 11 August 2015).
5. *Kamerstukken II*, 2011/12, 29 911, no. 59.
6. For example, J. Quinn and D. Koch, 'The Nature of Criminality within One-Percent Motorcycle Clubs', 24 *Deviant Behavior* 281 (2003); T. Barker, *Biker Gangs and Transnational Organized Crime* (2014); M. Lauchs, A. Bain & P. Bell., *Outlaw Motorcycle Gangs: A Theoretical Perspective* (2015).
7. Barker, above n. 6 at 71; Lauchs and others, above n. 6, at 92.
8. Barker, above n. 6; Blokland and others, above n. 2.
9. Politie Landelijk Eenheid, above n. 2, at 19.
10. K. Katz, 'The Enemy within: The Outlaw Motorcycle Gang Moral Panic', 36 *American Journal of Criminal Justice* 231, at 244 (2011).
11. Barker, above n. 6, at 208; L. Korsell and P. Larsson, 'Organized Crime the Nordic Way', 40 *Crime and Justice* 519, at 542 (2011). For more information about the 'Nordic approach' towards OMGs, *see also* T. Bjørgo, *Preventing Crime: A Holistic Approach* (2016), at 117.
12. Barkers, above n. 6, at 205; *See* <www.lto.de/recht/hintergruende/h/olg-hamburg-urteil-1-31-13-hells-angels-kutte/> (last visited 25 July 2016).
13. For a more in-depth view of the Canadian and Australian approach towards OMGs, *see*, for example, K. Katz, 'The Enemy within: The Outlaw Motorcycle Gang Moral Panic', 36 *American Journal of Criminal Justice* 231 (2011); A. Loughnan, 'The Legislation We Had to Have?: The Crimes (Criminal Organisations Control) Act 2009 (NSW)' 20 *Current Issues in Criminal Justice* 457 (2009); Lauchs and others, above n. 6, at 76-78; M.A. Moon, 'Outlawing the Outlaws: Importing R.I.C.O.'s Notion of 'Criminal Enterprise into Canada to Combat Organized Crime', 24 *Queens Law Journal* 451 (1999).
14. J. Ayling, 'Pre-emptive Strike: How Australia is Tackling Outlaw Motorcycle Gangs', 36 *American Journal of Criminal Justice* 250, at 259 (2011).
15. R. Ericson, *Crime in an Insecure World* (2007); R. Pieterman, *De Voorzorgscultuur. Streven naar Veiligheid in een Wereld vol Risico en Onzekerheid* (2008); A. Asworth and L. Zedner, *Preventive Justice* (2014).
16. T. Tulich, 'Prevention and Pre-emption in Australia's Domestic Anti-terrorism Legislation', 1 *International Journal for Crime, Justice and Social Democracy* 52, at 58 (2012).

increasingly dominated by the logic of risk management, a logic which calls for the management and government of risky populations by means of (statistical) calculations and proactive management rather than through the reactive management of real events and threats'.[17]

This article is organised as follows: Section 2 provides the theoretical framework and discusses the theoretical difference between pre-emptive and prevention strategies. A brief introduction to the Dutch approach towards OMGs is set forth in Section 3. Section 4 describes the three cases that are subsequently discussed within the 'pre-emption–prevention framework' in Section 5. The conclusion is presented in Section 6, and Section 7 discusses the importance of making a clearer distinction between pre-emption and prevention.

2 Tackling the Future

In this section, I first discuss the concept of pre-emption in relation to prevention. As Kortleven argued in his dissertation about the meaning of pre-emption in the Netherlands, the word 'prevention' is often used as an all-purpose concept. As a result, in the literature the concepts of *pre-emption* or *precaution* and *prevention* are often put forward interchangeably. That is, the author noted that in the context of pre-emption, strategies are also just referred to as preventative strategies.[18] This is not strange because the differences between prevention and pre-emptive strategies do not represent a clear 'black and white' distinction. In this respect, Dershowitz argued that 'prevention, as an element of criminal justice, is best seen as a continuum …'.[19] Thus, as both strategies aim to tackle a feared danger in the future, pre-emption is best seen as a *category* of various preventive strategies. Hebenton and Seddon seem to agree on this by referring to a form of 'radical prevention'.[20] Using both concepts interchangeably unjustly nullifies the different rationales underlying these two concepts. In this article, I therefore take the differences between pre-emption and prevention into consideration somewhat more strictly, arguing that prevention as a broad and umbrella term (including pre-emption) is to be distinguished from prevention in a narrow sense, which is thus distinct from pre-emption. It is important to make such a distinction because today, crime prevention runs the risk of becoming, as Haggerty puts it, 'an overly inclusive concept'.[21] By confronting the concept of prevention with that of pre-emption – emphasis is sought to be placed on the differences between both concepts.

The distinction I would like to address here is very closely related to the often described changing nature of how contemporary societies cope with risks and their related dangers.[22] While Garland speaks of a 'Culture of Control', Beck has qualified contemporary society as a (world) 'Risk Society'.[23] While the latter two have somewhat divergent arguments, Borgers and Van Sliedregt conclude that both studies agree that the modern-day adagio is: '… the protection of citizens against all manner of dangers'.[24] According to Ericson, this has led to '… the alarming trend across Western countries of treating every imaginable source of harm as a crime'.[25]

Several other authors have thus noticed a temporal shift towards responding to crime in the direction of controlling risks.[26] Generally, instead of focusing on committed crimes, crime fighting has shifted towards anticipating crimes that have not yet materialised. Thus, while the 'post-crime society' aims to detect actual wrongdoers by taking a committed criminal offence as the guiding principle (*e.g.* in order to prevent re-offending), the 'pre-crime society' aims to thwart future harms for the purpose of 'security'. This pursuit of security entails identifying threats and consequently, making interventions before a criminal offence takes place.[27] While McCulloch and Wilson, in their recent book on pre-crime, emphasise that the novelty of pre-crime should not be exaggerated, the authors do recognise that today, interventions are made to tackle less-imminent dangers or crimes. Thus, so the authors argue, pre-crime is more forward looking than prevention in the sense that it does not take past (criminal) conduct as the benchmark to assess the imminence of threat or future crimes: '… crime prevention is principally aimed at thwarting the recurrence of the past. Pre-crime, conversely, is not aimed simply at preventing a repeat of past offending,

17. M. van der Woude, 'Dutch Counterterrorism: An Exceptional Body of Legislation or just an inevitable Product of the Culture of Control?', in A. Ellian and G. Molier (eds.), *The State of Exception and Militant Democracy in a Time of Terror* (2002) 57, at 78-79.
18. W.J. Kortleven, *Voorzorg in Nederland. Ontwikkelingen in de Maatschappelijke Omgang met Kindermishandeling, Verkeersonveiligheid en Genetische modificatie* (2013), at 70.
19. A.M. Dershowitz, *Preemption: A Knife That Cuts Both Ways* (2006), at 32.
20. B. Hebenton and T. Seddon, 'From Dangerousness to Precaution: Managing Sexual and Violent Offenders in an Insecure and Uncertain Age', 49 *British journal of Criminology* 343, at 344 (2009).
21. K.D. Haggerty, 'From Risk to Precaution: The Rationalities of Personal Crime Prevention', in R. Ericson and A. Doyle (eds.), *Risk and Morality* (2003) 193, at 193.
22. It is important to emphasise that danger is '… the potential for harm that inheres in a thing, a person, or a situation…', while risk is '… a measure of that potential's likelihood and extent'. The likelihood of a particular danger to occur is thus expressed through risks. As a result, Garland argues that there is no such thing as objective or actual risks: '… risk-assessments depend for their validity upon a prior system of categorizations and metrics, which are in turn, grounded in specific conventions, institutions, or ways of life'. D. Garland, 'The Rise of Risk', in R. Ericson and A. Doyle (eds.), *Risk and Morality* (2003) 48, at 50-57.
23. U. Beck, *Risk Society: Towards a New Modernity* (1992, reprint 2005); D. Garland, *The Culture of Control. Crime and Social Order in Contemporary Society* (2002).
24. M. Borgers and E. Van Sliedregt, 'The Meaning of the Precautionary Principle for the Assessment of Criminal measures in the Fight against Terrorism', 2 *Erasmus Law Review* 171 (2009), at 172.
25. Ericson, above n. 15, at 1.
26. *See*, for example, B. Hudson, *Justice in the Risk Society. Challenging and Reaffirming Justice in Late Modernity* (2003); L. Zedner, 'Pre-crime and Post-criminology?', 11 *Theoretical Criminology* 261 (2007); Ericson, above n. 15; Pieterman, above n. 15.
27. Zedner, above n. 26.

but at pre-empting offending altogether'.[28] The result is that the 'pre-crime society' tends to focus on identifying and classifying suspicious groups – without worrying about false positive identifications – rather than dealing with individual offenders. Liability for pre-crime offences, consequently, '… is established on the basis of suspicion about the crimes an accused of this "type" might commit, given the opportunity'.[29] As a result of this, the distinction between the offender and the suspect is not as clear-cut as it was before. Ericson has stated that agencies tend to criminalise not solely the people who have actually committed a crime, but also the people who are suspected of committing a crime in the future.[30] In a similar way, Feeley and Simon have elaborated on the subject of controlling groups rather than punishing individual offenders. The authors explain that an important element of today's 'New Penology' is the process of identifying and managing groups justified by their risk profiles.[31] As a result, groups that are regarded as 'dangerous' tend to be excluded from society.[32] Recently, there has also been a stronger focus on addressing, or criminalising, seemingly innocent acts that are less imminent and temporally further removed from the actual substantive crime.[33] One striking example of this is the imprisonment of five OMG members in Australia in 2014, because of their buying ice creams as a group. This followed from the controversial Vicious Lawless Association Disestablishment Act 2013.[34]

2.1 Pre-Emptive Strategies versus Prevention Strategies

Hence, it seems agreed upon that coping with crime is concerned not only with *reacting* to conducted crimes but increasingly with the prevention of crime. However, prevention of (organised) crime is at the same time a rather broad and vague concept, and some scholars have argued that '… new developments *are* occurring under the rubric of crime prevention'.[35] That is, the shift towards the 'pre-crime society' approach seems to be increasingly dominated by a precautionary principle.[36] While the latter principle has been a dominant principle in international environmental law since the 1990s,[37] various scholars have argued that this principle has also been adopted in relation to other fields. As a result, similarly to what Ayling has done with regard to the Australian approach towards OMGs, and McCulloch and Pickering in relation to counterterrorism strategies, it has been advocated that a differentiation is called for between the meaning of pre-emptive strategies and what is commonly understood as crime prevention strategies.[38] In this respect, as noted in the introduction, the Australian approach towards OMGs in Australia has deliberately been characterised as a 'pre-emptive strike'.[39] Thus has Ayling emphasised the difference between pre-emption and prevention.

In general, crime prevention is about non-punitive measures that take away opportunities to commit crime.[40] Furthermore, crime prevention is about fighting dangers that are calculable and demonstrable and are thus put forward on the basis of predictions and risk assessments. In theory, whether or not to apply a certain prevention strategy depends on a cost-benefit analysis. In other words, the risk that a danger will actually occur and the costs of the prevention strategy are both taken into account.[41] The concept of (crime) prevention and thus the underlying decision-making processes are grounded in a more objectified risk assessment of the feared danger. Pre-emption, on the other hand, focuses more on the prevention of (future) dangers despite the uncertainty that the feared dangers will actually unfold. These uncertain dangers are treated '… as if they had already happened …', and the (pre-emptive) interventions are implemented in order to prevent a possible hazardous situation *at all costs*.[42] While prevention focuses on imminent or foreseeable threats, pre-emption thus targets uncertain situations. Simply put, pre-emption is about preventing uncertain dangers that might arise in the future. Importantly, pre-emptive strategies are also – compared with prevention strategies – to a lesser extent attuned to the level of threat. Pre-emption therefore puts more emphasis on the possible negative effects of a particular situation and pays less attention to the actual chance that the danger will occur.[43]

Treating both concepts as 'ideal types', Kortleven has pointed to three key features that help to untangle the

28. J. McCulloch and D. Wilson, *Pre-crime. Pre-emption, Pre-caution and the Future* (2016), at 3.
29. *Ibid*., at 20.
30. Ericson, above n. 15, at 1.
31. M. Feeley and J. Simon, 'The New Penology: Notes on the Emerging Strategy for Corrections', 30 *Criminology* 449 (1992).
32. Hudson, above n. 26, at 75.
33. McCulloch and Wilson, above n. 28, at 17-18.
34. *Ibid*., at 136; *See* <www.goldcoastbulletin.com.au/news/crime-court/bikie-association-charges-dropped-against-men-buying-ice-cream-on-gold-coast-holiday/news-story/d0ca09cf34d61c140380257bb5e1215b>.
35. H. van de Bunt and C. van der Schoot, 'Introduction', in H. van de Bunt and C. van der Schoot (eds.), *Prevention of Organised Crime. A Situational Approach* (2003) 17, at 17; Haggerty, above n. 21, at 193.
36. M. Schuilenburg, 'De paradox van het Voorzorgsbeginsel. Over 'unkunk' en uitsluiting', in D. Siegel and others (eds.), *Culturele criminologie* (2008) 57.
37. At the United Nations Conference on Environment and Development held in Rio de Janeiro (3-14 June 1992), the following definition of the precautionary approach was adopted (Principle 15): 'in order to protect the environment, the precautionary approach shall be widely applied by States according to their capabilities. Where there are threats of serious or irreversible damage, lack of full scientific certainty shall not be used as a reason for postponing cost-effective measures to prevent environmental degradation …'. UNCED, Rio-Declaration, Principle 15.
38. Ayling, above n. 14; J. McCulloch and S. Pickering, 'Pre-Crime and Counter Terrorism: Imagining Future Crime in the War on Terror', 49 *British Journal of Criminology* 628 (2009).
39. Ayling, above n. 14, at 259.
40. McCulloch and Pickering, above n. 38, at 629.
41. R. Prins and H. Boutellier, 'De Lokale Voorzorgcultuur. Over de steeds naar voren erkende Overheid in de Aanpak van Sociale Onveiligheid', 9 *Tijdschrift voor Veiligheid* 3, at 5-7 (2010).
42. McCulloch and Wilson, above n. 28, at 1.
43. Schuilenburg, above n. 36, at 57; Prins and Boutellier, above n. 41, at 7.

different underlying principles of prevention strategies and strategies of pre-emption.[44] These differences are believed to act as a justification for distinguishing between both concepts. By doing so, Kortleven has built on the literature proclaiming that contemporary society has shifted from a modern risk culture towards a late modern precautionary culture.[45] I will elaborate on these three features in what follows. Note that the following three features are interrelated and thus show some overlap. Untangling the concept of pre-emption in this way, however, is helpful to pinpoint the differences with prevention strategies.

2.1.1 Prevention at All Costs

First, the prevention of loss is deemed much more important with pre-emptive strategies than with prevention strategies. Although prevention strategies are indeed aimed at preventing harm, they are not expected to prevent *all* possible harms.[46] In other words, a certain amount of damage is accepted and is believed to be unavoidable. Whether or not to promote a prevention strategy in a certain situation is largely a result of 'calculation and scientific insight'.[47] In other words, a cost-benefit analysis is carried out in which the costs of a strategy are weighed against the chance that the danger will occur vis-à-vis the estimated damage that it causes (the risk). These costs, unsurprisingly, include the amount of money it costs to implement the particular strategy, but could also include other possible side effects of a measure such as the limitation of one's personal freedom and/or negative (crime) displacement effects. Damage, on the other hand, is to be understood as the costs that are involved when the feared danger eventually materialises. In this respect, one can think of all sorts of costs, such as material costs, physical costs or environmental costs, depending on the specific context.[48] Pre-emptive strategies, however, do not reckon with the idea of damage or loss to begin with. That is, pre-emptive measures aim to prevent damage at all costs and do not weigh the costs of a certain intervention. In other words, the costs of an intervention are deemed to be less important as the prevention of the harm is regarded as the topmost priority. In this way, prevention strives for *optimal* security, while pre-emption seeks to provide *maximal* security.[49] To make this distinction even clearer, it is insightful to refer to a distinction Hudson (2003) has made between the concepts of *risk management* and *risk control*.[50]

In describing how contemporary societies cope with 'risky' situations and people, Hudson has emphasised the difference between risk management and risk control. *Risk management* agrees with the notion that a risk situation is always associated with a certain amount of uncertainty. Since uncertainty is accepted and believed to be inherent to risk situations, risk management techniques do not focus on eliminating these uncertainties. In fact, techniques of risk management aim to cope with these uncertainties in such a way that they are reduced to a minimum. In doing so, risk management takes into account the costs of so-called 'false positives'. That is, it aims to prevent people from being falsely accused of having committed a crime. The strategy of *risk control*, on the other hand, does not aim to actually manage risks, but focuses on controlling risks. This means that risk control strategies do not accept the existence of uncertainties. As a result, risk control measures aim to take absolute control over situations that are deemed risky as a means to reassure that a would-be offender is unable to commit a crime. Consequently, risk control strategies attach less weight to false positives since the primary objective of these strategies is to prevent the risky situation at all costs, even when it is not entirely certain whether the feared 'risky' situation will unfold. By differentiating between these two strategies, Hudson stated that contemporary society increasingly tends to act upon strategies of risk control in order to cope with risky situations in such a way that (presumed) risky situations are neutralised beforehand.[51] With this in mind, one could, for example, argue that holding presumed 'terrorists' captive at the Guantanamo Bay detention camp is not a measure of risk management, but one of risk control.

2.1.2 Preventing Uncertain Situations

The second feature described by Kortleven relates to the problem of uncertainty. Put simply, the author has argued that today's spirit of pre-emption prescribes that – contrary to prevention strategies – a lack of knowledge about the nature, size and cause of the risk at hand is no reason not to implement a (pre-emptive) measure.[52] Therefore, many authors have argued that strategies of pre-emption are based on the previously mentioned 'precautionary principle'. Although it is agreed that it is difficult to provide a clear-cut definition of this principle and that the practical meaning is, moreover, believed to differ from one context to the other, this principle is usually operationalised as follows: '… if and when a threat of serious or irreparable harm arises, a lack of scientific certainty cannot apply as a reason not to take or to postpone preventive measures'.[53] This principle urges one to pre-empt danger even when it is far from certain that the danger will actually unfold. In the face of irreversible damage to society, there is no place for risk in the meaning of risk management as the costs of these risks are deemed to be high when materialised. With

44. Kortleven, above n. 18, at 54.
45. Pieterman, above n. 15.
46. Kortleven, above n. 18, at 41.
47. Prins and Boutellier, above n. 41, at 6.
48. For a further reading on the role of cost-benefit analysis in crime policies, *see*, for example, F. van Tulder, 'Afweging van kosten en baten in criminaliteit(sbestrijding)', 47 *Tijdschrift voor Criminologie* 291 (2005).
49. Pieterman, above n. 15; Schuilenburg, above n. 36, at 58.
50. Hudson, above n. 26, at 50; for a further discussion on this difference *see also* T. Clear, T. and E. Cadora, 'Risk and Correctional Practice', in K. Stenson and R. Sullivan (eds.), *Crime, Risk and Justice: The Politics of Crime Control in Liberal Democracies* (2001) 51.
51. Hudson, above n. 26, at 50.
52. Kortleven, above n. 18, at 54.
53. Borgers and Van Sliedregt, above n. 24, at 183.

respect to these types of risks (*e.g.* environmental disasters or large-scale terrorist attacks), one longs for certainty.[54] In other words, where prevention strategies avoid calculated risks, pre-emptive strategies aim to avoid uncertainty (better safe than sorry).[55] Obviously, this does not mean that all preventative action related to severe and irreversible damage is pre-emptive by definition. What makes these strategies pre-emptive, however, is the notion that the uncertainty often related to such cases calls for far-reaching risk-aversive strategies. While the precautionary principle was originally developed as a way of reasoning in the context of averting potential environmental dangers, Ericson has argued that this principle can also be recognised in contemporary approaches towards crime. The author has argued that the problem of uncertainty (*i.e.* the problem of not being able to base decisions on scientific forms of knowledge) has led to a 'politics of uncertainty', which has consequently resulted in the intensification of security measures.[56] As 'uncertainty' gives rise to the desire to avoid risks, 'uncertainty' has become the new basis for governing crime and thus for safeguarding security. The amount of knowledge upon which pre-emptive strategies are based is also lower because '… pre-emption permits interventions that are so far removed from the anticipated harm …'.[57]

2.1.3 Risk Assessments Are Less Important

The third feature that can also be recognised when thinking about pre-emption is closely linked to the two preceding differences. That is, besides the idea that uncertain risks as such do not constitute a barrier to the implementation of an intervention, less importance is also attached to risk assessments as a whole. In other words, risk assessments are to a lesser extent the determining factor for preventative action. This is due to the idea that taking risks is not accepted under the precautionary logic. Namely, taking risks would leave open the possibility of false 'negatives', which Hebenton and Seddon described as '… incorrectly rating a person as "safe" …'.[58] Such an error could subsequently result in (catastrophic) dangers. As I noted before, it is the sole possibility of such a consequence that pre-emptive interventions aim to eliminate. In this respect, Furedi also speaks of a shift towards possibilistic risk management, which symbolises a shift away from 'probability-based risk analysis'.[59]

54. Hebenton and Seddon, above n. 20, at 358.
55. Prins and Boutellier, above n. 41, at 7.
56. Ericson, above n. 15, at 1.
57. Tulich, above n. 16, at 59.
58. Hebenton and Seddon, above n. 20, at 252.
59. F. Furedi, 'Precautionary Culture and the Rise of Possibilistic Risk Assessment', 2 *Erasmus Law Review* 197, at 205 (2009).

3 The Dutch Approach towards Outlaw Motorcycle Gangs

Before applying and further discussing the aforementioned differences between pre-emption and prevention, this section will briefly provide the context in which OMGs are being approached in the Netherlands. Moreover, it will explain why the approach towards OMGs, in particular, acts as an interesting case to explore the meaning of pre-emption.

3.1 The 'Uncertainty' of 'Outlaw Motorcycle Gangs'

As noted in the introduction, there remains a certain amount of 'uncertainty' in the literature about the exact (criminal) nature of OMGs as a whole.[60] Consequently, Ayling argued that it would be unjust to assume that OMGs consist solely of criminals.[61] The recent findings of Blokland and others seem to be in line with this view as some OMGs are believed to be more 'radical' than others.[62] In other words, '… the available literature on OMGs does not provide for a clear answer to the question: Are all outlaw motorcycle clubs (1%-clubs) criminal gangs …?'[63] While the latter is more an empirical and criminological question, up to now, no OMGs in the Netherlands have – by means of Criminal Law – been declared a criminal organisation.[64] The Dutch Public Prosecution Service has, moreover, unsuccessfully tried to prohibit the Hells Angels MC by means of the Dutch Civil Code on several occasions.[65] While it is beyond the scope of this article to discuss at length all the Civil cases, the judgments in these cases have shown that it is difficult to *legally* ascribe individual criminal

60. It is important to emphasise that this literature does not underplay the link of OMGs with (organised) crime. In fact, Blokland and others have shown that most members in their dataset have a criminal record. It is argued, however, that it is unclear whether all OMGs should be understood as criminal organisations by definition. Blokland and others, above n. 2.
61. Ayling, above n. 14, at 260-61.
62. Blokland and others, above n. 2.
63. Barker, above n. 6, at 71.
64. In 2007, the Public Prosecution Service tried to prosecute the Hells Angels MC as a criminal organisation (Art. 140 Dutch Criminal Code). It must be said that in this case, the Public Prosecution Service was declared inadmissible owing to infringements on the rights of the suspects. Therefore, the Court did not discuss this case on its contents (Dutch Court 20 December 2007, ECLI:NL:RBAMS:2007:BC0685).
65. When the activities of a legal entity are believed to be contradictory to the public order, the Public Prosecution Service is able to request the Court to prohibit and abolish the legal entity in question (Art. 20 subsection 1 of the Dutch Civil Code). It is important to notice that Art. 2:20 of the Civil Code is thus not based on Criminal Law. The Criminal Code in the Netherlands focuses on the individual offender. Instead, Art. 2:20 originates from the Dutch Civil Code and aims to prohibit foundations and associations of which the activity is alien to the public order. In this case, not the individuals within these organisations are the main concern, but organisations as such are being dissolved.

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behaviour to the legal entity of an OMG.[66] Any criminal activities of a single OMG member cannot, by their very nature, be ascribed to the legal entity of the OMG.[67] A request to prohibit an entity can be granted only if it is deemed to be a necessary means to prevent conduct that actually violates commonly accepted democratic foundations and could possibly have a disruptive effect on society. Kesteloo, however, concluded that this 'public order principle' – in the context of the prohibition and abolishment of a legal person – is applied with great reticence.[68] All in all, the Supreme Court gives much weight to respecting the right to freedom of peaceful assembly and freedom of association (Article 11 ECHR).[69] Hence, although there are ample indications that members of some OMGs are guilty of various serious crimes, in the Netherlands there remains some (legal) 'uncertainty' surrounding the criminality of some OMGs as a whole.

Moreover, while in the Netherlands no OMGs have been prohibited yet, something else might have further amplified the uncertainty surrounding the criminal nature of OMGs. As noted in the introduction, the Dutch Government currently maintains that the term 'outlaw motorcycle gang' refers to motorcycle clubs that are believed to undermine the rule of law. However, the Dutch National Police has noted that not all clubs that have been listed as 'outlaw motorcycle gang' have – by definition – been under criminal investigation.[70] In other words, it is not necessary for members of a motorcycle club to be guilty of crimes in order to have their club listed as an 'outlaw motorcycle gang'. In the meantime, these listed 'gangs' are, as a result, subject to a nationwide policy. In this way, one could say that the perception of the existence of 'outlaw motorcycle gangs' is real in its consequences.

I would like to stress that this line of reasoning does not underplay the gravity of crime within some OMGs. In fact, ample examples have revealed that members of some OMGs are indeed guilty of a wide range of serious and organised crimes. This paragraph, however, does reveal that it remains uncertain whether *all* listed 'outlaw motorcycle gangs' can – in legal terms – be regarded as criminal organisations. As the concept of uncertainty plays a pivotal role under the 'logic-of-pre-emption', the example of OMGs is an interesting case to reveal how state agencies deal with this uncertainty.

66. *See e.g.* Dutch Court of Appeal 10 April 2008, ECLI:NL:GHAMS:2008:BC9212; Dutch Court of Appeal 25 April 2008, ECLI:NLGHSHE:2008:BD0560; Dutch Supreme Court 26 June 2009 ECLI:NL:HR:2009:BI1124.
67. Dutch Court of Appeal 10 April 2008, ECLI:NL:GHAMS:2008:BC9212, at no. 4.10.2.
68. A. Kesteloo, *Deelneming aan een Criminele Organisatie. Een Onderzoek naar de Strafbaarstellingen in Artikel 140 Sr* (2011), at 87.
69. T.J. van der Ploeg, 'Hoe moeilijk is het om een vereniging -of andere rechtspersoon- te verbieden?', 16 *Nederlands Juristenblad* 1094 (2012).
70. Politie Landelijke Eenheid, above n. 2, at 19.

3.2 A Zero-Tolerance Approach towards OMGs

At the start of the year 2012, the former Minister of Security and Justice, Mr. Opstelten, stated that the problems with OMGs are persistent and severe. According to the Minister, members of some OMGs are relatively often connected with various criminal activities. It is argued that members of OMGs have been striving for a key position in organised crime. OMGs are, moreover, associated with extortion, intimidation and violence (*e.g.* in the hotel and catering industry), which has led to the belief that outlaw bikers are assuming an undermining position within society. In other words, the activities of OMGs are believed to threaten the integrity of a democratic society. The Minister has also pointed to signs of tax and social security fraud. Finally, local governments have experienced a rise in the number of OMG chapters in their municipality, which is believed to be the cause for increased tensions between rival OMGs. All in all, this has led to the notion that OMGs disobey the rule of law and consider themselves to be inviolable.[71]

The Minister stated that OMG members who consider themselves untouchable and thus undermine the rule of law need to be stopped in any possible way. Those who violate the law should, he argued, in any way pay back the bill.[72] To put a stop to OMGs, the Dutch Minister of Security and Justice – in cooperation with agencies such as the Dutch National Police, local governments, the Dutch Tax Authority, the National Intelligence and Expertise Centre (LIEC) and the Regional Intelligence and Expertise Centres (RIEC) – announced a whole-of-government and zero-tolerance approach towards 'outlaw motorcycle gangs' in 2012. Under this whole-of-government approach, a so-called 'framework of barriers' (in Dutch: *barrièremodel*) has been developed in order to – by means of administrative, fiscal and criminal law enforcement – raise barriers and, consequently, prevent rule-breaking behaviour of OMGs and its members. To do so, the Dutch Minister of Security and Justice formalised eight guidelines or priorities to fight OMGs.[73]

One of these guidelines, for instance, advocates a strong focus on OMG clubhouses. That is, in order to put a stop to the inviolability of OMGs, local governments are required to take a critical stance towards clubhouses and aim to hinder the establishment of new clubhouses in their municipality. Clubhouses that do not comply with the local development plan or that do not have a liquor licence are shut down with administrative force, the ultimate goal being to lower the total number of clubhouses in the Netherlands. From January 2012 to May 2014, a total of 111 clubhouses were either closed or deterred.[74] A second guideline aims to counteract the influence of OMGs in the hotel and catering industry.

71. *Kamerstukken II*, 2011/12, 29911, no. 59, at 1-2.
72. *Ibid.*, at 1.
73. *Kamerstukken II*, 2011/12, 29911, no. 71.
74. Annual Progress Report Outlaw Motorcycle Gangs, June 2014 (RIEC/LIEC), available at: <www.riec.nl/doc/140616-integrale-landelijke-voortgangsrapportage-omgs-def-2.pdf>, at 9.

Since restaurants, pubs and clubs are expected to be used for money laundering activities or to act as clubhouses, the main goal here is to scrutinise the possible weaknesses of companies for any involvement with OMGs. By cooperating with entrepreneurs, the police and local governments aim to avoid any influence of OMGs in the hotel and catering industry.[75] The remaining six priorities put the focus on the criminal prosecution of OMGs and its members; hindering the influence of OMGs within security companies and football hooliganism; tax evasion by OMG members; OMG members working in the public sector; and OMG-related events. These guidelines are assumed to break the OMGs' inviolability, reduce their effectiveness and, as a result, have a preventative effect.[76]

4 Prohibiting OMG-Related Events

Over the past three years, the aforementioned priorities have been the starting point for many interventions towards OMGs in the Netherlands. To further assess the differences between prevention and pre-emptive strategies, I will zoom in on three cases related to the focal point of not facilitating OMG-related events.[77] According to the former Minster of Security of Justice, 'it is important to give a clear statement that concerned motorcycle clubs and members are being approached and that all necessary means to do so will be used'.[78] Following from this, the idea is that OMGs – by definition – should not be granted any stage or platform. This means that especially the government should not, so it is argued, facilitate the possibility for an OMG to organise, for example, an event. Here lies a task for the mayor as he or she is the provider of the permit that is needed for these events.[79] Following from this, part of the Dutch Approach thus entails the focus on the prevention of OMG-related events, based on the principle that the government should not partake in any OMG-related event.[80]

As said, I will zoom in on three occasions where motorcycle events were cancelled by a local government (*i.e.* no new permits were distributed, and granted permits were withdrawn. The first example can be understood as a direct result of the aforementioned policy to not facilitate any OMG-related event. The two other cases were cancelled on the basis of the advice of the Police not to facilitate any motorcycle-related events in April and May of 2014. The Police has issued this advice in the context of possible large-scale public order distortions.

4.1 The 'Brothers in Arms Run'

As I briefly mentioned in the introduction of this article, members of the Veterans MC were planning to organise the 'Brothers in Arms Run' in May of 2013, which was supposed to involve the gathering of ex-military motorcyclists from various countries.[81] Part of this three-day event was a motorcycle tour planned on 11 May 2013. However, the local government of 'Cuijk' prohibited this get-together by not providing the permit that was required for the event.[82] This refusal was grounded in public order and safety regulations, and the Mayor of Cuijk argued that the prohibition of this event would be in line with the prescribed nationwide policy to hinder OMG-related events. Interestingly, after the Veterans MC appealed against this decision in a preliminary proceeding, the Court decided that banning this event would be unlawful.[83] As a result, the ban on the 'Brothers in Arms Run' event was lifted.

It follows from this verdict that the initial ban of the event by the mayor was based on two arguments –first, because of the earlier described nationwide policy of the Ministry of Security and Justice, which proscribes support of any OMG-related events, and, second, on the grounds of maintaining public order. In short, it was feared that this event would attract members of other OMGs such as the Hells Angels MC. Yet it seemed that the mayor based his decision mainly on the policy of the Minister of Security and Justice and, to a lesser extent, on a report (*i.e.* a risk analysis of the event) created by the Dutch National Police on 2 April 2013.[84] However, the Court reasoned that a nationwide policy in itself cannot serve as a valid ground for prohibiting a local event. In a case like this, the municipality is duty-bound not to act solely on general (nationwide) policies but to also consider the local circumstances.

The Court argued that the arguments of the municipality to cancel the planned events were based mainly on general assumptions rather than specific risks of danger. That is, the report by the police revealed that no previous incidents were known in respect of other events of the Veterans MC. The 'Brothers in Arms Run' in 2008 – which also took place at this venue – moreover, passed off without any trouble.[85] Since the municipality was at

75. *Ibid.*, at 10.
76. It is beyond the scope of this article to provide a comprehensive overview of all eight guidelines. For a more extensive view of the 'framework of barriers' *see ibid*.
77. It has to be emphasised that these three examples by no means reflect the Dutch approach as a whole. Analysing only three occasions simply does not offer enough 'power' to do so. I use these three examples merely to initiate a discussion on the difference between prevention and pre-emption.
78. van der Ploeg, above n. 69, at 3.
79. *Ibid*.
80. Annual Progress Report Outlaw Motorcycle Gangs, June 2015 (RIEC/LIEC), retrieved from: <https://www.rijksoverheid.nl/documenten/rapporten/2015/06/12/integrale-landelijke-voortgangsrapportage-outlaw-motorcycle-gangs-omg-s-juni-2015>, at 12.
81. The Veterans MC is one of the motorcycle clubs that the Dutch National Police regards as an 'outlaw motorcycle gang'. Politie Landelijke eenheid, above n. 2, at 23.
82. Above n. 4.
83. The outcome of this preliminary proceeding was not published by the Court itself. Instead, the verdict was found on the website of the Veterans Motorcycle Club. *See* <http://veteransmc.com/Vonnis-VoorzieningenRechter.pdf> (last visited 11 August 2015).
84. *Ibid.*, at no. 5.
85. *Ibid.*, at no. 6.

that moment unaware of any criminal investigations related to the applicant and the event itself was not accessible to everyone, the Dutch National Police estimated the risk of public order disturbances at this event as being *low*. All in all, the Court ruled that the mayor was unable to provide enough indications that that year's 'Brothers in Arms Run' would cause serious trouble or would in fact disrupt the public order.

The decision not to provide the needed permit was – according to the Court – also based on the notion that the Veterans MC, being a member of the Dutch Council, is a so-called 'outlaw motorcycle gang'.[86] The sole argument of being an 'OMG', however, was considered to be inadequate to inhibit this event. Thus, although this event was initially prohibited, the arguments put forward by the mayor for doing so turned out to be based mainly on (nationwide) assumptions, which could not support the fear of any future public order disturbances.

4.2 The 'Harley-Day Valkenswaard'

One year later, a somewhat similar case took place in the municipality of Valkenswaard (located in the same province as the municipality of Cuijk). In this case the 'Foundation Harley-day Valkenswaard' (in Dutch: Stichting Harleydag Valkenswaard) requested authorisation for its seventh edition of the 'Harleydag Valkenswaard', which was planned on 26 April 2014. This freely accessible event usually involves live music, a market for motorcycles, entertainment for children and was expected to attract approximately 12,000 visitors. The organisation committee received permission to carry through their plans and activities on 26 February 2014. However, on 28 March, one month before the event was scheduled, the mayor of Valkenswaard revoked this permit. As was the case in the preceding example, the 'Foundation Harley-day Valkenswaard' appealed against this decision in a preliminary proceeding.[87]

The decision to revoke the permit was based on a (confidential) note-of-advice of the Dutch National Police (Police region Oost-Brabant). This note prescribed a negative advice for *all* motorcycle-related events planned in April and May 2014 in the Police region of Oost-Brabant. This advice also had a direct bearing on events that had already been granted a permit to organise such an event. This negative advice was based on the fear that motorcycle events could attract OMGs, which in turn might result in (large-scale) public order disturbances. Besides this, the Police also made a risk assessment on this particular event and concluded that there was a *high* risk of large-scale public order disturbances.[88] This conclusion was, among other reasons, grounded on the notion that the Harley-day of Valkenswaard might possibly be the ideal platform for the Bandidos MC to provoke the Hells Angels MC.[89] This stemmed from the idea that members of the latter are well-known visitors to this particular event and are generally seen as being in dispute with the Bandidos MC. Thus, the possibility of the Bandidos MC attending this event was believed to result in heightened tensions and possible public order and safety disturbances. At the same time, the Police reported that it was still not certain or at least somewhat uncertain that if both clubs met, it would indeed come to a direct confrontation.[90] Some concern also related to the uncertainty surrounding the position of chapters of No Surrender MC, which might be taken over by the Bandidos MC. It was, furthermore, argued that as other motorcycle events in the same area were also cancelled, allowing the 'Harley-day Valkenswaard' could instigate a 'honeypot effect' for various OMGs. Overall, the mayor of Valkenswaard attached more significance to safeguarding the public order and safety at the expense of the interests of the 'Foundation Harley-day Valkenswaard'.[91]

The Court argued that the mayor was justified in grounding his decision on the risk assessment made by the police. That is, the assessment contained risks that related directly to this particular event. So contrary to the previous case, local circumstances were taken into account on this occasion. The assessment was believed to be grounded in a realistic threat as the risk of a conflict between the Hells Angels MC and the Bandidos MC was deemed plausible.[92]

4.3 The 'Easter Show DCA Motorcycles'

On the same day, the same Court ruled differently in yet another similar case. In this case, the owner of a motorcycle shop ('DCA Motorcycles') applied for a permit to organise a relatively small event on 21 April 2014. This event was set up as an 'open day' to promote the company of 'DCA Motorcycles'. However, the mayor refused to provide the company with the needed permit for fear of public order and safety disturbances.[93]

The mayor followed the same note-of-advice of the Police as was referred to in the previous case (*i.e.* advising against all motorcycle-related events in April and May). This fear for disturbances was fuelled mainly by the fact that all other motorcycle-related events in neighbouring municipalities were also cancelled.[94] The mayor did not intend to make an exception for this event, as this was believed to have the effect of drawing

86. This Dutch Council, also known as the 'Council of eight' (in Dutch: 'Raad van Acht'), was founded in 1996 and was regarded as a way to reassure stability between the OMGs in the Netherlands. To take one example, members of this Council (*e.g.* the Hells Angels MC, Satudarah MC and the Veterans MC) discussed whether a motorcycle club was allowed to wear three back-patches on their vests, which stands for being a so-called 'full colour MC'. At the end of 2013, the council was dissolved after several OMGs abandoned the Council (Politie Landelijke Eenheid, above 2, at 24-25).
87. Dutch District Court 17 April 2014, ECLI:RBOBR:2014:2146.
88. *Ibid*., at no. 1.
89. The Bandidos MC set up its first chapters in the Netherlands in March 2014 (Politie Landelijke eenheid, above n. 2, at 20).
90. Dutch District Court, above n. 87, at no. 1.
91. *Ibid*.
92. *Ibid*., at no. 13.
93. <www.omroepbrabant.nl/?news/209463932/Helmond+geeft+geen+vergunning+voor+paasshow+van+motorwinkel+DCA+Motorcycles.aspx> (last visited 11 August 2015).
94. Dutch District Court 17 April 2014, ECLI:RBOBR:2014:2271, at no. 5.

several OMGs to this particular event (resulting in a possible confrontation between warring OMGs). This was because members of OMGs had no other event to attend during this period and were therefore expected to go to any other motorcycle-related event that was available. As was the case in the previous examples, 'DCA Motorcycles' also appealed against this decision.[95]

In short, the Court argued that the report of the Police (advising against all motorcycle-related events in April and May) alone offered an unsatisfactory argument for refusing a permit for this particular event. The argument that this event would have been the only motorcycle-related event and would thus attract much attention from OMGs was not adequately justified. In other words, the mayor provided not enough concrete indications that the assumed disturbances of conflicting OMGs would take place at this particular venue.[96] Overall, the mayor should have motivated more precisely why the refusal of this permit was necessary. Consequently, the Court argued that the mayor had unjustly refused to provide 'DCA Motorcycles' with the required permit.

5 Pre-Empting OMG-Related Events

Having described these three cases, the next step is to apply the 'framework of pre-emption' outlined in Section 2; to what extent can these cases be understood through the concept of pre-emption?

The first distinction between the concepts of prevention and pre-emption relates to the difference between 'risk management' and 'risk control'. As I have explained, pre-emption aims to prevent harm and danger *at all costs*. This is done not solely by *managing* risks, but by taking complete *control* over a 'risky' situation. Either by retrieving a permit or by not providing a permit, to begin with, the mayors in the foregoing examples aimed to ensure that these particular events would not take place. So – apart from the question of whether these decisions were legally justified – the mayors sought to take full control over the risks related to these events, and thus strived for maximum security. The costs of retrieving such a permit (*e.g.* expenditure made by the organising committee) were deemed less important than the possible risks arising from the event. A simple example of a strategy that would have taken these 'costs' into account would be the increase of police surveillance during the permitted event. By doing this, the risk of public disorder would be minimised and *managed*, while a certain amount of risk was still tolerated (*i.e.* the event is permitted, which leaves open the opportunity of OMGs disrupting the event). By prohibiting an event beforehand, the respective mayors do not accept any risk of danger and thus aim to take *control* over the risks related to the event.

Another important (interrelated) concept that explains the difference between pre-emption and prevention strategies is 'uncertainty'. That is, pre-emptive strategies tend to avert dangers whose manifestation is yet highly uncertain. However, a lack of knowledge about the problem at hand does not constitute a barrier to the implementation of a controlling measure. In this regard, it is relevant to review what the underlying rationale for taking action was in the aforementioned examples. Considering the first example ('The Brothers in Arms Run'), the Court ruled that the decision to cancel the event was based mainly on the nationwide policy implemented by the Dutch Ministry of Security and Justice, that is, not to facilitate an OMG-related event to begin with. In fact, the Police assessed the risk of large-scale public disorder during this event as being low. The decision to cancel the event was thus grounded in a more general policy line rather than in concrete indications that the event would actually cause any trouble. I therefore tend to conclude that – especially considering the fact that previous occasions of this event did not cause notable troubles – there was a great amount of uncertainty about the dangers of this particular event. The second example ('Harley-day Valkenswaard') reaches a somewhat different conclusion. On this occasion, the Court argued that the municipality had based its decision to cancel the event on more local and concrete risk indications. In fact, this decision was grounded in a risk assessment linked to the local circumstances of the event. The third event ('Easter show DCA Motorcycles') was, however, banned on the basis of a more uncertain and general risk. As the remaining motorcycle events in that period were also banned, the mayor assumed that this event would attract significantly more motorcycle enthusiasts and, more importantly, more OMGs as well. The general presumption of this possible gathering of (rival) OMGs acted as a ground on which to refuse the necessary permit. According to the Court, this line of reasoning was not justified, or in other words, the risk of such a danger was deemed yet too uncertain to justify banning this event. Thus, it is not so much uncertainty as such (of some particular future danger) that is of importance here; the occurrence of future dangers is always to some extent uncertain. This particular danger was, however, regarded as too uncertain and not sufficiently backed up by a concrete risk assessment, which thus did not reasonably justify the cancellation of the event beforehand.

The third difference relates to the importance of risk assessments. It was argued that decisions under the logic-of-pre-emption are to a lesser extent the result of risk assessments. Prevention strategies are based on risk assessments that take the gravity of the particular risk into consideration, while pre-emption, on the other hand, is grounded in the idea that risks are not accepted to begin with. Overall, one cannot conclude that the importance of risk assessments in the aforementioned examples is reduced to zero. In fact, the Dutch National

95. *Ibid.*
96. *Ibid.*, at no. 9.

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Police made a risk assessment on the specific and local dangers of the 'Harley-day Valkenswaard' event, which made the mayor of Valkenswaard decide to cancel the event. As a result, this case can hardly be typified as a form of pre-emption. In the case of the 'Easter show DCA Motorcycles', however, such a specific risk assessment was absent. That is, its refusal was based mainly on general assumptions, and no sufficient cause was provided as to why public disorder was to be expected at this specific local and small event. In the first example, the role of a risk assessment is somewhat different. As previously mentioned, 'The Brothers in Arms Run' was cancelled mainly on the basis of the national guideline forbidding facilitation of any OMG-related events issued by the former Minister of Security and Justice in 2012. This is not to say that there was no risk assessment drawn up for this particular event to begin with. However, this risk assessment revealed that the risk of any danger was perceived as low. Hence, although a risk assessment was actually drawn up, its conclusions did not constitute a decisive role for the adopted decision to cancel the planned event. This risk assessment thus seems to have had no or a marginal role in the decision to cancel the event. The fact that the latter event was organised by a listed OMG itself (unlike the other two events) seemed to have played a decisive role in cancelling the event.

5.1 Pre-Emption: The Denial of Rationality

As I have tried to explain in the first section of this article, pre-emptive strategies – similarly to prevention strategies – aim to prevent risk of dangers. The examples in this article similarly focus on changing situations that are believed to facilitate dangers. The motorcycle events are regarded as situations that might facilitate a clash between rival OMGs, which ultimately would lead to a situation of public disorder. Although it might be true that the Police had indications of a possible clash between rivalling OMGs, this fear inherently constituted an uncertain and perceived risk. However, whether or not any danger will occur in the future is inherently uncertain for all types of future dangers. It would thus be too simplistic and unjust to – for this reason – 'label' these cases as examples of pre-emption. In fact, given the infamous reputation of some OMGs, it is understandable for a mayor to be on his guard with OMG-related events. Revoking permits for events can be regarded as a useful way to prevent possible public disorder and, more precisely, a clash between warring OMGs. By cancelling such an event beforehand, however, the local government tries not only to minimise the risks ('risk management'), but also to foreclose all possible risks in such a way that the level of risk is reduced to zero. The uncertain risk of public disorder is not accepted as the event – by not providing the needed permit – cannot pose any danger to public security to begin with. Thus, one could state that in the aforementioned examples, the local government tries to neutralise or take total control over the 'risky situation'. As a result, as the events cited in this article were cancelled beforehand, the possibility of any public disorder became real in its consequences. That is, the feared yet not materialised danger is acted upon (by means of cancellation) as if this danger *will* materialise. The consequence is real in the sense that the event is actually cancelled and, consequently, cannot be attended to begin with.

Not providing a permit for a motorcycle event also cancels out the possibility that (in these cases) OMG members will not use the event to cause any trouble ('false positive'). Where prevention strategies solely try to alter one's decision-making process, pre-emptive strategies thus take a more radical step by ensuring that the individuals do not come in a situation where he or she is able to make his or her own rational decision. A strategy of prevention would have, for instance, advocated – after the event was permitted – initiation, for example, of more police surveillance at the particular venue. This strategy would still have treated visiting OMG members as rational individuals capable of making their own calculated decisions. By treating the uncertain as certain, and thus by taking total control over an uncertain situation, one cancels out the possibility that a subject (*i.e.* members of OMGs) will not cause any trouble. In this way, pre-emptive strategies tend to disrespect what Smilansky has termed the 'window of moral opportunity'.[97]

It is important to emphasise here that it would be wrong to suggest that cancelling any risky event beforehand would subsequently make an example of pre-emption. In fact, the decision to cancel the 'Harley-day Valkenswaard' clearly showed a relation to the outcome of a risk assessment that qualified this event as a 'high-risk' event. The mayor in this case thus seems not to have cancelled this event in order to take full control over 'uncertainty', but actually based his decision on concrete risk indications. Interestingly, the 'Brothers in Arms Run', on the other hand, was prohibited because of a more general and political line of reasoning that a municipality should not make OMG-related events (*e.g.* parties organised by an OMG) possible to begin with (in this case by not providing a permit). The general notion that OMGs should not be granted any stage and that the government should not partake in any of its activities proscribes to cancel out, or raise barriers, to various OMG-related activities beforehand. Not providing a permit because of this line of reasoning, as the latter case shows, causes the role of 'the risk assessment' to fade into the background. That is, when put into practice, the decision not to provide a permit for an OMG-related event is decoupled from the outcome of a risk assessment (*e.g.* the risk of a possible clash between warring OMGs).

Therefore, the 'denial' of one's ability to make law-abiding decisions becomes mostly apparent when looking at this latter case, as this example followed from the general focus on OMGs as briefly described in Section 3, and not from concrete and situation-specific risks. The belief of prohibiting any OMG-related event before-

97. S. Smilansky, 'The Time to Punish', 54 *analysis* 50 (1994), at 52.

hand (regardless of its 'riskiness'), subsequently takes away the capacity of OMG members to decide not to act in a disorderly or criminal way, which denies the rationality of its members. The notion that local governments should not facilitate any OMG events by definition, seems to move beyond the statement of the former Minister of Security and Justice (Section 3) that those who transgress the law should, in any way, pay back the bill. While the latter refers to a *reaction* to misconduct (tit for tat), the former pre-empts the possibility of misdemeanor by making sure there is nothing to be paid back.

6 Conclusion

It is clear that today's crime fighting policies attach much relevance to the prevention of crime. Quite simply, crime fighting today constitutes more than only reacting to criminal conduct by tracking down and prosecuting criminals. This preventative shift has been discussed in much detail by many scholars. At the same time, some authors have argued that some prevention strategies are increasingly based on the principle of pre-emption. While such pre-emptive strategies also aim to prevent crimes, it is believed that pre-emption is somewhat different from what is commonly understood as prevention. This article was an attempt to untangle the broad and all-embracing term of crime prevention by exploring and untangling the differences between prevention and pre-emption. This was done by analysing three examples in which local governments tried to prevent a motorcycle club-related event from taking place. Although the three cases are most certainly not perfectly clear examples of pre-emption, the present analysis has shown that there might indeed be different underlying rationales to be recognised, which justifies the statement that pre-empting crime is different from preventing crime. Overall, the distinction between pre-emptive and prevention strategies can be found in how one deals with the uncertainty inherently related to the future risk of danger. The measures described in this article aimed to take full control over the uncertain risk related to a particular event. In other words, the uncertainty surrounding the problem of OMGs (*e.g.* a possible clash between the Hells Angels MC and the Bandidos MC) called for a far-reaching strategy in an attempt to control (and not only manage) the feared danger before it actually emerged. One could say that, as the risk of public disorder was not accepted to begin with, the feared danger became real in its consequences. Under pre-emption, the uncertainty surrounding a threat is thus treated as certain. It must be noted, however, that the denial of the permit in the case of the 'Harley-day Valkenswaard' was based largely on a specific and locally embedded risk assessment, which clearly makes that this case cannot be explained through the concept of pre-emption. The role of a risk assessment was, however, rather marginal in the 'Brothers in Arms Run' case, as the Mayor of Cuijk based his decision largely on a general approach that OMGs are not to be facilitated by the government. Such a belief devalues the role of risk assessments and treats an uncertain risk as certain. By doing so, it also denies the possibility that OMG members will not cause trouble at one of these events.

I think it is important to emphasise that – with this article – I do not claim that the Dutch approach as a whole is to be characterised as a pre-emptive approach. As already noted, the difference between prevention and pre-emption constitutes a gradual difference, and 'reality' could be too complex to clearly distinguish a prevention strategy from a pre-emptive strategy. To come to such a conclusion, more empirical research is needed (*e.g.* interviews with the people responsible for taking the decision to refuse a permit for a 'risky' event). With this article, I merely attempted to start a theoretical discussion about the difference between the two concepts, without drawing any hasty conclusions about the Dutch approach towards OMGs as such. However, I do believe that this article provided enough reason to do more empirical research into the concept of 'pre-emption'. I will elaborate somewhat more on why this is the case in the following discussion.

7 Discussion

Until now, the difference between pre-emptive strategies and prevention strategies seems to be only a matter of theoretical and abstract importance. However, I believe that accentuating this difference is not only theoretically interesting, but also important in a more practical way. I would like to take this opportunity to endorse what has been argued by Matthias Borgers. He stated that it is important to keep an eye on what one wants to achieve by implementing pre-emptive measures and also to pay more attention to the possible negative effects of such strategies.[98] In my opinion, it is possible to come to a greater realisation and understanding of the effects of certain crime policy strategies by making a clearer distinction between pre-emption and prevention. This article has revealed that prevention and pre-emptive strategies have different underlying rationales. Both strategies have different goals. For instance, the former Minister of Security and Justice, Mr. Opstelten, has pointed to the importance of not facilitating any OMG-related events as one of the eight guidelines to fight OMGs. This article has advocated the thesis that not providing a permit for an OMG-related event because of possible public disorder is not a prevention strategy per se. It is a pre-emptive strategy in the sense that it treats the uncertain future as certain by treating OMG members as being incapable of making rule-abiding decisions. In order words, it acts upon the presumption that the event will in fact cause a conflict between various OMGs. Initially, one could argue that not granting a permit to begin with is a far less expen-

98. M.J. Borgers, *De vlucht naar voren* (2007).

sive measure compared with, for example, the enforcement of more police surveillance around the event itself. However, this line of reasoning would nullify the idea that a stringent pre-emptive strategy might also have negative consequences not only for the organising party, but for the state agency as well. To cite a simple example, could the prohibition of all OMG-related events during a period result in a shift towards more illegal OMG events out of sight of the Police and the local government? Is it thus possible that such a pre-emptive logic is based on the false impression that it can indeed fully 'control' this risky situation beforehand, or do such measures simply result in other new uncertainties that are even more difficult to control? Although this article has been dominated by the case of OMGs, the discussed distinction undoubtedly fits within the broader context of how state agencies cope with the (uncertain) risk of dangers. For instance, how do local governments and the Police cope with 'risky' sport games (*i.e.* feared hooliganism), and how should we understand the (preventative) strategies put forward with respect to returning Syria fighters? Research has shown that the closing of all brothels located on the so-called 'Zandpad' in Utrecht in 2013 did not help much to *prevent* human trafficking.[99] Could this be the result of the local government's attempt to foreclose and control the problem by means of pre-emption? By thinking about these types of questions I would like to argue in favour of making a clearer distinction between pre-emptive and prevention strategies as it helps to think about the effects, limitations and consequences of crime policies. All in all, although the pre-emption–prevention distinction seems to be a theoretical and somewhat simulated distinction at first, it can be an interesting distinction to consider for law enforcement agencies and (local) governments. It forces agencies to reconsider whether the chosen 'preventative path' effectively prevents the commitment of crimes, or whether it only pre-empts uncertain and, to some extent, generalised risks that are inherently impossible to eliminate.

99. D. Siegel, *Het Zandpad – closing brothels or closing eyes? Utrechtse sekswerkers na sluiting van het Zandpad* (2015).

A Theoretical Framework to Study Variations in Workplace Violence Experienced by Emergency Responders

Integrating Opportunity and Vulnerability Perspectives

Lisa van Reemst*

Abstract

Emergency responders are often sent to the front line and are often confronted with aggression and violence in interaction with citizens. According to previous studies, some professionals experience more workplace violence than others. In this article, the theoretical framework to study variations in workplace violence against emergency responders is described. According to criminal opportunity theories, which integrate the routine activity theory and lifestyle/exposure theory, victimisation is largely dependent on the lifestyle and routine activities of persons. Situational characteristics that could be related to workplace violence are organisational or task characteristics, such as having more contact with citizens or working at night. However, they do not provide insight in all aspects of influence, and their usefulness to reduce victimisation is limited. Therefore, it is important to consider the role of personal characteristics of the emergency responders that may be more or less 'attractive', which is elaborated upon by the victim precipitation theory. Psychological and behavioural characteristics of emergency responders may be relevant to reduce external workplace violence. The author argues that, despite the risk of being considered as blaming the victim, studying characteristics that might prevent victimisation is needed. Directions for future studies about workplace violence are discussed. These future studies should address a combination of victim and situation characteristics, use a longitudinal design and focus on emergency responders. In addition, differences between professions in relationships between characteristics and workplace violence should be explored.

Keywords: Workplace aggression, workplace violence, emergency responders, blaming the victim, victimology

1 Introduction

Emergency responders are important for the safety of society by reducing the risk of crimes, deaths and diseases, as they are tasked with not only monitoring compliance with regulations (*e.g.* police officers), but also providing assistance and (health) care (*e.g.* emergency medical workers and firefighters). Because they are often sent to the front line, this group of professionals has specific risks of experiencing trauma while performing their duties.[1] One of these traumatic experiences is experiencing violence at work, directed towards the professionals. Studies have shown that law enforcement officers and workers in (health) care have an increased risk of experiencing workplace violence in various countries, such as in the UK,[2] the USA[3] and the Netherlands.[4]

Studies have shown that experiencing workplace violence may have several, potentially severe, consequences. For example studies suggest that experiencing workplace violence may result in increased feelings of distress,[5] emotional exhaustion and burnout symptoms,[6] insecurity,[7] sickness notifications, turnover intentions,[8] and injuries or even death of professionals,[9] which were

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1. D.S. Weiss, A. Brunet, S.R. Best, T.J. Metzler, A. Liberman, N. Pole, J.A. Fagan & C.R. Marmar, 'Frequency and Severity Approaches to Indexing Exposure to Trauma: The Critical Incident History Questionnaire for Police Officers', 23 *Journal of Traumatic Stress* 734 (2010).
2. *See* 'Violence at Work', available at: <www.hse.gov.uk/Statistics/causinj/violence/index.htm> (last visited 23 March 2016).
3. D.M. Gates, C.S. Ross & L. McQueen, 'Violence against Emergency Department Workers', 31 *The Journal of Emergency Medicine* 331 (2006); C.E. Rabe-Hemp and A.M. Schuck, 'Violence against Police Officers', 10 *Police Quarterly* 411 (2007).
4. J. Naeye and R. Bleijendaal, *Agressie en geweld tegen politiemensen* [Aggression and violence directed at police] (2008).
5. T.M. Leino, R. Selin, H. Summala & M. Virtanen, 'Violence and Psychological Distress among Police Officers and Security Guards', 61 *Occupational Medicine* 400 (2011).
6. M. Bernaldo-De-Quiros, A.T. Piccini, M.M. Gomez & J.C. Cerdeira, 'Psychological Consequences of Aggression in Pre-hospital Emergency Care: Cross Sectional Survey', 52 *International Journal of Nursing Studies* 260 (2015).
7. L. Middelhoven and F. Driessen, *Geweld tegen werknemers in de openbare ruimte* [*Violence against Employees in the (Semi-)Public Space*] (2001).
8. M. Abraham, S. Flight & W. Roorda, *Agressie en geweld tegen werknemers met een publieke taak* [*Aggression and Violence against Employees with a Public Task*] (2011), at 36.
9. *See* 'About Law Enforcement Officers Killed and Assaulted, 2013', available at: <www.fbi.gov/about-us/cjis/ucr/leoka/2013> (last visited 22 September 2015).

found also in other populations who experience workplace violence.[10] It should be noted that studies on workplace violence rarely have a longitudinal design, measuring violence and characteristics over time, and it is thus possible that some of these characteristics were present before experiencing workplace violence and were not a result from experiencing workplace violence. However, the longitudinal studies that were available suggest that professionals may suffer from psychological consequences after experiencing workplace violence.[11] Thus, workplace violence against emergency responders can affect professionals and organisations.

Therefore, reducing workplace violence of emergency responders is a priority for the political agenda in many countries.[12] In the Netherlands, this is reflected by the programme of the Ministry of the Interior and Kingdom Relations that has been set up to prevent aggression and violence against 'public sector professionals', who work for the public interest, work in public services and work for or on behalf of a public body. Measures that have been taken to prevent workplace violence against public sector professionals are encouraging organisations to communicate which behaviours of citizens are and are not acceptable, and to provide training to professionals.[13] In addition, the maximum sentence demanded for violent offenders may be raised up to three times the regular maximum sentence if the victim is a public sector professional.[14]

While all high-risk professions may frequently experience violence, it has been widely shown in general victimisation studies that experiencing violence is not equally distributed. Having experienced victimisation has often been found to be the strongest correlate of subsequent experiences of violence or other crimes, for many populations,[15] including professionals at work.[16] According to survey studies, some professionals experience workplace violence relatively often and others experience relatively little workplace violence.[17] This unequal distribution is related to the profession of people, but victimisation experiences are also unequally distributed *within* specific professions.[18] The unequal distribution within professions will be illustrated by a figure that was derived from the study of Fischer and Van Reemst.[19] The study was based on data from the Ministry of the Interior and Kingdom Relations, who have monitored workplace violence in the public sector in the Netherlands. In this study, latent class analyses were used to identify categories of self-reported victimisation of workplace violence (verbal, physical, intimidation, sexual and discrimination), in the past year, of emergency medical workers (N = 272, who experienced 1,049 workplace violence incidences in total), police officers (N = 556, who experienced 4,202 incidences in total) and other employees (excluding firefighters).

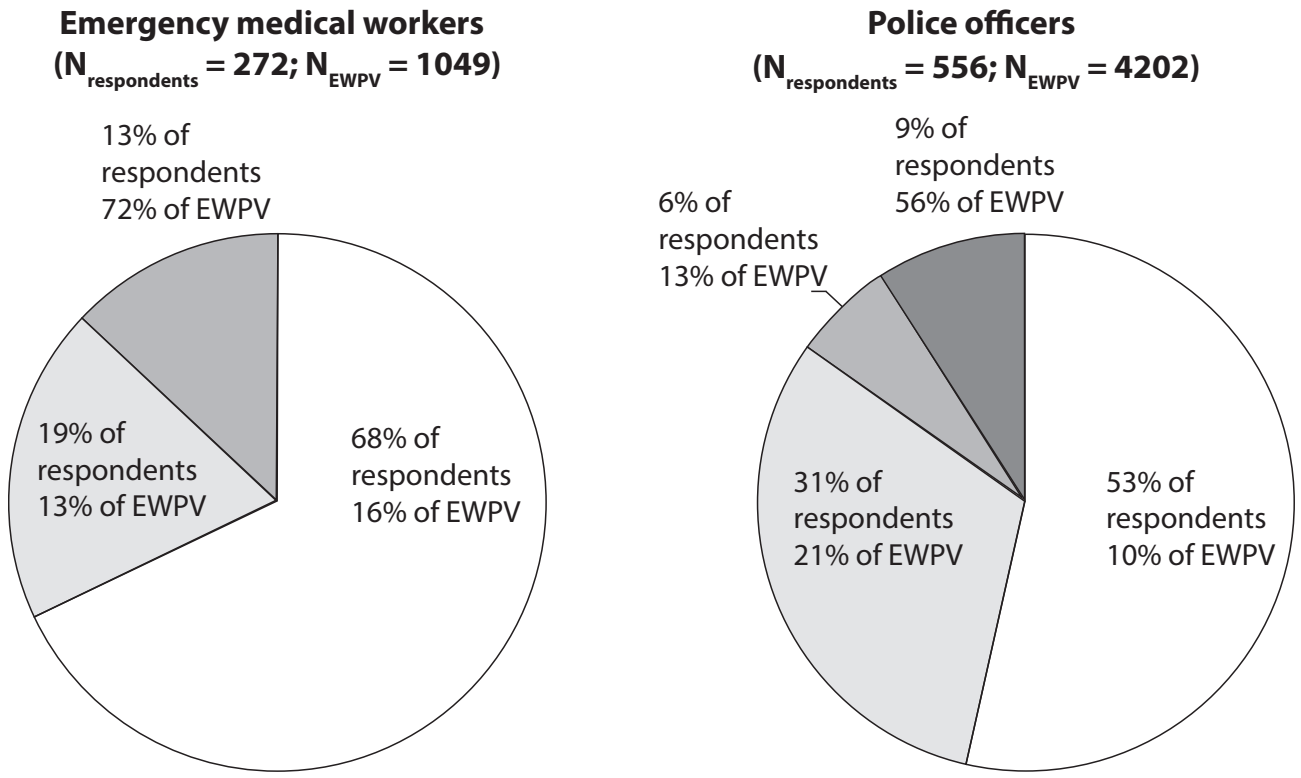
As can be seen in Figure 1, a relatively large percentage of professionals experienced only a small percentage of total workplace violence incidences, whereas a small percentage of professionals experienced a high percentage of total workplace violence incidences. For emergency medical workers, a group of only 13% of professionals reported 72% of all workplace violence incidences, and for police officers, 9% of professionals reported 56% of incidences. The results of this study suggest that, also within specific professions, some professionals experience more workplace violence than others.

Overall, the differences in experiencing workplace violence raise the following question: which characteristics of professionals are related to experiencing more external workplace violence within professions, and to what extent? This knowledge is needed to reduce external workplace violence in the future and to provide directions for future studies. This paper will present a theoretical framework to study variations in workplace violence experienced by emergency responders, by applying and integrating criminological theories that have been used in victimology, and highlighting empirical applications and ethical dilemmas related to the theories. Thereby, in this paper, differences in victimisation are explained using the victim's perspective.

This paper makes contributions to the literature on theory development of workplace violence against emergency responders: as studies about workplace violence against emergency responders are often published in journals focusing on practitioners in (pre-hospital)

10. A.A. Grandey, J.H. Hern & M.R. Frone, 'Verbal Abuse from Outsiders versus Insiders: Comparing Frequency, Impact on Emotional Exhaustion, and the Role of Emotional Labor', 12 *Journal of Occupational Health Psychology* 63 (2007); M.T. Sliter, S.Y. Pui, K.A. Sliter & S.M. Jex, 'The Differential Effects of Interpersonal Conflict from Customers and Coworkers: Trait Anger as a Moderator', 16 *Journal of Occupational Health Psychology* 424 (2011).
11. *Id*.
12. Eurofound, *Physical and Psychological Violence at the Workplace* (2013).
13. Ministry of the Interior and Kingdom Relations, *Handreiking agressie en geweld* [*Guide to Aggression and Violence*] (2011).
14. *See* 'Geweld tegen werknemers met publieke taak', available at: <www.rijksoverheid.nl/onderwerpen/geweld-tegen-werknemers-met-publieke-taak/inhoud/aanpak-geweld-tegen-werknemers-met-publieke-taak> (last visited 22 September 2015).
15. *See e.g.* K.H. Breitenbecher, 'Sexual Revictimization among Women. A Review of the Literature Focusing on Empirical Investigations', 6 *Aggression and Violent Behavior* 415 (2001); G. Farrell and A.C. Bouloukos, 'International Overview: A Cross-National Comparison of Rates of Repeat Victimization', 12 *Crime Prevention Studies* 5 (2001).
16. L. van Reemst, T.F.C. Fischer & B.W.C. Zwirs, *Geweld tegen de politie: De rol van mentale processen van de politieambtenaar* [*Violence against the Police: The Role of Mental Processes of the Police Officer*] (2013).
17. It is important to note that victimisation, as measured in self-report victimisation surveys, is probably a combination of the actual frequency of victimisation and how likely it is that people report this victimisation in a survey (*e.g.* based on to what extent they remember the incidence or experienced harm from the victimisation incidence). This is often considered a limitation of victimisation surveys, as it does not allow the separation of actual and perceived victimisation. However, if we are interested in decreasing *experiences* of victimisation, this combination of frequency and remembrance or harm of victimisation could be considered our concept of interest in victimisation studies.
18. Abraham *et al*. (2011), above n. 8; A. Ettema and R. Bleijendaal, *Slachtofferprofielen* [*Victim Profiles*] (2010); T.F.C. Fischer and L. Van Reemst, *Slachtofferschap in de publieke taak* [*Victimisation in the Public Task*] (2014).
19. Fischer and Van Reemst, above n. 18.

Figure 1 *Distribution of incidences of EWPV of emergency medical workers and police officers, based on Fischer and Van Reemst.*



emergency care,[20] studies are often limited in their theoretical foundations. Therefore, classic victimisation theories have rarely been applied to workplace violence against emergency responders.[21] Applying victimological theories helps us to identify and categorise possible 'risk factors' of workplace violence, and integrating theories helps us to explain workplace victimisation better. Applying victimological theories seems justified because we can consider professionals who experience workplace aggression and violence as 'victims', even though definitions of victims differ and the word is subject to stigma (or at least related to concepts such as suffering, passivity and forgiveness).[22]

In this paper, first, the context of workplace violence against emergency responders will be described, including the function of emergency responders, and the nature and extent of workplace violence against emergency responders. Second, criminal opportunity theories and personal vulnerability notions (originating from the victim precipitation theory) will be applied to experiencing workplace violence. These two victimological perspectives address the role of situational and victim characteristics in victimisation. The results from studies about correlates of workplace violence of emergency responders will be described in relation to these theories, and arising opportunities for future research will be described. Lastly, I will reflect on 'victim blaming', which is an ethical topic related to studying differences in workplace violence and provides a direction for future research about workplace violence against emergency responders.

2 Role and Function of Emergency Responders

The three groups of professionals working as emergency responders (police officers, firefighters and emergency medical workers) share many common work circumstances because they all respond to emergencies and are needed for public safety. Emergency respondents' work also requires fitness of the professionals and has physical demands.[23] All emergency responders are thought to have a relatively high risk of experiencing violence at work, because of the frequent contact with citizens (or patients, family or bystanders), the negative emotions and frustrations an emergency may cause to these citi-

20. *See e.g.* C.C. Mechem, E.T. Dickinson, F.S. Shofer & D. Jaslow, 'Injuries from Assaults on Paramedics and Firefighters in an Urban Emergency Medical Services System', 6 *Prehospital Emergency Care* 396 (2002); S. Koritsas, M. Boyle & J. Coles, 'Factors Associated with Workplace Violence in Paramedics', 24 *Prehospital and Disaster Management* 417 (2009).
21. Some examples in other populations: T.F.C. Fischer, L. van Reemst & J. de Jong, 'Workplace Aggression Toward Local Government Employees: Target Characteristics', *International Journal of Public Sector Management* (2016); S. Landau and Y. Bendalak, 'Personnel Exposure to Violence in Hospital Emergency Wards: A Routine Activity Approach', 34 *Aggressive Behavior* 88 (2008); F. van Mierlo and S. Bogaerts, 'Vulnerability Factors in the Explanation of Workplace Aggression', 11 *The Journal of Forensic Psychology Practice* 265 (2011).
22. J. van Dijk, 'Free the Victim: A Critique of the Western Conception of Victimhood', 16 *International Review of Victimology* 1 (2009).
23. *See also* S.N. Kales, A.J. Tsismenakis, C. Zhang & E.S. Soteriades, 'Blood Pressure in Firefighters, Police Officers, and Other Emergency Responders', 22 *American Journal of Hypertension* 11 (2009).

zens and the broad variety of citizens they deal with, including citizens who are more likely to be offenders, such as people who are under the influence of alcohol or drugs or have a mental illness.[24]

In addition to these similarities, each profession is unique. Police officers enforce laws and de-escalate (potential) threats, firefighters safeguard people by rescuing or fire extinguishing, and emergency medical workers provide medical care before arriving at the hospital. Although it will not be possible to give an exhaustive list of differences in this paper, I will describe some additional differences between the professions that might influence professional-citizen interactions. First, police officers can legitimately use physical force in interaction with citizens[25] and can use weapons to do so, such as batons or a service weapon, whereas firefighters and emergency medical workers cannot. Second, firefighters leave for an emergency with more professionals than police officers and emergency medical workers. Third, the frequency of contact of citizens varies between professions, with police officers having the most and firefighters having the least contact with citizens. Police officers may remain outside even if no emergency calls were received, whereas many firefighters work as volunteers and only work if a call was received. Lastly, in severe or complex emergencies, the three professions may work together, each having their own work task. These differences in work situations may cause differences in professional-citizen interactions and experienced workplace violence (EWPV).[26] However, because of their similarities, all have a heightened risk of experiencing workplace victimisation. Therefore, it is important to study workplace violence in this population.

3 Nature and Extent of Workplace Violence against Emergency Responders

In studies, the act of violence and aggression against professionals is often referred to as 'workplace aggression' or 'workplace violence'. Schat and Frone's definition of workplace violence is 'behaviour that a target wants to avoid, takes place in a work-related situation, and is potentially physically or psychologically damaging to the target'.[27] 'Workplace' thus refers to the type or context of the situation and not the actual location, and it can occur in public space, for example. Regarding the nature of external workplace violence, studies have shown that workplace violence can take physical and psychological shapes. This includes being hit, punched and grabbed (physical), being yelled at and being called names (psychological). Threats are sometimes studied as a separate type (or included in the definition of psychological workplace violence), as are sexual harassment and being discriminated against. Overall, types of workplace violence that have been addressed in studies have varied greatly.[28]

In this paper, I focus on external workplace victimisation. I will not focus on *internal workplace violence*, which is violence initiated by an individual within the organisation, for example bullying or assault between workers or between a supervisor and a worker, and is more often the focus of research.[29] *External workplace violence* occurs more frequently[30] and is a type of workplace violence initiated by people outside the organisation, such as clients, patients, students, suppliers, intruders and citizens in general.[31] Specifically, emergency responders most often experience victimisation from people they provide a (safety) service to.[32]

The extent of external workplace violence varies depending on the definition of workplace violence. For example, in 2011, the monitor of the Ministry of the Interior and Kingdom Relations of the Netherlands studied the extent of EWPV in many public sector employees. Their conceptualisation of workplace violence included five types of behaviour: verbal aggression (including name-calling and yelling), physical aggression (including pushing and hitting), threats and intimidation (including threatening of family members and

24. *See e.g.* M.M. LeBlanc and E.K. Kelloway, 'Predictors and Outcomes of Workplace Violence and Aggression', 87 *Journal of Applied Psychology* 444 (2002).
25. *See e.g.* G.P. Alpert, R.G. Dunham & J.M. MacDonald, 'Interactive Police-Citizen Encounters that Result in Force', 7 *Police Quarterly* 475 (2004).
26. Similar to other occupations. For example studies in the general health care sector have indicated that different occupations may result in differences in EWPV and correlates of EWPV. E. Viitasara, M. Sverke & E. Menckel, 'Multiple Risk Factors for Violence to Seven Occupational Groups in the Swedish Caring Sector', 58 *Industrial Relations* 202 (2003); S. Winstanley and R. Whittington, 'Violence in a General Hospital: Comparison of Assailant and Other Assault-Related Factors on Accident and Emergency and Inpatient Wards', 106 *Acta Psychiatrica Scandinavica* 144 (2002).
27. A.C.H. Schat and M.R. Frone, 'Exposure to Psychological Aggression at Work and Job Performance: The Mediating Role of Job Attitudes and Personal Health', 25 *Work & Stress* 23 (2011); K.E. Dupre, K.A. Dawe & J. Barling, 'Harm to Those Who Serve: Effects of Direct and Vicarious Customer-Initiated Workplace Aggression', 29 *Journal of Interpersonal Violence* 1 (2014).
28. J. Barling, K.E. Dupre & E.K. Kelloway, 'Predicting Workplace Aggression and Violence', 60 *Annual Review of Psychology* 671 (2009).
29. K. Aquino and S. Thau, 'Workplace Victimization: Aggression from the Target's Perspective', 60 *Annual Review of Psychology* 717 (2009); N.A. Bowling and T.A. Beehr, 'Workplace Harassment from the Victim's Perspective: A Theoretical Model and Meta-Analysis', 91 *Journal of Applied Psychology* 998 (2006); B.J. Tepper, 'Abusive Supervision in Work Organizations: Review, Synthesis and Research Agenda', 33 *Journal of Management* 261 (2007).
30. B.L. Bigham, J.L. Jensen, W. Tavares, I.R. Drennan, H. Saleem, K.N. Dainty & G. Munro, 'Paramedic Self-Reported Exposure to Violence in the Emergency Medical Services (EMS) Workplace: A Mixed-Methods Cross-Sectional Survey', 18 *Prehospital Emergency Care* 489 (2014).
31. C. Mayhew and D. Chappell, 'Workplace Violence: An Overview of Patterns of Risk and the Emotional/Stress Consequences on Targets', 30 *International Journal of Law and Psychiatry* 327 (2007); D. Yagil, 'When the Customer Is Wrong: A Review of Research on Aggression and Sexual Harassment in Service Encounters', 13 *Aggression and Violent Behavior* 141 (2008).
32. *See e.g.* M.M. LeBlanc, K. Dupre & J. Barling, 'Public-Initiated Violence', in E. Kelloway, J. Barling & J. Hurrell (eds.), *Handbook of Workplace Violence* (2006) 261.

stalking), sexual intimidation (including sexual harassment and rape) and discrimination (including negative comments about skin colour, age or sexual preference). The results of their study indicates that 68% to 73% of police officers, 79% to 89% of emergency medical workers and 44% to 48% of firefighters reported experiencing external workplace violence in the previous year.[33] It should be noted that, in their research, police officers who work in other departments, including those who work mostly behind desks were included, which suggests that the percentage of police officers who experienced workplace violence among those who respond to emergency calls might be higher. Studies have suggested that emergency responders most commonly experience psychological workplace violence, followed by physical (and sexual) workplace violence.[34]

4 Explaining Variations in Workplace Violence against Emergency Responders

Victimisation is generally considered to be an interaction between the offender and victim. From the victim's perspective, characteristics that could influence the likelihood of becoming a victim of external workplace violence are based on the situation the victim is in (including *to what extent* they are in contact with possible offenders) or on the individual victim (and *how they* interact with possible offenders). Important theories, predominantly referring to situational characteristics, are the criminal opportunities, such as the lifestyle/exposure theory,[35] and the routine activity theory. These were developed around the same time (late 1970s) and are often used in combination.[36] Meier and Miethe[37] suggested in their work on victimisation theories that these were the more sophisticated theories compared to previous, more limited, ideas about victimology. I will first explain criminal opportunity theories, after which I will present to what extent these theories have been tested and supported in external workplace violence studies.

4.1 Criminal Opportunity Theories

In a nutshell, criminal opportunity theories claim that people vary in the likelihood of experiencing victimisation because they differ in the activities they perform.[38] The lifestyle/exposure theory[39] tries to explain differences in victimisation risks by focusing on the differences in lifestyle, which could be routine daily activities, work/school or leisure activities. These lifestyles are said to explain the differences in exposure to dangerous time, place and others. Hindelang and colleagues elaborate upon various demographic characteristics that may influence peoples' risk of victimisation indirectly. Because of shared expectations or structural constraints, socio-demographic characteristics such as gender, age or race may affect people's lifestyle and thus their risk of victimisation.

The routine activity theory adds that routine activity influences the convergence in time and space of three important elements: a motivated offender, a suitable target and the absence of a capable guardian.[40] Although originally the routine activity theory has been developed to explain differences in crime rates instead of victimisation risks, this theory has been applied across units of analysis, including victimisation.[41] This means that victimisation is more likely to occur if an individual is in the presence of a motivated offender, is a suitable target (*e.g.* has valuable possessions or is 'attractive' for other reasons) and lacks guardianship (*e.g.* lacks safety precautions). For example someone who is present in high crime areas and among (repeat) offenders more often is thought to be more likely to be a victim, than someone who rarely finds him or herself in these situations.

The lifestyle/exposure theory and the routine activity theory have similarities. In both theories, the main focus is on the opportunity to become a victim, provided by their activities and lifestyle, instead of the personal motivations of offenders to commit crime. Because of the similarities in the lifestyle/exposure theory and the routine activity theory, these theories have often been used in combination, as an integrated theory.[42] Overall, the idea that victimisation risks vary because of variations in activities and related socio-demographic characteristics is still dominant in many victimisation studies.[43] To test these theories, studies focus on to what extent socio-demographic characteristics of the potential victim and situational characteristics of their activities (routine, work/school or leisure) are related to victimisation. Situational characteristics that could be related to victimisation of professionals are characteris-

33. Abraham *et al*. (2011), above n. 8, at 29.
34. *See e.g.* Bigham *et al*., above n. 30.
35. M.J. Hindelang, M.R. Gottfredson & J. Garofalo, *Victims of Personal Crime: An Empirical Foundation for a Theory of Personal Victimization* (1978).
36. L.E. Cohen and M. Felson, 'Social Change and Crime Rate Trends: A Routine Activity Approach', 44 *American Sociological Review* 588 (1979).
37. R.F. Meier and T.D. Miethe, 'Understanding Theories of Criminal Victimization', 17 *Crime and Justice* 459 (1993); R.F. Meier and T.D. Miethe, *Crime and Its Social Context: Towards an Integrated Theory of Offenders, Victims, and Situations* (1994).
38. L.E. Cohen, J.R. Kluegel & K.C. Land, 'Social Inequality and Predatory Criminal Victimization: An Exposition and Test of a Formal Theory', 46 *American Sociological Review* 505 (1981).
39. Hindelang *et al*., above n. 35.
40. Cohen and Felson, above n. 36.
41. Meier and Miethe (1993), above n. 37, at 470.
42. Cohen *et al*., above n. 38.
43. *See e.g.* K. Holtfreter, M.D. Reisig & T.C. Pratt, 'Low Self-Control, Routine Activities, and Fraud Victimization', 46 *Criminology* 189 (2008); Landau and Bendalak, above n. 21; T.J. Taylor, A. Freng, F.A. Esbensen & D. Peterson, 'Youth Gang Membership and Serious Violent Victimization: The Importance of Lifestyles and Routine Activities', 23 *Journal of Interpersonal Violence* 1441 (2008); M.S. Tillyer, R. Tillyer, H.V. Miller & R. Pangrac, 'Reexamining the Correlates of Adolescent Violent Victimization: The Importance of Exposure Guardianship and Target Characteristics', 26 *Journal of Interpersonal Violence* 2908 (2011).

tics related to the time and place of peoples' activities, such as the type of work they do, how often, when and where they work, and the type of citizens they work with.

4.2 Criminal Opportunity Theories and External Workplace Victimisation

Socio-demographic characteristics that have previously been studied in relation to workplace violence of emergency responders are typically age and gender. Often, men are found to experience more workplace violence than females,[44] with the exception of sexual harassment, which is more often experienced by females.[45] Often, younger professionals are found to be more likely to experience workplace violence.[46] No association was found between ethnicity and victimisation of professionals.[47] As described, these characteristics are theoretically related to workplace violence by people having specific lifestyles because of their socio-demographic characteristics. However, studies have not shown which lifestyle characteristics are mediating the relationship between being young and male, and experiencing workplace violence. For example, theoretically, young professionals could experience more victimisation, because they have had less experience and training (lacking safety precautions) or because older professionals have less contact with citizens (possibly motivated offenders) because they do more desk work.

According to previous studies, various situational characteristics explain differences in victimisation of emergency responders. To explain differences in workplace violence experiences *between* emergency responders, the profession itself is an important situational indicator.[48] The profession determines the situation professionals are in and the type of contact they have with citizens (as described in para. 2). However, other characteristics are important to explain differences in victimisation *within* professions. Professionals who are more in contact with people are more likely to experience victimisation, as indicated by studies that found working more hours per week and having more contact with citizens to be related to external workplace violence.[49] In addition, the type of contact with citizens (including location and time of contact) and the type of citizens they work with are related to experiencing workplace violence. According to studies, professionals experience more workplace violence if they work in economically depressed areas, in urban areas, in public spaces, on their own, during the evening or at night, or, more often, in contact with citizens who are unknown to the professional.[50] In addition, professionals who deal with more 'incidents' (such as arresting people)[51] or have more 'bad news conversations' are more often confronted with workplace violence. Regarding their work location, professionals who work in an urban area are found to experience more workplace victimisation.[52] Also, professionals who work with people who use alcohol or drugs, who have previously been in contact with the police or who have a mental illness are more likely to experience external workplace violence.[53] All these characteristics seem related to how often professionals are in the presence of possible motivated offenders or lack guardianship.

It is possible also that the organisational climate influences the amount of workplace victimisation by their prevention and aftercare policies with respect to aggression and violence, as this is found to be related to workplace violence in other populations.[54] Prevention and aftercare measures of organisation may affect the nature of interaction between professionals and citizens, for example by training, which may provide a safety precaution against experiencing workplace violence.

As shown, many characteristics have already been found to be related to experiencing workplace violence. However, there is still the need to improve the explanation of differences in victimisation for three reasons. First, because it is rather difficult to directly use these situa-

44. M. Abraham, A. van Hoek, P. Hulshof & J. Pach, *Geweld tegen de politie in uitgaansgebieden* [*Violence against the Police in Nightlife*] (2007); J.T. Grange and S.W. Corbett, 'Violence against Emergency Medical Services Personnel', 6 *Prehospital Emergency Care* 186 (2002); Middelhoven and Driessen, above n. 7; A. Oliver and R. Levine, 'Workplace Violence: A Survey of Nationally Registered Emergency Medical Services Professionals', *Epidemiology Research International* (2015).
45. C. Mayhew and D. Chappell, 'Occupational Violence: Types, Reporting Patterns and Variations between Health Sectors', *Taskforce on Prevention and Management of Violence in the Health Workplace Working Paper Series no. 139:1* (2001). M. Boyle, S. Koritsas, J. Coles & J. Stanley, 'A Pilot Study of Workplace Violence Towards Paramedics', 24 *Emergency Medicine Journal* 760 (2007).
46. Abraham *et al*. (2007), above n. 44; Grange and Corbett, above n. 44; Middelhoven and Driessen, above n. 7.
47. Ettema and Bleijendaal, above n. 18.
48. Abraham *et al*. (2011), above n. 8.
49. Abraham *et al*. (2007), above n. 44; J. Broekhuizen, J. Raven & F. Driessen, *Geweld tegen de brandweer* [*Violence against Firefighters*] (2005); Gates *et al*., above n. 3; Koritsas *et al*., above n. 20; Middelhoven and Driessen, above n. 7; LeBlanc and Kelloway, above n. 24; C. Sikkema, M. Abraham & S. Flight, *Ongewenst gedrag besproken* [*Undesirable Conduct Discussed*] (2007); Van Reemst *et al*., above n. 16.
50. *Id*.; Boyle *et al*., above n. 45; R.J. Kaminski, 'Assessing the County-Level Structural Covariates of Police Homicides', 12 *Homicide Studies* 350 (2008); Oliver and Levine, above n. 44.
51. J. Timmer, *Politiegeweld: Geweldgebruik van en tegen de politie* [*Police Violence: Violence by and against the Police*] (2005).
52. K. Barrick, M.J. Hickman & K.J. Strom, 'Representative Policing and Violence towards the Police', 8 *Policing* 193 (2014); M.G. Jenkins, L.G. Rocke, B.P. McNicholl & D.M. Hughes, 'Violence and Verbal Abuse against Staff in Accident and Emergency Departments: A Survey of Consultants in the UK and the Republic of Ireland', 15 *Journal of Accident & Emergency Medicine* 262 (1998).
53. Grange and Corbett, above n. 44; Jenkins *et al*., above n. 52; L. Loef, M. Heijke & B. Van Dijk, *Typologie van plegers van geweldsdelicten* [*Typology of Perpetrators of Violence*] (2010); Naeye and Bleijendaal, above n. 4; J.L. Taylor and L. Rew, 'A Systematic Review of the Literature: Workplace Violence in the Emergency Department', 20 *Journal of Clinical Nursing* 1072 (2010).
54. S.R. Kessler, P.E. Spector, C. Chang & A.D. Parr, 'Organizational Violence and Aggression: Development of the Three-Factor Violence Climate Survey', 22 *Work & Stress* 108; P.E. Spector, M.L. Coulter, H.G. Stockwell & M.W. Matz, 'Perceived Violence Climate: A New Construct and its Relationship to Workplace Physical Violence and Verbal Aggression, and their Potential Consequences', 21 *Work & Stress* 117 (2007).

tional and socio-demographic characteristics in interventions, as they are either relatively stable or unwanted to change. For example even though working at night seems to pose more threat, we would not want to stop emergency care at night. I will come back to this issue in the discussion of this paper. Second, because studies show that the differences in experiences of workplace violence that are explained by (only) situational and socio-demographic characteristics is limited.[55] Lastly, because criminal opportunity theories mainly focus on being in the same time and place as an offender and not the motivation of offenders. Therefore, studies using these theories rarely, or indirectly, describe victim characteristics that may influence the motivation of the offender, thereby lacking a possibly important element for explaining workplace violence.

4.2.1 Professionals' Vulnerability

The other element of being suitable as a target is the idea of being more 'attractive' (although some researchers have highlighted the unwanted connotations of this word),[56] as a possible target, which is the core idea of vulnerability notions of victims, originating from the victim precipitation theory. The victim precipitation theory explains that the victim might contribute to the victimisation experience.[57] According to further developments of the theory, this happens by being more 'vulnerable' to being victimised than others, in other words more 'victimisation prone'.[58] Originally, precipitation was considered to occur whenever the victim first used physical force against the subsequent offender.[59] Following this idea, several researchers studied the extent to which serious crime followed action from the victim, such as physical force.[60] The theory was debated because it was considered as blaming the victim, which I will elaborate upon later in this paper. However, the idea that some people are more vulnerable to victimisation than others remained.

This idea was further developed among others by Sparks,[61] who developed six characterisations of victim proneness: precipitation (precipitation or encouraging victimisation), facilitation (putting themselves consciously or subconsciously at risk, *e.g.* by forgetting to protect oneself), vulnerability (attributes which lead to higher victimisation risk), opportunity (people must be in the same place as the offender), attractiveness (*e.g.* wearing jewellery in case of theft) or impunity (unlikely to report to the police).

There seems to be overlap between these vulnerability notions and criminal opportunity theories, as both highlight the role of opportunity and protection (in other words, guardianship), but vulnerability notions seem to add the role victim may have in the motivation of the offender: They might encourage, facilitate or attract victimisation, besides being in the same time and space as offenders. In this way, the actual interaction between offender and victim receives more attention, than in opportunity theories. Finkelhor and Asdigian highlight that victims may have characteristics that an offender may want to obtain or use (influencing the 'instrumental goal' of aggressiveness[62] of possible offenders), may arouse anger or jealousy (influencing the 'frustration-aggression' of possible offenders), or may compromise the ability to resist or deter victimisation.[63]

Thus, some people may be more vulnerable to experiencing victimisation, for example by having certain psychological characteristics including emotional, cognitive, personality and behavioural characteristics. Probably, psychological characteristics are not directly, but rather indirectly related to victimisation. For example Egan and Perry[64] describe that having low self-regard may be associated to experiencing victimisation, because of lower motivation to act assertively or to defend oneself. As can be derived from the notion of Egan and Perry, emotional, cognitive and personality characteristics seem related to victimisation because of the behaviour victims perform.

In general victimisation literature, originally based on victims of bullying, two types of victims are distinguished based on their behaviour and related psychological characteristics: the passive (or submissive) and the provocative victim.[65] The passive victim is characterised to be passive, insecure and frequently rejected. The provocative victim is characterised to be aggressive, hostile or irritating. In many general victimisation studies, passive and aggressive behaviour have been found to be related to victimisation.[66]

55. Abraham *et al*. (2011), above n. 8; Fischer and Van Reemst, above n. 18; Naeye and Bleijendaal, above n. 4.
56. D. Finkelhor and N.L. Asdigian, 'Risk Factors for Youth Victimization: Beyond a Lifestyle/Routine Activities Theory Approach', 11 *Violence and Victims* 3 (1996) at 5.
57. Meier and Miethe (1994), above n. 37; M.E. Wolfgang, *Patterns in Criminal Homicide* (1958).
58. *See e.g.* J. Goodey, *Victims and Victimology: Research, Policy and Practice* (2005), at 70.
59. Wolfgang, above n. 57.
60. M. Amir, *Patterns in Forcible Rape* (1971); L.A. Curtis, 'Victim Precipitation and Violent Crime', 21 *Social Problems* 594 (1973); and more recently: S.M. Ganpat, J. van der Leuk & P. Nieuwbeerta, 'The Influence of Event Characteristics and Actors' Behaviour on the Outcome of Violent Events: Comparing Lethal with Non-lethal Events', 53 *British Journal of Criminology* 685 (2013); L.R. Muftic, L.A. Bouffard & J.A. Bouffard, 'An Exploratory Analysis of Victim Precipitation among Men and Women Arrested for Intimate Partner Violence', 2 *Feminist Criminology* 327 (2007).
61. R.F. Sparks, 'Multiple Victimization: Evidence, Theory and Future Research', 72 *Journal of Criminal Law & Criminology* 762 (1981).
62. R.B. Felson, 'Violence as Instrumental Behavior', in E. Kelloway, J. Barling & J. Hurrell (eds.), *Handbook of Workplace Violence* (2006) 7.
63. Finkelhor and Asdigian, above n. 56.
64. S.K. Egan and D.G. Perry, 'Does Low Self-Regard Invite Victimization?', 34 *Developmental Psychology* 299 (1998).
65. D. Olweus, *Aggression in the Schools: Bullies and Whipping Boys* (1978); D. Olweus, 'Victimization by Peers: Antecedents and Long-Term Outcomes', in K.H. Rubin and J.B. Asendorpf (eds.), *Social Withdrawal, Inhibition, and Shyness in Childhood* 315 (1993); D. Olweus, *Bullying at School* (1994).
66. J.N. Kingery, C.A. Erdly, K.C. Marshall, K.G. Whitaker & T.R. Reuter, 'Peer Experiences of Anxious and Socially Withdrawn Youth: An Integrative Review of the Developmental and Clinical Literature' 13 *Clinical Child and Family Psychology Review* 91 (2010); C. Salmivalli and T. Helteenvuori, 'Reactive, but not Proactive Aggression Predicts Victimization among Boys', 33 *Aggressive Behavior* 198 (2007).

4.2.2 *Psychological Characteristics and Behaviour of Professionals*

The passive and provocative victims were also proposed in mainly internal, but also external, workplace violence studies.[67] Studies that address individual characteristics and victimisation at a certain point in time (cross-sectional studies) indicate that victims score higher on aggressive and dominating behaviour and lower on self-determination than non-victims.[68] Whereas having more dominating behaviour supports the notion of the more provocative victim, lower self-determination could support the notion of the more passive victim. This was not yet structurally tested among emergency responders, although interviews performed in these populations point in the same direction.[69]

Regarding psychological characteristics, relatively little information was available about indicators of external workplace violence of emergency responders. Studies that have addressed psychological characteristics have mainly focused on police officers. These indicate that police officers who score higher on neuroticism and openness to experience,[70] who experience more job-related stress[71] and who select aggressive responses[72] experience more workplace violence. In other populations, more psychological characteristics have been addressed, such as victims having more general negative affectivity,[73] emotional exhaustion,[74] psychological distress,[75] feelings of unsafety,[76] risk perception,[77] mental and physical health,[78] and lower self-esteem[79] than non-victims. These could be related to workplace victimisation of emergency responders as well.

Again, it is important to note that it is often unclear whether these psychological characteristics preceded or were a result from experiencing workplace violence. More research is needed that studies psychological characteristics and workplace violence over time, to determine whether these are indicators or consequences of experiencing workplace violence. Especially for feelings of unsafety and physical health, it seems likely that these are consequences of experiencing workplace violence rather than indicators, whereas for stable personality characteristics, such as neuroticism and openness to experience, it seems likely that these characteristics existed before experiencing workplace violence. For other characteristics, the direction of the relationship is less obvious. For example one could experience more negative feelings as a result of victimisation. In the other direction, by having negative feelings, professionals could approach a situation more 'negatively', which could result in being less able to de-escalate a potentially threatening situation (because they did not perceive the threat on time, for example) or allowing a situation to escalate sooner (*e.g.* by being less friendly). Therefore, research is needed that studies the relationships over time.

In addition, more knowledge is needed about the relationship between psychological characteristics and workplace violence for emergency responders specifically, as many studies focus on other populations. For example as dominance, aggression and lower self-esteem have been linked to victimisation (including violence in the workplace) in other populations, this should also be studied in police officers, firefighters and emergency medical workers. Studying dominance could especially be interesting for police officers, as a certain degree of dominance seems relevant to accurately perform as a police officer, because of the work tasks of the police.

In addition, more characteristics could influence the degree of (de-)escalation of the situation and thus the extent of workplace violence the professional experiences. For example, in various contexts, people seem to adjust their behaviour according to how they interpret situations.[80] Studies in other populations also found these interpretations, referred to as hostile attributions of the situation, to be related to victimisation: people who interpret hypothetical situations as more hostile, generally, also experience more victimisation.[81] Aquino,

67. K. Aquino and K. Lamertz, 'A Relational Model of Workplace Victimization: Social Roles and Patterns of Victimization in Dyadic Relationships', 89 *Journal of Applied Psychology* 1023 (2004); E. Kim and T.M. Glomb, 'Get Smarty Pants: Cognitive Ability, Personality and Victimization', 95 *Journal of Applied Psychology* 889 (2010) at 890.
68. K. Aquino, S.L. Grover, M. Bradfield & D.G. Allen, 'The Effects of Negative Affectivity, Hierarchical Status and Self-Determination on Workplace Victimization', 42 *Academy of Management Journal* 260 (1999); K. Aquino and M. Bradfield, 'Perceived Victimization in the Workplace: The Role of Situational Factors and Victim Characteristics', 11 *Organization Science* 525 (2000); K. Aquino and K. Byron, 'Dominating Interpersonal Behaviour and Perceived Victimization in Groups: Evidence for a Curvilinear Relationship', 28 *Journal of Management* 69 (2002).
69. W. Roeleveld and I. Bakker, *Slachtofferschap van geweld binnen de publieke taak* [*Victimization of Violence in the Public Task*] (2010).
70. K. Ellrich and D. Baier, 'The Influence of Personality on Violent Victimization – A Study on Police Officers', *Psychology, Crime & Law* (2016).
71. E. Zavala, 'Examining the Offender-Victim Overlap among Police Officers: The Role of Social Learning and Job-Related Stress', 28 *Violence and Victims* 731 (2013).
72. L. van Reemst, T.F.C. Fischer & B.W.C. Zwirs, 'Response Decision, Emotions, and Victimization of Police Officers', 12 *European Journal of Criminology* 635 (2015).
73. A.A. Grandey, D.N. Dickter & H. Sin, 'The Customer Is Not Always Right: Customer Aggression and Emotion Regulation of Service Employees', 25 *Journal of Organizational Behavior* 397 (2004).
74. Grandey *et al*. (2004), above n. 73; Grandey *et al*. (2007), above n. 10; M.S. Hershcovis and J. Barling, 'Toward' a Multi-Foci Approach to Workplace Aggression: A Meta-Analytic Review of Outcomes from Different Perpetrators', 31 *Journal of Organizational Behavior* 24 (2010); S. Winstanley and L. Hales, 'A Preliminary Study of Burnout in Residential Social Workers Experiencing Aggression: Might It Be Cyclical?', 45 *British Journal of Social Work* 24 (2014).
75. H.J. Gettman and M.J. Gelfand, 'When the Customer Shouldn't Be King: Antecedents and Consequences of Sexual Harassment by Clients and Customers', 92 *Journal of Applied Psychology* 757 (2007).
76. Gates *et al*., above n. 3.
77. LeBlanc and Kelloway, above n. 24.
78. Dupre *et al*., above n. 27; Hershcovis and Barling, above n. 74; Schat and Frone, above n. 27.
79. Bowling and Beehr, above n. 29.
80. N.R. Crick and K.A. Dodge, 'A Review and Reformulation of Social Information-Processing Mechanisms in Children's social Adjustment', 1 *Psychological Bulletin* 74 (1994). K.A. Dodge, 'A Social Information Processing Model of Social Competence in Children', in M. Perlmutter (ed.), *Minnesota Symposium on Child Psychology* (1986) 77.
81. L. van Reemst, T.F.C. Fischer & B.W.C. Zwirs, 'Social Information Processing Mechanisms and Victimization: A Literature Review', 17 *Trauma, Violence, and Abuse* 3 (2016).

Douglas and Martinko[82] have found a relationship between workplace violence and various other negative attributions, namely the tendency to attribute negative outcomes as external to themselves, stable, intentional and controllable. Studying hostile attributions as a possible indicator of workplace violence could thus be worthwhile.

5 Blaming the Victim by Considering Professionals' Suitability

A risk in studying victim characteristics in workplace violence, such as their psychological or behavioural characteristics, is that it might be considered blaming the victim. This is one of the ethical dilemmas researchers have to deal with when studying this topic. In particular, the victim precipitation theory and related vulnerability notions are often considered to hold the victim to a greater or smaller extent responsible for experiencing victimisation.

The explanation that is commonly given for blaming the victim to occur is that people tend to believe in a just world.[83] According to the just world theory,[84] people have a basic need to believe that the world is just, that good things happen to good people and bad things happen to bad people. This protects them from the idea that something bad could happen to them. As a response, they may believe that the victim has done something to deserve what happened to them, and therefore blame the victim. In addition, Hamby and Grych[85] describe the high premium on risk reduction in American culture, and probably also in other Western cultures. This comes with the idea that people have a responsibility to protect themselves: they should take (sometimes extreme) steps to stop or avoid their vulnerability to violence.

5.1 Victim Blaming in Theories and Empirical Studies about Workplace Violence

In the context of victimological theories and in particular the victim precipitation theory, the study of victims originated from the culture of the criminal law, focusing on degrees of innocence or blame for events.[86] In addition, as described, the original study of victim precipitation focused on physical force performed by the victim, previous to the crime.[87] Focusing on the innocence or blame, this theory was soon considered to blame the victim. Although there are explanations for why people blame victims, blaming the victim does not seem considered politically correct or socially acceptable, which is reflected in the legal system that tries to find and prosecute offenders and tries to compensate victims. This resulted in the *fear* of blaming the victim and tendency to avoid blaming the victim.[88]

The fear of blaming the victim may cause the concern among researchers and professionals that addressing potential victim characteristics in research will be considered victim blaming and will promote further victim blaming.[89] No other victimological theory than the victim precipitation theory has looked so explicitly to the role of victims in victimisation. Therefore, this theory has probably received the most criticism and has been considered as blaming the victim.

Regarding empirical studies, this fear of blaming the victim might result in less cooperation in studies, and less acceptance of results of studies about victim characteristics or interventions about preventing workplace violence, thereby lowering the effectiveness of studies and interventions. Possibly as a response to the discussion on blaming the victim, research often does not explicitly refer to the victim precipitation theory, even though describing the vulnerability of the victim.[90] Victim blaming could even be a reason not to study or communicate about (specific) victim characteristics, although it is difficult to determine to what extent this has occurred.

However, the theory and empirical studies do not explicitly attribute blame or state that the victim deliberately provoked victimisation. As Hambly and Grych state: 'Attribution of blame hinges on the intentionality of an action'.[91] Victims, and in this case professionals, may not have freely chosen the behaviour or psychological characteristics that might influence experiencing violence, and did not intend it to result in the victimisation.[92] Vulnerability notions and studies do provide important information: they suggest that victims may have vulnerable characteristics, and it also suggests that victimisation is an outcome that is influenced by offender-victim interaction. Victim characteristics may thus indirectly or unknowingly influence victimisation. And this is also addressed by other victimo-

82. K. Aquino, S. Douglas & M.J. Martinko, 'Overt Anger in Response to Victimization: Attributional Style and Organizational Norms as Moderators', 9 *Journal of Occupational Health Psychology* 152 (2004).
83. S. Hamby and J. Grych, 'The Complex Dynamics of Victimization: Understanding Differential Vulnerability without Blaming the Victim', in C.A. Cuevas and C.M. Rennison (eds.), *The Wiley Handbook on the Psychology of Violence* (2016). M. Stel, K. van den Bos & M. Bal, 'On Mimicry and the Psychology of the Belief in a Just World: Imitating the Behaviors of other Reduces the Blaming of Innocent Victims', 25 *Social Justice Research* 14 (2012).
84. M.J. Lerner, *The Belief in a Just World* (1980).
85. Hamby and Grych, above n. 83.
86. Goodey, above n. 58; H. von Hentig, *The Criminal & His Victim* (1948); B. Mendelsohn, 'A New Branch of Bio-Psychological Science: La Victimology', 10 *Revue Internationale de Criminologi et de police technique* 782 (1956).
87. Wolfgang, above n. 57.
88. O. Zur, 'Rethinking "Don't Blame the Victim": The Psychology of Victimhood', 4 *Journal of Couple Therapy* 15 (1995).
89. Hamby and Grych, above n. 83.
90. Finkelhor and Asdigian, above n. 56; Tillyer *et al*., above n. 43.
91. Hamby and Grych, above n. 83.
92. K.G. Shaver, *The Attribution of Blame, Causality, Responsibility, and Blameworthiness* (1985).

logical theories such as the criminal opportunity theories, which address congruence of a suitable target, lacking guardianship and a motivated offender.

More recently, researchers in workplace violence seem to increasingly study victim characteristics in external workplace violence, but always seem aware of the possibility that it may be perceived as blaming the victim, by addressing some sentences to this discussion.[93] Studying victim characteristics is important to find out which characteristics *protect* people from being victimised, even though being in risky situations at times. If we do not study what characteristics pose more risk, we will not know which characteristics pose less risk for victimisation. Therefore, by increasingly allowing victim characteristics to be studied, we gain more knowledge on how to prevent victimisation, for example by using this knowledge in training for professionals.

6 Discussion

In this paper, I have provided a theoretical framework for studying differences in external workplace violence. I proposed that researchers should take into account both situational and victim characteristics to gain a broader perspective on experiencing workplace violence. Situational characteristics could be characteristics of the work task, the work situation (including the type of people they deal with) or the organisation of professionals. In addition, research should take into account victim characteristics, which are briefly mentioned by criminal opportunity theories but are elaborated upon in the (further developments of the) victim precipitation theory. Whereas criminal opportunity theories focus on the presence of motivated offenders, being suitable and lacking guardianship in time and place (and socio-demographic that are indicators of this presence), the victim precipitation theory focuses, primarily, on being vulnerable because of psychological or behavioural characteristics.

The reviewed knowledge and gaps in the literature provide important directions for future research and practice. First, many studies that were described focus on either situational characteristics or victim characteristics. We would gain more knowledge about workplace violence and how to prevent it, if we take both perspectives into account. In addition to studying both types of characteristics, researchers should examine the interaction between individuals and situations, as, in general, the relationship between person and situation seems to be reciprocal and interdependent.[94] Police officers, fire fighters and emergency medical workers may each have unique personal characteristics because of self-selection (particular kinds of persons may be chosen for these jobs), selection processes at the organisation, training received or experiences at work. Therefore, the profession or the specific work conditions (situational characteristics) should be analysed in interaction with victim characteristics, to examine which characteristics may, independently of other characteristics, prevent violence in which situations or jobs. For example the possible differences between the three types of emergency responders should be addressed. The unique characteristics and work situations of these types of professionals may allow differences in relationships between characteristics and workplace violence, which have, to my knowledge, not been tested among emergency responders yet.

Second, although an increasing number of studies focus on victim characteristics, few have addressed victim characteristics in studies about emergency responders. It would be interesting to study which characteristics are indicators of external workplace violence experienced by emergency responders, and by which emergency responders. Therefore, future studies will need to test to what extent the known correlates of workplace violence in other populations, such as dominance, aggression and self-esteem, are indicators of workplace victimisation of emergency responders as well.

Third, as described, the design of most studies about workplace violence is cross-sectional, measuring characteristics and workplace violence at a certain point in time. Future studies should provide more information about how characteristics are related, for example if victim characteristics were present before victimisation or were developed after victimisation. As an experimental study is unethical in case of experiencing victimisation, one way of addressing the direction of relationships would be research using a longitudinal design, such as a cross-lagged panel design.[95] Victim characteristics and experienced external workplace violence would be measured during multiple time points (*e.g.* six or twelve months apart), and the relationship between characteristics and experienced victimisation would be analysed while taking into account characteristics and victimisation at the other point in time. In this way, we gain knowledge about the direction of relationships.

Lastly, regarding implications of addressed characteristics for the prevention of workplace violence, the criminal opportunity theories propose adjustments to the context of the workplace, and the victim precipitation theory proposes adjustments to the professional. It is important to bear our other goals in mind when considering these adjustments, especially in the context of emergency care. Besides preventing workplace violence, we also want society and people to be safe. Even though preventing workplace violence can have positive effects on professionals, organisations and the quality of work, it could have negative side effects. For example if emer-

93. *See e.g.* Muftic *et al.*, above n. 60.

94. P. Wilcox, C.J. Sullivan, S. Jones & J.-L. Van Gelder, 'Personality and Opportunity: An Integrated Approach to Offending and Victimization', 41 *Criminal Justice and Behavior* 880 (2014); R. Wortley, 'Exploring the Person-Situation Interaction in Situational Crime Prevention', in N. Tilley and G. Farrell (eds.), *The Reasoning Criminologist: Essays in Honour of Ronald V. Clarke* (2012) 184.

95. D.A. Kenny 'Cross-Lagged Panel Correlation: A Test for Spuriousness', 82 *Psychological Bulletin* 887 (1975).

gency responders do not have any contact with citizens or do not work at night, they will most likely not be victimised by citizens, as these were found to be strong correlates of workplace violence based on the criminal opportunity theories. However, in this way, safeguarding citizens is difficult, or even impossible. Characteristics based on the victim precipitation theory could be addressed by training or selection. For example whereas dominant behaviour was suggested to increase the likelihood of experiencing violence, this behaviour could also be necessary for certain work tasks, such as arresting citizens (for police officers). If so, lowering dominant behaviour by training may not always be wanted. We would thus have to think about these possible side effects and consider developing alternative interventions if we believe unwanted side effects will occur. Possible alternatives are working in larger groups of professionals or having police officers present at night. However, these alternatives do not directly address the correlates and therefore it is needed to first evaluate these types of interventions with regard to their effectiveness. Studying characteristics of the situation and victim provide insight into what type of interventions could be affective.

In addition to possible characteristics related to workplace violence against emergency responders, I addressed how studying characteristics of targets of workplace violence are sometimes interpreted as blaming the victim, which could have negative side effects such as less research and knowledge about workplace violence and how to prevent it. While in particular the victim precipitation theory is often considered to blame the victim, others have argued that professionals may not have freely chosen the behaviour or characteristics that might be 'attractive' nor intended it to result in victimisation. For emergency responders, the fear of blaming the victim may be even more present, as emergency responders are important for the safety of society. Being (perceived as) heroes of society and being sent to the front line, any possible disrespect such as 'trying to blame the professional' may be disapproved of even more than in other populations. In addition, tension between acting with the risk of inviting violence and spectating with the risk of not avoiding violence is maybe even more difficult for professionals responsible for safety. Therefore, professionals invested in reducing workplace violence against emergency responders should be even more aware of the possibility of being perceived as blaming the victim. Careful and respectful communication about the topic could be a solution.

Overall, this paper contributed to theory development about workplace violence against emergency responders and providing an explanation why addressing characteristics related to differences in workplace violence needed more research. More knowledge about possible risk factors is needed, specifically by longitudinal research addressing a combination of victim and situational characteristics, while looking at differences between police officers, fire fighters and emergency medical workers. In this way, knowledge on workplace violence will be gained and effective prevention strategies can be developed.

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The Right to Mental Health in the Digital Era

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Abstract

People with mental illness usually experience higher rates of disability and mortality. Often, health care systems do not adequately respond to the burden of mental disorders worldwide. The number of health care providers dealing with mental health care is insufficient in many countries. Equal access to necessary health services should be granted to mentally ill people without any discrimination. E-mental health is expected to enhance the quality of care as well as accessibility, availability and affordability of services. This paper examines under what conditions e-mental health can contribute to realising the right to health by using the availability, accessibility, acceptability and quality (AAAQ) framework that is developed by the Committee on Economic, Social and Cultural Rights. Research shows e-mental health facilitates dissemination of information, remote consultation and patient monitoring and might increase access to mental health care. Furthermore, patient participation might increase, and stigma and discrimination might be reduced by the use of e-mental health. However, e-mental health might not increase the access to health care for everyone, such as the digitally illiterate or those who do not have access to the Internet. The affordability of this service, when it is not covered by insurance, can be a barrier to access to this service. In addition, not all e-mental health services are acceptable and of good quality. Policy makers should adopt new legal policies to respond to the present and future developments of modern technologies in health, as well as e-Mental health. To analyse the impact of e-mental health on the right to health, additional research is necessary.

Keywords: E-health, e-mental health, right to health, right to mental health

1 Introduction

Mental illness, as a disease with high prevalence worldwide, has a very high impact on the experienced quality of life. Mental disorders are one of the main causes of disability, morbidity and premature mortality.[1] The rate of disability and mortality is disproportionately high among people with mental disorders in comparison with others. These diseases affect patients' physical health, which in turn might affect patients' mental health. The economic consequences of mental health losses are considerable, especially because of the large number of mentally ill people. They are often excluded and marginalised from society and live in a disadvantaged situation. They may also be subjected to neglect, physical and sexual abuse, harmful and degrading treatment, and unhygienic and inhuman living conditions in health facilities.[2] Their fundamental rights and freedoms, such as the right to the highest attainable standard of health, are often violated.

The right to the highest attainable standard of health is a fundamental human right (hereinafter the right to health), recognised in various international human rights treaties.[3] States are required to use the maximum amount of their resources to adopt the necessary means to realise people's right to health. In order to promote, realise and improve the right to access to (mental) health services, countries should adopt progressive legislation[4] to respond to the new developments of science and technology without discrimination. In recent decades, the use of the information and communications technology (ICT) in health care has significantly increased. Various international bodies, such as the European Commission and the World Health Organization (WHO) expect this health-related use of ICT to improve health and health care.[5]

E-health applied in mental health care is referred to as e-mental health. This intervention has the potential to increase access to mental health care because it facilitates remote treatment at any place and any time. Furthermore, e-mental health services can be anonymous, which can take away initial restraints to contact a health care professional. E-mental health provides people with the possibility to manage their mental health care pro-

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1. World Health Organization (hereinafter WHO), *Mental Health Action Plan 2013-2020* (2013), at 7, available at: <www.who.int/mental_health/publications/action_plan/en/> (last visited 6 June 2016).
2. WHO (2013), above n. 1, at 4.
3. Art. 12 International Covenant on Economic, Social and Cultural Rights (hereinafter ICESCR), 16 December 1966, 6 ILM 1967, at 360; Art. 25 Universal Declaration of Human Rights (hereinafter UDHR), GA. Res 217A (III), 10 December 1948; Art. 11 European Social Charter (Revised) (hereinafter RESC), 3 May 1996, ETS 163.
4. WHO, *Resource Book on Mental Health, Human Rights and Legislation. Stop Exclusion Dare to Care* (2005), at 1, available at: <http://ec.europa.eu/health/mental_health/docs/who_resource_book_en.pdf> (last visited 2 September 2016).
5. European Commission, *eHealth Action Plan 2012-2020 – Innovative Healthcare for the 21st Century*, 6 December 2012, 736 final (2012), at 4-5, available at: <https://ec.europa.eu/digital-single-market/en/news/ehealth-action-plan-2012-2020-innovative-healthcare-21st-century> (last visited 6 June 2016); WHO, *eHealth*, 7 April 2005, A58/21, at 2 (para. 7).

cess and leads them to take control of their own health.[6] Therefore, e-mental health is expected to decrease the number of people suffering from mental disorders.[7]

In spite of these promising expectations, questions related to e-mental health and the right to health can be raised. It is likely that not everyone can benefit from these developments. For instance it can be questioned whether e-mental health can be beneficial for the digitally illiterate. This paper will examine under what conditions e-mental health can contribute to realising the right to health by analysing its impact on the availability, accessibility, acceptability and quality of mental health services from a legal point of view by applying the AAAQ framework. This framework has been developed by the Committee on Economic, Social and Cultural Rights (CESCR).[8]

To carry out this analysis, an auxiliary multidisciplinary approach will be applied. Studies from other disciplines will partially be included. Where legal practice standards are not present, guidelines on medical ethics will be used. After an explanation of the right to health and the problems that people with mental disorders usually face in their enjoyment of this right (Section 2), the concepts of e-health in general and e-mental health in particular, together with the probable barriers they aim to resolve will be clarified (Section 3). Subsequently, a further analysis of the effects of e-mental health on the availability, accessibility, acceptability and quality of mental health services will follow (Section 4). In the conclusion part, issues regarding AAAQ, which should be considered in current and future e-mental health systems, will be addressed (Section 6).

2 The Right to the Highest Attainable Standard of Health

The Universal Declaration of Human Rights (UDHR) states that everyone is born with inherent dignity and equal in rights and entitled to the protection of his fundamental rights without discrimination of any kind.[9] The right to health is one of those fundamental rights, recognised in several international treaties and regulations. The UDHR refers to this right as the right to a standard of living adequate to the health and well-being of individuals and their family. This encompasses food, clothing, housing, medical care and necessary social services. Furthermore, it includes the right to social security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond the person's control.[10] In the European Social Charter (ESC)[11] and the Revised European Social Charter (RESC),[12] the right to health is formulated as the right to protection of health. The ESC and the RESC instruct State Parties to take away causes of ill health, to promote health education and individual responsibility for health, and to commit themselves for the control of diseases and accidents.[13]

The International Covenant on Economic, Social and Cultural Rights (ICESCR) encompasses the right to health as well. In this covenant, the right is formulated in Article 12 as the right to the enjoyment of the highest attainable standard of physical and mental health. This provision explicitly mentions that the right to health includes the right to mental health.[14] In order to be able to fully understand what the right to health entails, first, it is essential to know what is meant by 'health'. According to the WHO, 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.[15] Mental health, as an aspect of health, is 'a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community'.[16]

After clarifying the concept of health, the right to the highest attainable standard of health has to be interpreted. The Committee on Economic, Social and Cultural Rights (CESCR) provided an additional explanation on the right to health as laid down in Article 12 ICESCR in its General Comment No. 14. The right to health does not imply a right to be healthy.[17] Such a right cannot be realised by states because individual's biological and socio-economic preconditions also affect their health. Moreover, governments cannot protect people against all diseases. Rather, the right to health has to be interpreted as a 'right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health'.[18] Equal opportunity should be provided to everyone to enjoy this right without any discrimination.[19]

According to the CESCR, a State party should provide available, accessible and acceptable health facilities,

6. Mental Health Network, NHS Confederation, 'e-Mental Health: What's all the Fuss About?' *Discussion Paper* 2013:12, at 1, available at: <www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/E-mental-health.pdf> (last visited 6 June 2016).
7. Beyondblue, 'Improved Access – e-Mental Health Programs', *Information Paper* 2013, at 1, available at: <https://www.beyondblue.org.au/docs/default-source/policy-submissions/bw0161.pdf?sfvrsn=2> (last visited 6 Jun 2016).
8. UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, 11 August 2000, E/C.12/2000/4, para. 12.
9. Arts. 1 and 2 UDHR.
10. Art. 25 (1) UDHR.
11. European Social Charter (hereinafter ESC), 18 October 1961, ETS 35.
12. European Social Charter (Revised) (hereinafter RESC), 3 May 1996, ETS 163.
13. Art. 11 ESC; Art. 11 RESC.
14. Art.12 (1) ICESCR.
15. Preamble to the Constitution of the WHO, adopted by the International Health Conference, from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States, *Off. Rec. Wld Hlt Org., 2, 100*, entered into force on 7 April 1948.
16. WHO (2013), above n. 1, at 6.
17. Para. 8 General Comment No. 14 (CESCR).
18. Para. 9 General Comment No. 14 (CESCR).
19. Para. 8 General Comment No. 14 (CESCR).

goods and services of good quality in order to realise the right to health. These elements are complementary and interdependent. Thus, an adequate number of health services should be available, and these health services should be physically as well as economically accessible to everyone without discrimination. Accessibility includes the accessibility of information as well. Furthermore, health services should be both culturally and ethically acceptable, and the patients' confidentiality should be respected. Acceptable health services should aim to improve the health status of the persons involved. These available, accessible and acceptable health services should be of good quality, in other words they should be scientifically as well as medically appropriate.[20] These requirements are referred to as the AAAQ framework. Although General Comment No. 14, which introduces the AAAQ framework, is a so-called soft law instrument, it is seen as authoritative.[21] Furthermore, the implementation of AAAQ will depend on the level of development of a particular State party.[22] In realising the right to health, states have three kinds of obligations: they have to respect, protect and fulfil the right.[23] Because of scarcity of available resources, states are usually not able to realise economic, social and cultural rights within a limited amount of time. Article 2 ICESCR urges State parties to progressively realise the rights established in the covenant. In other words, they have to realise the rights over time, using the maximum of their available resources, although they are expected to realise minimum core obligations immediately.[24] They can also ask the international community for technical and financial help.[25] In addition, retrogressive actions are not allowed. When a State party takes measures that retrogressively affect a social, economic or cultural right in the ICESCR, the State violates that right.[26] The latter shows that in spite of the right to health being a social right and being not or hardly justiciable, it is not an 'empty shell'. On the contrary, the right to health includes several elements, such as the principle of non-discrimination, that, in fact, are justiciable.[27] Even though it might remain disputable whether the right to health is justiciable, this right is a fundamental human right. The extent of the enjoyment of this fundamental right affects the extent of enjoyment of other fundamental rights, such as the rights to food, work, housing and education.[28] Furthermore, the right to health is an inclusive right, which means that it not only includes the right to health care but the underlying determinants of health, such as access to clean drinking water, sufficient and safe food and shelter, healthy working conditions, a healthy environment and access to health-related information and education, as well.[29]

3 Mental Health Worldwide

According to the WHO, in 2001 about 450 million people worldwide suffered from a mental disorder. Nearly 10% of adults, females and males, rich and poor and in rural and urban settings have a mental disorder, and 25% will face a mental disorder in the future.[30] Furthermore, the WHO states that 'around 20% of the world's children and adolescents have mental disorders or problems'.[31] Despite the fact that the right to health explicitly includes mental health,[32] in many parts of the world, mental health services are not adequate and accessible. Between 76% - 85% of people with severe mental disorders in low- and middle-income countries and between 35% - 50% in high-income countries receive no mental health treatment.[33] National legislation frameworks, especially in developing countries, do not offer equality of access to health care services. Some countries lack legislation to safeguard and respect human rights of the mentally ill people. The fundamental aim of mental health legislation is to protect, promote and improve the life and mental well-being of citizens.[34] Often, people with mental disorders, who are categorised by the WHO as vulnerable,[35] face discrimination, stigma, social exclusion, isolation, economic and social burdens because of their disability or illness. Accessibility to mental health

20. Para. 12 General Comment No. 14 (CESCR).
21. *See*, for instance N.S. Rodley, 'The Role and Impact of Treaty Bodies', in D. Shelton (ed.), *The Oxford Handbook of International Human Rights Law* (2013) 621, at 639 as quoted by S. Michalowski and W. Martin, 'Research Note: The Legal Status of General Comments', MoJ/EAP UNCRPD Project (23 May 2014), available at: <http://autonomy.essex.ac.uk/wp-content/uploads/2014/07/Legal-status-of-General-Comments-.pdf> (last visited 6 June 2016).
22. Para. 12 General Comment No. 14 (CESCR).
23. Paras. 50-52 General Comment No. 14 (CESCR).
24. Art. 2 (1) ICESCR; UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 3: The Nature of States Parties' Obligations*, 23 January 1991, E/C.12/1990/3, at paras. 1, 2, 9 and 10.
25. Art. 2 (1) ICESCR.
26. Para. 48 General Comment No. 14 (CESCR).
27. Para. 1 General Comment No. 14 (CESCR). For a further statement on the justiciability of the right to health, *see* M. San Giorgi, *The Human Right to Equal Access to Health Care* (2012). In this dissertation, San Giorgi concludes that the right to health and several of its elements are justiciable.
28. Office of the United Nations High Commissioner for Human Rights and WHO, *The Right to Health, Factsheet No. 31* (2008), at 6, available at: <www.ohchr.org/Documents/Publications/Factsheet31.pdf> (last visited 6 June 2016); para. 1 General Comment No. 14 (CESCR).
29. Para. 11 General Comment No. 14 (CESCR).
30. WHO, *The World Health Report 2001. Mental Health: New Understanding, New Hope* (2001), at 3 and 19 as cited in WHO, *Improving Health Systems and Services for Mental Health* (2009), at 2, available at: <http://apps.who.int/iris/bitstream/10665/44219/1/9789241598774_eng.pdf> (last visited 31 August 2016).
31. WHO, *10 Facts on Mental Health*, Fact 1, available at: <www.who.int/features/factfiles/mental_health/en/>, updated August 2014 (last visited 28 June 2016).
32. Art. 12 (1) ICESCR.
33. WHO, *Global Burden of Mental Disorders and the Need for a Comprehensive, Coordinated Response from Health and Social Sectors at the Country Level*, EB130.R8, 130th session, Agenda item 6.2, 20 January 2012, at 2, available at: <http://apps.who.int/gb/ebwha/pdf_files/EB130/B130_R8-en.pdf> (last visited 6 June 2016).
34. WHO (2005), above n. 4, at 1.
35. According to the WHO (2013), above n. 1, at 6, the term 'vulnerable groups' refers to individuals or groups of individuals who become vulnerable by the situation and environment that they are exposed to, as opposed to any inherent weakness or lack of capacity. Whether a specific group is a vulnerable group, should be determined according to countries' national situation.

services in rural areas, particularly in developing countries, is poor because of the inappropriate infrastructure and financial burden.[36] Moreover, the geographic distribution of professionals such as psychiatrists, psychologists and general practitioners (GPs) is inequitable worldwide. Some of the mental health services are of poor quality, ineffective, unfunded or harmful. In other cases, mental health services are not or hardly covered by health insurance. Sometimes psychiatric hospitals detain people rather than helping them to recover and rehabilitate.[37] Human rights and freedoms of people with mental disorders are often violated, too.[38] The aforementioned factors make the access to mental health services a fragile issue.

According to the UN Convention on the Rights of Persons with Disabilities (UNCRPD), 'persons with disability include those who have long term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society in equal basis with others'.[39] Therefore, not everyone who has a mental disorder is disabled. In the UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities, mental disease is mentioned as a cause for disability.[40] Mental illness might cause a disability (temporarily or permanent)[41] that inhibits the person to fully participate in society. According to the WHO, 'disability is an umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors)'.[42]

To realise the right to mental health, people with mental disorders should have access to and benefit from necessary medical and social services that enable them to become independent, prevent further disabilities and support their social integration. Furthermore, to reach and maintain the optimum level of functioning and independence, they must be provided with rehabilitation services.[43] In addition to general health services, necessary health services for people with (mental) disabilities, such as early diagnosis and intervention, minimising and preventing further disabilities, should be provided. Health services and goods should be provided free or at a reasonable price. Furthermore, provision of health insurance for these people in a fair and reasonable manner is important.[44]

Apart from the ICESCR, several international and regional treaties, such as the International Covenant on Civil and Political Rights (ICCPR),[45] the Convention on the Rights of the Child (CRC)[46] and the UNCRPD, have defined rights for people with mental disorders. Furthermore, the UN has developed principles for the protection of persons with mental illness.[47] These rights and principles mostly relate to the prohibition of discrimination based on disability and the right to health, equally for everyone.[48] The CESCR states that governments are required to take all the measures, with the maximum use of their resources to enable these people to enjoy their rights equal to others and to overcome the disadvantages caused by their disability.[49] On the other hand, states should provide health services and centres as close as possible to these patients' communities, including rural areas.[50] More specifically, states are required to undertake or promote the development of goods, services, equipment and facilities, which are used worldwide, to meet the needs of people with disabilities. In this respect, states should use high technology to improve the standard and effectiveness of health services[51] and to promote access of people with disabilities[52] at an affordable cost.[53] ICT is increasingly applied in health care: This health-related use of technology is called e-health and is subject to many expectations. E-health might be able to help governments in realising the right to health of the mentally ill people.

4 The Concept and the Potential of E-Health and E-Mental Health

E-health is the use of ICT in health care. E-health and other forms of the use of ICT in health care, such as tel-

36. UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 5: Persons with disabilities*, 9 December 1994, E/1995/22, para. 8.
37. WHO, *Quality Rights Tool Kit. Assessing and Improving Quality and Human Rights in Mental Health and Social Care Facilities* (2012), at 4, available at: <www.who.int/mental_health/publications/QualityRights_toolkit/en/> (last visited 6 June 2016).
38. WHO (2005), above n. 4, at 1.
39. Art. 1(2) UN Convention on the Rights of Persons with Disabilities (hereinafter UNCRPD), GA. Res 61/106, 13 December 2006.
40. UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities, GA Res. 48/96, 20 December 1993.
41. Standard Rules on the Equalization of Opportunities for Persons with Disabilities, annexed to General Assembly resolution 48/96 of 20 December 1993 (Introduction, para. 17), as quoted in para. 3 General Comment No. 5 (CESCR).
42. WHO, *International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICDF-10), Volume 2, Instruction Manual* (2011), at 10, available at: <www.who.int/classifications/icd/en/> (last visited 6 June 2016).
43. Para. 5 General Comment No. 5 (CESCR).
44. Art. 25 UNCRPD.
45. International Covenant on Civil and Political Rights (hereinafter ICCPR), 16 December 1966, 6 ILM 1967, at 368.
46. Convention on the Rights of the Child (hereinafter CRC), GA Res. 44/25, 20 November 1989.
47. UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, GA Res. 46/119, 17 December 1991.
48. Such as Art. 26 ICCPR (non-discrimination); Art. 24 CRC (right to health for children); Art. 25 UNCRPD (right to health without any discrimination for persons with disabilities).
49. Para. 5 General Comment No. 5 (CESCR).
50. Office of the United Nations High Commissioner for Human Rights and WHO (2008), above n. 28, at 18; Art. 25 UNCRPD.
51. Rule 4 UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities, GA Res. 48/96, 4 March 1994.
52. Art. 9 UNCRPD.
53. Art. 4 UNCRPD.

emedicine, have existed for a longer period.[54] The emergence of the Internet in the 1990s accelerated the development and popularity of e-health.[55] The European Commission provided the following definition of e-health:

> eHealth is the use of ICT in health products, services and processes combined with organisational change in healthcare systems and new skills, in order to improve health of citizens, efficiency and productivity in healthcare delivery, and the economic and social value of health. E-health covers the interaction between patients and health-service providers, institution-to-institution transmission of data, or peer-to-peer communication between patients and/or health professionals.[56]

In this study, we adopt this definition of e-health because it not only provides an explanation of the concept of e-Health but also provides information on the purpose and goal of digital health care. One of the main purposes of e-health is to improve health care and to make delivery of health care services more efficient. An additional objective of e-health is to enhance the access to health care.[57] By using e-health, patients can have access to health care at any place, anytime and anywhere, even across borders and in remote areas. Real-time contact with a physician is possible as long as an ICT infrastructure is available. Communication between the patient and the physician can be synchronous as well as asynchronous. Furthermore, patients can employ the intervention on their own, without interference of medical professionals.[58] At the European level, the emerging use of e-health is highly supported in developing the European Union (EU)'s single (health) market through the freedom of movement[59] and the freedom to offer services.[60] Through different ICT technologies, users will be able to maintain the desired treatment and care throughout the EU.[61]

E-mental health is a subcategory of e-health related to the use of ICT in mental health care. A literature review conducted by Lal and Adair in 2014 shows that no consensus exists on the definitions or on the applications of e-mental health.[62] According to Riper *et al.*, e-mental health refers to:

> the use of information and communication technology (ICT) – in particular the many technologies related to the Internet – when these technologies are used to support and improve mental health conditions and mental health care, including care for people with substance use and comorbid disorders. E-mental health encompasses the use of digital technologies and new media for the delivery of screening, health promotion, prevention, early intervention, treatment, or relapse prevention as well as for improvement of health care delivery (such as electronic patient files), professional education (e-learning), and online research in the field of mental health.[63]

E-mental health can be offered through different services, using different devices. Examples include telemedicine and telerehabilitation, remote data-collection, telemonitoring, remote assessments, training and support of health personnel, and to share professional expertise.[64] E-mental health applications can differ from the provision of information to peer support services, online apps and games, or real-time communication between patients and health care professionals.[65] E-mental health, as a part of e-health, is changing and complementing the traditional and predominant model of face-to-face interaction between mental health professionals and service users.

E-mental health includes ICT applications, which facilitate treatment. Such applications offer patients the possibility to contact a health professional from a distance, or enable health professionals to discuss the situation of a patient over distance. Furthermore, ICT applications used by a patient without the interference of a health professional are a part of e-mental health. E-mental health in the broadest sense also includes online prevention and online public health information. As indicated earlier, the European Commission's definition of e-health distinguishes between different kinds of e-health applications. First, e-health applications that are used between patients and health professionals; secondly, e-health applications that are used to disseminate informa-

54. For an overview of early e-health utilisation, *see* C.A. Meier, M.C. Fitzgerald & J.M. Smith, 'eHealth: Extending, Enhancing, and Evolving Health Care', 15 *Annual Review of Biomedical Engineering* 359, at 369-74 (2013).
55. Meier *et al*., above n. 54, at 369; H. Oh, C. Rizo, M. Enkin & A. Jadad, 'What is eHealth? A Systematic Review of Published Definitions', 7 *Journal of Medical Internet Research*, at 374 (2005), available at: <www.ncbi.nlm.nih.gov/pmc/articles/PMC1550636/> (last visited 6 June 2016).
56. European Commission (2012), above n. 5, at 3.
57. Saliba, Legido-Quigley, Hallik, Aaviksoo, Car & McKee mention this in the case of telemedicine, a field under the umbrella term e-health: V. Saliba, H. Legido-Quigley, R. Hallik, A. Aaviksoo, J. Car & M. McKee, 'Telemedicine Across Borders: A Systematic Review of Factors that Hinder or Support Implementation', 81 *International Journal of Medical Informatics*, 793, at 795 (2012). Piette *et al*. also mention that e-health can solve access-related problems in J.D. Piette, K.C. Lun, L.A. Moura Jr, H.S.F. Fraser, P.N. Nechael, J. Powell & S.R. Khoja, 'Impacts of e-Health on the Outcomes of Care in Low- and Middle-Income Countries: Where Do We Go from Here?', 90 *Bulletin of the World Health Organization* 365, at 368 (2012).
58. For a list of examples, *see* S. Timmer, *eHealth in de praktijk. Handreiking voor iedereen die wil kennismaken of starten met eHealth* (2011), at 27-66.
59. Title IV, Chapter 1 Treaty on the Functioning of the European Union (hereinafter TFEU), OJ C 326/47.
60. Title IV, Chapter 3 TFEU.
61. P. Quinn, A.K. Habbig, E. Mantovani & P. De Hert, 'The Data Protection and Medical Device Frameworks – Obstacles to the Deployment of mHealth Across Europe?', 20 *European Journal of Health Law* 185, at 188 (2013).
62. S. Lal and C.E. Adair, 'e-Mental Health: A Rapid Review of the Literature', 65 *Psychiatric Services* 24 (2014).
63. H. Riper, G. Anderson, H. Christensen, P. Cuijpers, A. Lange & G. Eysenbach, 'Theme Issue on e-Mental Health: A Growing Field in Internet Research', 12 *Journal of Medical Internet Research* (2010).
64. WHO and World Bank, *World Report on Disability* (2011), at 118.
65. Beyondblue, above n. 7, at 1-2.

tion between health institutions; thirdly, e-health applications that enable patients to communicate with each other and, finally, e-health applications that facilitate communication between health professionals.[66] The same categorisation is reflected in the definition of e-mental health formulated by Riper et al.

Throughout this paper, two types of e-mental health and their relation with the right to health will be discussed. The first type concerns e-mental health used within the mental health care process. This type of e-mental health includes contact between a patient and a health care professional in the form of an online consultation and contact between two health professionals consulting each other about a patient's condition. Such consultations can be synchronous or asynchronous. The second type that will be considered in this paper is e-mental health with the aim of prevention, such as online mental health information. Other types of e-(mental) health, such as electronic patient records or mobile health applications, which are used without the involvement of a mental health professional (m-mental health), fall outside the scope of this paper. E-mental health is often provided as a supplement to the existing mental health services, through universal design[67] of services. The use of e-mental health services in combination with regular mental health services is referred to as blended care.[68] In this way, e-mental health can be used to ensure the full participation and integration of people with mental health problems. In summary, e-mental health does not aim to replace the regular mental health services; in underserved areas with a shortage of mental health professionals, it can be the only opportunity to access mental health service. This difference will be taken into account throughout the paper.

E-mental health has the potential to increase the access to mental health care because it facilitates remote treatment at any place and any time. Furthermore, e-mental health services can be anonymous, which can take away the initial restraints to contact a health care professional. GPs and health workers can use e-mental health in offering and improving (mental) health services in the community. E-mental health provides people with the possibility to manage their mental health care process and leads them to take the control of their own health.[69] Preventing a mental illness (relapse) through e-mental health is cost-effective compared with the total costs of treatment in a psychiatric hospital, community-based treatment or a rehabilitation centre. However, empirical studies are needed to show whether e-mental health services are cost-effective and how their efficiency in practice should be improved. E-mental health aims to improve access of certain disadvantaged groups such as the homeless, adolescents, elderly people, people with disabilities, ethnic minorities, indigenous groups, drug abusers, prisoners and women, especially housewives and violated women to mental health services. Moreover, different services offered by e-mental health contribute to reduce both public and self-stigma and to build self-confidence in people with mental disorders.

Nevertheless, not everyone has equal opportunities to use e-mental health services worldwide. The economic development of a country plays a crucial role in the implementation of these services. Not all countries can afford the same level of implementation of ICT. However, they are obliged to remove the barriers and obstacles for implementing ICT and to include ICT in their domestic legislative framework for people with (mental) disabilities.[70] In this regard, normative frameworks, such as e-mental health policies, strategies, ethical codes and guidelines, are needed. These normative frameworks should include issues related to privacy, e-consent, liability, data protection and confidentiality. Even within countries, some e-mental health services are more developed than others, because of priorities of the government. Other barriers in access to e-mental health might be language, low education, low income, physical impairments, poor health, literacy, cultural intolerance, public stigma and self-stigma, and poor training of health professional in e-mental health issues. These all might cause a digital divide and create a treatment gap in the accessibility of e-mental health services.

In summary, e-mental has the potential to make a positive contribution to realising the right to health. In the following part of this study, the impact of e-mental health on the availability, accessibility, acceptability and quality mental health services will be analysed from a legal point view.

5 Effects of E-Mental Health on the Right to Health

5.1 Availability

Availability of health facilities, goods and services in sufficient quantity within a country's jurisdiction is an essential part of the realisation of right to health.[71] One of the steps that countries should take in order to realise the right to health is to assure that medical services are provided when they are necessary.[72] The distribution of skilled human resources for mental health is highly inequitable worldwide. Especially low- and middle-income countries suffer from shortages of psychologists, psychiatrists, psychiatric nurses and social workers.

66. European Commission (2012), above n. 5, at 3.
67. Art. 2, Definitions (UNCRPD) 'Universal design means the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design. Universal design should include assistive devices and technologies for people with mental disabilities without discrimination'.
68. R.M.F. Kenter, P.M. van de Ven, P. Cuijpers, G. Koole, S. Niamat, R.S. Gerrits, M. Willems & A. van Straten, 'Costs and Effects of Internet Cognitive Behavioral Treatment Blended with Face-to-Face Treatment: Results from a Naturalistic Study', 2 *Internet Interventions* 77, at 78 (2015).
69. Mental Health Network, NHS Confederation, above n. 6, at 1.
70. Paras. 27-28 General Comment No. 2 (CRPD).
71. Para. 12(a) General comment No. 14 (CESCR).
72. Art. 12(2) ESCR.

This is one of the main reasons for the limited availability of mental health care in those countries.[73]

The primary aim of establishment of mental health services from a distance has been to increase the availability in areas with a limited number of mental health professionals.[74] Because of the possibility to rapidly deliver health information, e-mental health can assist to and provide a variety of different treatments and services.[75] E-mental health makes mental health care available at any place and any time. For example a person with mental health disorder can contact his or her psychiatrist through online consultation while he or she is in another country for holidays. It is even stated that- e-mental health services can find its users without the users having to search for them. A study gives an example where googling about suicide will lead you to the contact information of a mental health charity.[76] Furthermore, e-mental health has the potential to increase the availability of trained medical personnel, it might contribute to a more efficient delivery of care. For instance, medical professionals from Germany can assist health professionals in Romania, over distance through the Internet. In addition, e-mental health supports cross-border health care,[77] which might resolve the shortage of health care professionals, as patients are not dependent on the availability of mental health services in their region anymore.[78] By using e-mental health, patients can easily contact a health professional in another region. Mental health rules and programmes suggested that community workers in primary care should receive training in detecting mental health problems at an early stage and refer patients to the right specialist.[79] E-mental health can facilitate the community workers' network for communication between patients and specialists.

In summary, e-mental health seems to be able to make a positive contribution to the availability of mental health services. However, e-mental health cannot always lead to the availability of health services in the case of emergencies. This might be difficult when health care is provided over distance. The International Society for Mental Health Online (ISMHO) and the Psychiatric Society for Informatics (PSI) considered this in their suggested Principles of Professional Ethics for the Online Provision of Mental Health Services.[80] In these principles, it is stated that the patient has to be informed of a way to reach the professional in an emergency. In the case of e-mental health care over a large geographical distance, a local professional should be available when an emergency occurs. The mental health care professional should try to find the local professional's contact information. This local professional should be a professional who already knows the patient's medical history, such as the patient's GP.[81] Furthermore, the interoperability of e-health systems is a complicating factor for the availability of health care across borders.[82] Interoperability between various e-health systems should be realised to increase the availability of care.[83] In cross-border e-mental health care, language can be a barrier as well.

Another issue related to the availability of mental health care is the availability of the ICT itself. Not all countries in the world have the same level of ICT infrastructure. This is called the digital divide. A digital divide can exist both between and within countries. It is imaginable that, for some countries, it is hard or even impossible to provide an ICT infrastructure to carry out e-mental health, whereas others already have a functioning ICT infrastructure. The number of people who have access to the Internet also differs per country. For example poor countries, such as Eritrea and Ethiopia, cannot have the same level of e-mental health, as the Netherlands. Poor countries might have other emergent issues than e-mental health, but under international obligations, they are also required to take measures gradually in realising the right to health.[84] These poor countries have the possibility to seek technical and financial support from the international community.[85]

Similarly, a digital divide within countries can exist between certain groups in society, such as the elderly and the young or between people in different areas of the country.[86] A digital divide can also be induced by economic or knowledge barriers within a country.[87] It would be more cost-effective to consider the availability and accessibility of ICT from the early stages of universal design of mental health services.[88] Finally, because of

73. WHO, *10 Facts on Mental Health*, Fact 8, available at: <www.who.int/features/factfiles/mental_health/en/>, updated August 2014 (last visited 29 June 2016).
74. D. Lambert, J. Gale, A.Y. Hansen, Z. Croll & D. Hartley, 'Telemental Health in Today's Rural Health System', *Research & Policy Brief* (2013), at 4.
75. H. Christensen, K.M. Griffiths & K. Evans, 'e-Mental health in Australia: Implications of the Internet and Related Technologies for Policy', *Centre for Mental Health Research, The Australian National University, Information Strategy Committee Discussion Paper* 2002:3, at 4-5.
76. P. Wicks, 'E-mental health: A medium reaches maturity', 4 *Journal of Mental Health* 323, at 333 (2012).
77. Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare, OJ 2011 L 88/45.
78. European Commission, *Green Paper on Mobile Health ('mHealth')*, COM (2014) 219 final, 10 April 2014, at 13.
79. Rule 2(2) UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities, GA Res. 48/96, 4 March 1994; WHO, *Integrating Mental Health Services into Primary Health Care*, information sheet, at 1 and 2, available at: <www.who.int/mental_health/policy/services/3_MHintoPHC_Infosheet.pdf?ua=1> (last visited 21 October 2015).
80. ISMHO/PSI Suggested Principles of Professional Ethics for the Online Provision of Mental Health Services, version 3.15.psi, 9/13/00.
81. *Ibid*., section C.
82. A.V. Gaddi and F. Capello, 'The Debate Over eHealth', in A.V. Gaddi, F. Capello & M. Manca (eds.), *eHealth, Care and Quality of Life* (2014) 1, at 6.
83. European Commission (2012), above n. 5, at 6.
84. Art. 2(1) ICESCR and UNCRPD.
85. Art. 2(1) ICESCR.
86. International Telecommunication Union, *What is the Digital Divide?* Available at: <https://www.itu.int/net/wsis/basic/faqs_answer.asp?lang=en&faq_id=43> (last visited 21 October 2015); International Telecommunication Union, *Measuring the Information Society Report 2014* (2014), at 55; International Telecommunication Union, *World Information Society Report 2007* (2007), at 21.
87. *Ibid*.
88. Paras. 15 and 35 General Comment No. 2 (CRPD).

the digital divide, implementing e-mental health might be too costly or at least financially unattractive for less developed countries. If ICT is not included in the health care system from the beginning, additional costs to adopt the existing services and to access e-mental health are necessary.[89]

5.2 Accessibility

To realise the right to (mental) health, equal and timely access to preventive, curative, and rehabilitative health services, education and essential drugs should be provided.[90] This is preferably provided at the community level, as the process of treatment of people with mental problems, which includes recovery, rehabilitation and integration, is long. Providing rehabilitation services in local communities offers the opportunity for family to participate in the process of integrating the patient in the society.[91]

At first sight, e-mental health interventions seem to be able to break down barriers in the access to health care. Accessible health services include four preconditions: non-discrimination, physical accessibility, economic accessibility (often referred to as affordability) and information accessibility. E-mental health affects all these dimensions.

5.2.1 Non-Discrimination

First, in order to be accessible, health services should be free of discrimination. Nevertheless, misunderstanding, stigma and discrimination towards mental illness are widespread and remain important barriers to access mental health services. To prevent facing discrimination and misunderstanding, people with mental disorders might be unwilling to seek health services.[92] Through e-mental health, people who were excluded from treatment previously can gain access to mental health care. A study has shown that a web-based cognitive behavioural intervention for bulimia nervosa was perceived as accessible by its participants. The anonymity, the ease and the non-judgemental character of these services were perceived as an advantage.[93] E-mental health might thus be beneficial for the more sensitive subjects or for those that evoke a feeling of fear or shame and discrimination.

Furthermore, e-mental health aims to meet the needs of people who have restricted access or no access to mental health services at all, such as the homeless, adolescents, elderly people, people with disabilities, ethnic minorities, indigenous groups, drug abusers, prisoners and women, especially stay-at-home mothers, violated women and unemployed women. Cultural differences, the stigma and the shame of having a mental problem or disability may hinder them from seeking treatment and having access to health care. Furthermore, medical professionals do not always treat people with mental diseases with respect, and sometimes they neglect the rights of these people as patients.[94]

Through e-mental health, public stigma and self-stigma will be reduced. Both public and self-stigma are characterised by the same elements, such as stereotypes, attitudes or prejudice, and avoidant behaviour or discrimination. All these elements have an impact on seeking and receiving the formal and informal mental health services. People with mental health disorders will be less afraid of stereotypes, prejudice and discrimination while using e-mental health services. For example online consultation is offered to everyone; mental health professionals cannot see what nationality, age, sex or which minority group a person who is asking for help belongs to. On the other hand, online consultations will also contribute to reduced self-stigma. Therefore, people with mental disorders who belong to one of the aforementioned groups will not be afraid and ashamed of asking the appropriate help in the right time and they can do so at any place. However, this will depend on different e-mental health services chosen by a person with a mental disorder. For example a Roma mentally ill person will not feel discriminated if he or she is chatting with a health professional online. Because he or she does not feel discriminated, he or she is more likely to ask for help in the right time.

Consequently, e-mental health has the potential to decrease patients' unpleasant feeling about the services and the behaviour of professionals, although such feelings might not be eliminated altogether. Continuous education of professionals about the rights of these patients and the way to treat them online with respect must be added to the system.

Analysing the effects of e-mental health on accessibility, it seems that e-mental health is able to increase the access to mental health care for everyone without discrimination. However, this service can lead to new discrimination issues itself. Generally, e-health applications have to be accessible to all, and therefore, e-health applications and websites should be developed to be understandable for everyone, taking into account the users' physical, sensory, intellectual and communicational capabilities.[95] Possible challenges for the digitally illiterate have to be considered as well. This group does not know how to use technology or is not capable to do so. A study showed that this can be solved by adjusting the technology to these users. The capabilities of these patients have to be taken into account when e-health applications are developed. In the aforementioned study, patients started to use the technology when it was

89. Para. 15 General Comment No. 2 (CRPD).
90. Para. 17 General Comment No. 14 (CESCR).
91. Rule 2(3) UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities, GA Res. 48/96, 4 March 1994.
92. WHO, *Mental Health and Human Rights: Fact Sheet* (2006), at 6.
93. N. Pretorius, L. Rowlands, S. Ringwood & U. Schmidt, 'Young People's Perceptions of and Reasons for Accessing a Web-based Cognitive Behavioral Intervention for Bulimia Nervosa', 18 *European Eating Disorders Review*, at 205 (2010).
94. Office of the United Nations High Commissioner for Human Rights and WHO (2008), above n. 28, at 16.
95. S.G. Cunningham, D.J. Wake, A. Waller & A.D. Morris, 'Definitions of eHealth', in A.V. Gaddi, F. Capello & M. Manca (eds.), *eHealth, Care and Quality of Life* (2014) 15, at 20-21.

designed to meet their specific needs.[96] Another group that risks to be discriminated is the group of people who are self-excluded from technology. The digitally self-excluded are not interested in using modern technologies and thus exclude themselves from the use of digital health services. Health care, however, is increasingly digitalised. When no measures are taken to involve this group, they will eventually be digitally as well as socially excluded.[97]

5.2.2 Physical Accessibility

To solve the problem of shortage of mental health professionals, mental health programmes suggested that mental health services can be introduced into primary health care centres within communities.[98] In this system, e-mental health provides the network for communication between community workers, specialists and patients.

E-mental health increases the accessibility of mental health services because it provides the opportunity to contact a health care professional at any time and anywhere. Patients can contact a mental health professional from their house, on request, which is designed to meet their specific needs.[99] E-mental health can increase access to health care for certain groups who experience difficulties to travel to a mental health care facility, such as adults with serious mental illnesses, children and the elderly.[100] It will probably lead to shorter waiting lists[101] and a decreased travel time for visiting a specialist. Furthermore, e-mental health decreases the geographic limitations of the workforce, especially in rural or remote areas. A general access-related advantage of e-mental health is that it makes geographical borders non-existent. At the EU level, e-health can facilitate the free movement of people to receive health care. However, the access to health care cannot increase if health professionals and patients do not understand each other. Cross-border e-mental health can also lead to new issues, such as a language barrier. On the other hand, e-health applications provided in only one language can be a problem within a (multilingual) country too[102] but it is thinkable that a language barrier will mostly be a hurdle to access to cross-border care. Through online consultations, health professionals residing oversees might contribute to improve access to mental health for patients of their country of origin and thus help resolving the shortage of mental health professionals in that particular country. By e-mental health, consultations over distance can take place between both patients and health professionals and among health professionals. According to the UNCRPD, Member States are obligated to support each other in realisation and implementation of the Conventions' provisions by 'facilitating access to and sharing of accessible and assistive technologies, and through transfer of technologies' through international cooperation.[103]

Physical accessibility of mental health services has shown to be better in urban rather than in remote areas, but this is not always true. Difficulties in accessing mental health services in urban areas are related to complex urbanisation, overcrowded areas, and more sophisticated and expensive ICTs. For this reason, e-mental health tends to reduce the inequalities and to ensure the accessibility of mental health services, no matter where the person lives. It is the duty of State parties to elaborate comprehensive and individualised supportive assistance, taking into account the age difference and diversity of people with mental disorders.[104] Therefore, for people with severe mental illness living in remote areas, e-mental health would help remove the above-mentioned barriers and improve access to mental health care. This should contribute to improving the universal design of mental health care, providing appropriate support services and reasonable accommodation according to the needs of people with mental disorders. For example, e-mental health enables an adult with schizophrenia, who lives in a remote area and cannot go to the city hospital because of his or her severe conditions, to consult his or her psychiatrist online. It is the psychiatrists' duty to call the GP of that remote area in order to offer the appropriate mental health care together.

5.2.3 Affordability

Little is known about the cost-effectiveness of e-mental health. This should be measured according to different interventions and diseases. Furthermore, it depends on the severity of mental illness, whether a person has more than one illness and the type of intervention that is required. A study in Sweden, Australia and the UK showed e-mental health is cost-effective.[105] A study conducted in the Netherlands showed that e-mental health has been cost-effective for the treatment of dif-

96. L. Lind and D. Karlsson, 'Telehealth for "the Digital Illiterate" – Elderly Heart Failure Patient's Experiences', in C. Lovis, B. Séroussi, A. Hasman, L. Pape-Haugaard, O. Saka & S.K. Andersen (eds.), *e-Health – For Continuity of Care: Proceedings of MIE2014* (2014), at 353.
97. M. Zajicek, 'Web 2.0: Hype or Happiness?', *W4A '07 Proceedings of the 2007 International Cross-Disciplinary Conference on Web Accessibility (W4A)* (2007), 35; G.W. Coleman, L. Gibson, V.L. Hanson, A. Bobrowicz & A. McKay, 'Engaging the Disengaged: How Do We Design Technology for Digitally Excluded Older Adults?', *Proceedings of the 8th ACM Conference on Designing Interactive Systems* (2010) 175, at 176.
98. Rule 2, UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities, GA Res. 48/96, 4 March 1994.
99. K.M. Myers and D. Lieberman, 'Telemental Health: Responding to Mandates for Reform in Primary Healthcare', 19 *Telemedicine and e-Health* 438, at 440 (2013).
100. A. H. Smith, and A. R. Allison, *Telemental Health: Delivering Mental Health Care at a Distance: A Summary Report*, (Unpublished Summary Report) U.S. Department of Health and Human Services, Office for the Advancement of Telehealth (1998), at 21.
101. K. Cavanagh and D. Shapiro, 'Computer Treatment for Common Mental Health Problems', 60 *Journal of Clinical Psychology* 239, at 247 (2004).
102. Cunningham *et al*., above n. 95, at 26.
103. Art. 32 (1) UNCRPD.
104. *See e.g.* UNCRPD, *General Comment no, 2: Article 9: Accessibility*, 22 May 2014, paras. 13-26.
105. H. Riper and J.H. Smit, *eMental-Health in Europe, Accelerating Implementation of Evidence Based Treatments for Mental Disorders*, available at: <www.triple-ehealth.nl/wp-content/uploads/2014/10/2014_09_23-ggz-e-compered.pdf> (last visited 6 June 2016).

ferent mental diseases such as depression and anxiety.[106] Another study indicates that even when the costs of implementing ICT are taken into account, the costs of this service are lower than the costs of usual mental health services.[107] Furthermore, by utilising e-mental health, the costs of health care become lower, which in turn enhances the financial viability of the community hospital or clinic. Furthermore, early prevention and treatment can prevent the costs of treatment of a disease in an advanced stage.

Although different countries worldwide have embraced the use of e-mental health into mental health services, in a broader perspective, not all countries can afford to apply e-mental health strategies, because of the high costs of deployment and maintenance. Some countries are still in the first steps of embracing these interventions into their health care services, or cannot afford its implementation yet because of their financial situation.

Inadequate financial reimbursement of these services can be a barrier to access to mental health services as well. When states do not provide reimbursement, people who cannot afford e-mental health care will be excluded.[108] Provision of health insurance in a fair and reasonable manner for disabled people including the mentally ill[109] can be regarded as a precondition for increasing the access to mental health services. Within the EU regulations for reimbursement of cross-border health care exist. Based on Article 7 of the Directive on the application of patients' rights in cross-border healthcare (EU Patient Mobility Directive) which is applicable to telemedicine, the costs of health care across borders have to be reimbursed when it is covered by the Member State where the health service user resides.[110] Whenever an e-mental health treatment is covered within a certain Member State, e-mental health received in another Member State through cross-border care can be reimbursed as well. However, not all countries offer their citizens the possibility of reimbursement of digital health care. In the United States, for example, difference in the reimbursement of telemedicine services exists between the states.[111] In the Netherlands, it is considered to reimburse anonymous e-mental health services too.[112] This service will be paid from public funds.[113]

5.2.4 Information Accessibility

According to the WHO, every mental health system should have a mental health information system (MHIS). The MHIS is 'a system for collecting, processing, analyzing, disseminating, and using information about a mental health service and the mental health needs of the population it serves'.[114] E-mental health can assist in the process of gathering information in the MHIS.

E-mental health facilitates dissemination of information at any time and can be used for health promotion, prevention of mental illness and to increase the awareness regarding mental health through online campaigns on mental health issues. Furthermore, this system can be used for education of both the population[115] and professionals about mental illness.[116] A better understanding of mental illness helps in better integration of patients and decreases the stigma towards people with mental disorders.[117] Easy and early access to information can help patients address their problems in an early stage of disease. In addition, information about mental health professionals can be accessed online, which can help the patient in choosing his or her health care provider.[118]

On the other hand, increased access to information might lead to increased access to misinformation as well.[119] Furthermore, it might lead to unrealistic expectations or be potentially harmful when the patient, based on incorrect information, does not seek appropriate assistance for his or her health problems. Other concerns are health information that leads to commercial surveys, as well as information that disturbs the relationship of trust between patients and health care providers.[120] Therefore, mental health professionals and patients together should interpret the online information obtained by patients.[121]

Another potential challenge of online mental health information is posed by websites 'pro' certain illness, such as pro-anorexia and pro self-harm websites. These websites can contribute to deteriorating the patient's condition and may lead to (additional) damage.[122] Partly, this can be prevented by providing quality marks to certain websites that can inform the patient whether the website is supported or approved by health professionals. In the Netherlands, for example, <www.thuisarts.nl> is a website initiated by the *Nederlands Huisartsen Genootschap* [Dutch College of General Practitioners] (NHG) that contains health information and links to additional information.[123] In the UK, health information is already subject to the Information Standard, a certification programme of the National Health Services (NHS) that provides certificates to organisations producing evidence-based health care information for the

106. GGZ Nederland, *e-Mental Health in the Netherlands, Factsheet e-Mental Health*, available at: <www.ggznederland.nl/uploads/assets/Factsheet%20e-mental%20health%20in%20the%20Netherlands%20def.pdf> (last visited 6 June 2016).
107. Cavanagh and Shapiro, above n. 101, at 243-45.
108. Christensen *et al.*, above n. 75 at 4-7.
109. Art. 25, UNCRPD.
110. Art. 3 (d) Directive 2011/24/EU.
111. L. Thomas and G. Capistrant, *50 State Telemedicine Gaps Analysis. Coverage & Reimbursement*, American Telemedicine Association (2015).
112. *Kamerstukken II* 2012/13, 33675, n. 3 at 1.
113. *Ibid.*, at 7.
114. WHO (2001), above n. 30, at 42.
115. Cavanagh and Shapiro, above n. 101, at 247.
116. Myers and Lieberman, above n. 99, at 439.
117. Smith and Allison, above n. 100, at 8 and 10-12.
118. Mental Health Network, NHS Confederation, above n. 6, at 2.
119. Myers and Lieberman, above n. 99, at 442 and Gaddi and Capello, above n. 82, at 8.
120. Gaddi and Capello, above n. 82, at 8.
121. Myers and Lieberman, above n. 99, at 442.
122. Mental Health Network, NHS Confederation, above n. 6, at 3.
123. *See* <https://www.thuisarts.nl/> (in Dutch) (last visited 22 October 2015).

public.[124] Its website encompasses a list of certified organisations.[125] The Royal College of Psychiatrists is such an organisation; it provides evidence-based information on mental health on its website.[126]

In summary, E-mental health can increase the information accessibility with the condition that people know where to find appropriate and reliable information.[127] People who do not have adequate information about the e-mental health system will not have access to this type of mental health care.[128]

5.3 Acceptability

The third element necessary to realise the right to health is acceptability. According to General Comment No. 14, acceptability implies that health services should respect medical ethics, be culturally appropriate and should improve the health status of those concerned.[129]

5.3.1 Ethical Issues

First, in order to be acceptable, e-mental health services should respect medical ethics. According to the UNCRPD, and the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles), people with mental disorders should be treated with humanity and respect to their dignity.[130]

Several codes can be helpful in assessing how e-mental health can respect medical ethics, such as the International Code of Medical Ethics by the World Medical Association (WMA). This international code imposes several duties on physicians.[131] Examples are the duty to maintain the highest standards of professional conduct, to accept the patient's right to give consent to treatment or to decline it, the duty to respect human dignity, the prohibition to refer patients or to prescribe certain products merely for financial gain, and the duty to act in the patient's best interests when providing health care.[132] When a patient does not accept the use of e-mental health, face-to-face care should be provided instead. If, however, a patient does give his or her consent, the e-mental health care provider should respect the patient's dignity. The prohibition to refer patients or to prescribe certain products solely for financial gain entails that health professionals cannot prescribe or advise the use of medical apps or other e-mental health applications because they have a financial interest in these applications. Decisions to utilise such interventions should rely on the question of whether the use of such applications is the best treatment for a particular patient. Whether the use of e-mental health is in the patient's best interest has to be judged by the physician on a case-by-case basis, depending on the patient's health situation.

On the other hand, it is imaginable that a need for personal contact and long conversations is inherent to the nature of some illness. For those patients, regular, face-to-face care might be more beneficial. However, e-mental health might still function as a supplement to the care for these patients. E-mental health will help the mental health care services being more inclusive and comprehensive. It will also help in promoting participation and integration of people with mental illness into the society. In this way, e-mental health should be considered as an addition to existing mental health services (blended care). This additional service intends to improve mental health care and public health. Therefore, blended care will be an appropriate method to offer the necessary care in time, in place and with the right health care professionals. Moreover, an emergency can be easily managed if it is identified on time. Through blended care, a person with a mental disorder can obtain a tailored treatment plan according to his or her needs.

The number of people who need face-to-face contact differs per country, community and group. Probably patients with severe mental diseases need face-to-face contact with the professional. It is estimated that about 5% of the working-age workers have severe mental illness.[133]

In addition, in order to ensure all these ethical implications of e-mental health, the ISMHO, in collaboration with the PSI, suggested principles of professional ethics, especially for online mental care.[134] These principles include informed consent, procedural standards and emergencies. Informed consent is a human right of significance for people with mental health problems in receiving health care including e-mental health care. According to the principle of informed consent, a medical treatment can be started only after the patient's explicit consent. Consent can be given only after receiving adequate information. The right to informed con-

124. *See* <www.england.nhs.uk/tis/about/the-info-standard/> (last visited 22 October 2015).
125. *See* <www.england.nhs.uk/tis/our-members/certified-organisations/> (last visited 22 October 2015).
126. *See* <www.rcpsych.ac.uk/> (last visited 22 October 2015).
127. Cunningham *et al*., above n. 95, at 21.
128. Christensen *et al.*, above n. 75, at 4-7.
129. Para. 12(c) General Comment No. 14 (CESCR).
130. Art. 3 (a) UNCRPD and Principle 1, UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, GA RES. 46/119, 17 December 1991.
131. International Code of Medical Ethics, Adopted by the 3rd General Assembly of the World Medical Association, London, England, October 1949 and amended by the 22nd World Medical Assembly Sydney, Australia, August 1968 and the 35th World Medical Assembly Venice, Italy, October 1983 and the WMA General Assembly, Pilanesberg, South Africa, October 2006.
132. In this place we provide a few examples of what this code implies for e-mental health. This is not an exhaustive or complete enumeration of the duties imposed by this code. International Code of Medical Ethics, Adopted by the 3rd General Assembly of the World Medical Association, London, England, October 1949 and amended by the 22nd World Medical Assembly Sydney, Australia, August 1968 and the 35th World Medical Assembly Venice, Italy, October 1983 and the WMA General Assembly, Pilanesberg, South Africa, October 2006.
133. OECD, *Focus on Health, Making Mental Health Count*, July 2014, available at: <https://www.oecd.org/els/health-systems/Focus-on-Health-Making-Mental-Health-Count.pdf>, at, 1. (last visited 6 June 2016).
134. ISMHO/PSI Suggested Principles of Professional Ethics for the Online Provision of Mental Health Services, version 3.15.psi, 9/13/00.

sent also includes the right to refuse treatment.[135] In the digital era, the 'electronic consent' or 'e-consent' deals with managing and administering integrated health care information by different stakeholders in the health care decision-making process.[136] Through the e-consent system, service users determine and agree with whom they will share their personal health information. It is essential that e-mental health services provide enough information and enable the patient to give consent. The methods of providing information and giving consent should be as user-friendly as possible.[137]

The Recommendation on the Protection of Medical Data indicates that e-consent concerning medical data should be free, express and informed.[138] The person with a mental disorder should give his or her consent written or orally, or by recording his or her consent after a clear and informed explanation. This information should be understandable for the person concerned.[139] People with mental disorders are free to refuse, to withdraw or to modify their e-consent, as long as they understand the information and the consequences. During emergencies, medical data might be processed or collected without the consent of mentally ill people only for treatment purposes. Other situations where medical data might be collected or processed without e-consent is in the case of public health interest, the prevention of a real danger or the suppression of a specific criminal offence, or other public interest.[140] Furthermore, medical data can be collected and processed for preventive, diagnostic or therapeutic purposes in order to protect the interest of a person with a mental disorder or to protect the fundamental rights of others.

In order to be able to give consent to be treated, legal capacity is required. If a person with mental disorder lacks legal capacity, his or her legal representative or an authoritative body established by a domestic court might also give e-consent.[141] Based on Article 12 of UNCRPD, everyone in principle has legal capacity on equal basis.[142] According to the WHO, mental illness does not necessarily entail incapacity. In principle, everyone possesses capacity, until evidence to the contrary is found. Whenever an individual's legal capacity is subject to doubt, the physician is responsible for determining whether this individual has the capacity to give his or her informed consent. Capacity should be determined again in every new situation.[143] For a health professional, assessing someone's capacity to make decisions about his or her health care process is difficult, especially online and over distance. The use of online follow-up questions to help assessing someone's capacity to make decisions might assist in this matter. However, it will remain difficult to determine the legal capacity over distance.

The principles by ISMHO and PSI also suggest that additional measures should be taken to protect the patients who are not able to give consent themselves.[144] The suggested principles state that, besides the usual components of informed consent, such as information about the proposed treatment, the alternatives and risks, e-mental health treatment requires additional information. This additional information entails the explicit mention that misunderstandings are more probable to occur in e-mental health than in regular face-to-face mental health care because the patient and the physician possess less information about each other and cannot take advantage of non-verbal communication in an online environment. Both the health professional and the patient should be aware of the risk of misunderstandings before they start an online therapy session. These suggestions by the ISMHO serve as precautions that health professionals should take and do not necessarily entail that e-mental health always leads to misunderstandings and should not be used at all. Whether online treatment is suitable for a particular patient will depend on the mental health specialists' professional judgement. Mental health professionals must consider the mental capabilities of patients before starting the treatment. Because of the risk of misunderstanding, severe mental illness might be better treated face-to-face. Online therapy is best provided as a supplement to face-to-face therapy. For example, a patient can visit a mental health professional once a month and have weekly online consultations. Therefore, the patient does not have to travel to the health care facility every week.

Furthermore, information should be provided to the patient about the way of communication, which can be synchronous as well as asynchronous, and about the time within which he or she can expect the physician's reaction. The health professional has to provide his or her personal information to the patient, and the patient should be offered information about security measures he or she can undertake, especially when he or she uses a shared computer.[145] Especially using a shared computer can cause conflicts with the patient's informational

135. UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, GA Res. 46/119, 17 December 1991, principle 11, para. 4.
136. P.A.B. Galpottage and A.C. Norris, 'Patient Consent Principles and Guidelines for e-Consent: A New Zealand Perspective', 11 *Health Informatics Journal* 5, at 7 (2005).
137. SI 336 of 2011-European Communities (Electronic Communications Networks and Services) (Privacy and Electronic Communication) Regulation 2011, at 11.
138. Principle 6 (1) Recommendation No. R (97) 5 on the Protection of Medical Data (1997).
139. UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, GA Res. 46/119, 17 December 1991, principle 11, paras. 1 and 2.
140. Art. 4 (3) (a) Recommendation No. R (97) 5 on the Protection of Medical Data (1997).
141. *See also* UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, GA Res. 46/119, 17 December 1991, principle 11, para. 6, under b and Art. 4 (3) (a) Recommendation No. R (97) 5 on the Protection of Medical Data (1997).
142. Art. 12 (2) (UNCRPD).
143. WHO (2005), above n. 4, at 40 and 41.
144. ISMHO/PSI Suggested Principles of Professional Ethics for the Online Provision of Mental Health Services, version 3.15.psi, 9/13/00, section A.
145. ISMHO/PSI Suggested Principles of Professional Ethics for the Online Provision of Mental Health Services, version 3.15.psi, 9/13/00 section A.

privacy as well as with his or her spatial privacy.[146] A study showed that the acceptance of e-health systems is lower when patients are concerned about invasion of their privacy.[147] Additional attention should be paid to confidentiality of the patient's data. Protection of personal data and privacy are fundamental rights set out in several human rights treaties.[148] The UNCRPD explicitly mentions the right to privacy of persons with disabilities.[149]

The Data Protection Directive[150] prohibits processing of data concerning health issues,[151] although there are some exceptions such as when the data subject is physically or legally incapable of giving consent.[152] Preventive medicine, medical diagnosis, provision of care or treatment, or management of health care services are exceptions as well. The data should always be processed by a health professional.[153] Another often heard fear is that the health data could be accidentally disclosed to unauthorised parties.[154]

The ISMHO and PSI principles include principles on to the procedure of online mental health care, too. First, the health care provider should act according to his or her competence, and he or she should be allowed to provide health care at his or her location. For cross-border care, additional problems rise because he or she might need the qualifications to provide health care at the place where the patient resides.[155] As e-mental health facilitates cross-border health care, this is a substantial issue. Furthermore, the patient and the professional should agree on the prevalence and the way the online communication takes place. This includes appointments with regard to fees and payment of services. Health care provider should assess the patient's health condition as good as he possibly can in an online environment, while respecting the patient's confidentiality and keeping a medical record of the treatment.[156]

In 2009, the WMA developed ethical guidelines for the use of telehealth.[157] These guidelines also elaborate on the duty of care, communication with patients, standards of practice and quality of care, patient confidentiality and informed consent. Notable is the provision that the professional who offers telehealth services should be familiar with the technology and even has to educate himself or herself in 'telehealth communication skills' before he or she can offer such services.[158] Apart from these international principles for online (mental) health care, numerous national guidelines[159] about the application of e-mental health as well as e-health and online behaviour of health professionals, in general,[160] exist.

5.3.2 Cultural Acceptance

In providing mental health services from distance, special attention should be paid to differences in race, ethnicity, region, religion, socioeconomic status and sexual orientation of patients. The cultural background of patients, such as their psychosocial environment, and cultural explanations for the problem should be considered by mental health providers.[161] These elements might affect the acceptability of the service by patients.

E-mental health has the potential to enhance coordination and participation in care between psychiatrists and GPs and between family members and patients. Furthermore, e-mental health can be a mean to take cultural and linguistic barriers away. Evidence that e-mental health can contribute to the cultural acceptability can be found in several studies such as the pilot study among Korean immigrants in Georgia. This group received telepsychiatric care from a health care professional who was 'culturally competent' and spoke their native language. In general, this type of care was seen as accepta-

146. A study conducted in the UK showed that the black, minority and ethnic respondents use computers outside their own homes more frequently than white respondents, which leads to questions related to their right to privacy. *See* L. Ennis, D. Rose, M. Denis, N. Pandit & T. Wykes, 'Can't Surf, Won't Surf: The Digital Divide in Mental Health', 21 *Journal of Mental Health* 395, at 400 (2012).
147. R. Gajanayake, R. Iannella & T. Sahama, 'Consumer Acceptance of Accountable-eHealth Systems', in C. Lovis, B. Séroussi, A. Hasman, L. Pape-Haugaard, O. Saka & S.K. Andersen, *e-Health – For Continuity of Care* (2014) 980.
148. Such as Arts. 7 and 8 CFR, Art. 17 ICCPR and Art. 12 UDHR.
149. Art. 22 UNCRPD.
150. Directive 95/46/EC of the European Parliament and of the Council of 24 October 1994 on the protection of individuals with regard to the processing of personal data and on the free movement of such data, OJ 1995 L281, at 31-50.
151. Art. 8 (1) Directive 95/46/EG.
152. Art. 8 (2) (c) Directive 95/46/EG.
153. Art. 8 (3) Directive 95/49/EG.
154. European Commission (2014), above n. 78, at 8.
155. ISMHO/PSI Suggested Principles of Professional Ethics for the Online Provision of Mental Health Services, version 3.15.psi, 9/13/00, section B.
156. *Ibid*.
157. Telehealth includes telemental health, which is comparable, albeit a bit narrower, with e-mental health.
158. WMA Statement on Guiding Principles for the Use of Telehealth for the Provision of Health Care, Adopted by the 60th WMA General Assembly, New Delhi, India, October 2009, at 2 and 3.
159. For instance: National Board for Certified Counselors, *Policy Regarding the Provision of Distance Professional Services* (2012), available at: <www.nbcc.org/Assets/Ethics/NBCCPolicyRegardingPracticeofDistanceCounselingBoard.pdf> (last visited 29 June 2016); American Telemedicine Association, *Practice Guidelines for Videoconferencing-Based Telemental Health* (2009), available at: <www.americantelemed.org/docs/default-source/standards/practice-guidelines-for-videoconferencing-based-telemental-health.pdf> (last visited 29 June 2016), American Telemedicine Association, *Practice Guidelines for Video-Based Online Mental Health Services* (2013), available at: <www.americantelemed.org/docs/default-source/standards/practice-guidelines-for-video-based-online-mental-health-services.pdf?sfvrsn=6> (last visited 29 June 2016).
160. For instance: American Telemedicine Association, *Core Operational Guidelines for Telehealth Services Involving Provider-Patient Interactions* (2014), available at: <www.americantelemed.org/docs/default-source/standards/core-operational-guidelines-for-telehealth-services.pdf?sfvrsn=6> (last visited 29 June 2016), KNMG, *Richtlijn Online Arts-Patient Contact* (2007), available at: <http://knmg.artsennet.nl/Publicaties/KNMGpublicatie/62422/Richtlijn-online-artspatient-contact-2007-met-aanvulling-Handreiking-Artsen-en-Social-Media-2011.htm> (last visited 29 June 2016); NHG, *NHG-Checklist e-Consult* (2014), available at: <https://www.nhg.org/sites/default/files/content/nhg_org/uploads/nhg-checklist_e-consult_1.3_-_februari_2014.pdf> (last visited 29 June 2016).
161. M.A. Jones, M.K. Shealy, K. Reid-Quiñones, D.A. Moreland, M.T. Davidson, M.C. López, C.S. Barr & A.M. de Arellano, 'Guidelines for Establishing a Telemental Health Program to Provide Evidence-Based Therapy for Trauma-Exposed Children and Families', 11 *Psychological Services* 398, at 404 (2014).

ble for the studied patients.[162] Another study among aboriginal people in Australia shows that e-mental health tools offer a possibility for accessible, effective and acceptable treatment.[163] However, the acceptance of e-mental health among different groups is not the same. Elderly patients, for example, are less likely to rely on and to accept health services from a distance.[164] In addition, in some countries, women tend to be more conservative and therefore less likely to accept this service.[165]
While e-mental health applications might seem helpful in delivering culturally appropriate care, this section explained that they are not acceptable to everyone. Acceptance of e-mental health among health care professionals is another issue related to the acceptability of these services. E-health services will only contribute to the accessibility of mental health services when not only patients but also health care professionals accept them. Evidence exists that e-health is sometimes underutilised because health professionals are at times reluctant to use them.[166] They have to be convinced of the tremendous possibilities of e-health in order to realise the potential for e-(mental) health to increase the accessibility of mental health care.

5.4 Quality

Finally, in order to contribute to realising the right to health, health services should be scientifically and medically appropriate and of good quality. This implies, among other things, skilled medical personnel and scientifically approved drugs.[167] As mentioned in the introduction, e-mental health is expected to improve the quality of mental health services.[168]
According to Jefee-Bahloul,[169] different studies have found that telemedicine as a type of health services is clinically effective.[170] As patients gain easier access to mental health care in an early phase of their illness, deterioration might be prevented. E-mental health also enhances involvement in care and continuity of care for patients in rural areas. A better connection between hospital and community providers increases the quality of service in local areas by increasing the diagnosis and treatment rate at early time and by improving the referral process. Growing participation of patients and reduction of no-show rates as a result, improves mental health outcomes. Empowerment of the e-mental health service user leads to a faster recovery process and better integration into the community. E-mental health applications, such as online self-tests, for instance might help patients to recognise and assess their problems in an early stage. When desired, the results of such a test can be discussed with a physician and the treatment can be started rapidly.[171] Moreover, e-mental health gives mentally ill people the opportunity to stay as much as possible with their families and community. The latter reduces the lengths of stay and readmission rates to psychiatric facilities. A report by the American Telemedicine Association showed that the number of inpatient psychiatric admissions and hospital stays significantly decreased by providing health services via new communication technologies.[172] To summarise, e-mental health has the potential to improve the quality of community mental health services.
E-mental health treatments can also lead to several quality-related implications. For instance, in order to be able to provide care of good quality, additional measures should be taken. With regard to the criterion of skilled medical personnel, licensing of mental health professionals to use e-mental health might be a solution. In the Draft International Convention on Telemedicine and Telehealth, licensing for health professionals who intend to use telehealth is recommended.[173] Furthermore, this draft convention states that online health care should be dealt with in the same way as regular, face-to-face care.[174] However, this draft convention was never ratified.
The national and international practice guidelines as discussed in Section 5.3.1 give an indication of what e-(mental) health care of good quality should entail. The ISMHO and PSI principles, for example, indicate that misunderstandings can be expected when the professional and the patient do not have all the information about each other. These principles also indicate that it might be difficult to fully assess the patients' health condition because the advantages of non-verbal communication

162. J. Ye *et al.*, 'Telepsychiatry Services for Korean Immigrants', 18 *Telemedicine and e-Health* 797 (2012).
163. J. Povey, P.P.J.R. Mills, K.M. Dingwall, A. Lowell, J. Singer, D. Rotumah, J.B. Levy & T. Nagel, 'Acceptability of Mental Health Apps for Aboriginal and Torres Strait Islander Australians: A Qualitative Study', 18 (3) *Journal of Medical Internet Research* (2016), available at: <www.ncbi.nlm.nih.gov/pmc/articles/PMC4825593/> (last visited 6 June 2016).
164. Lind and Karlsson, above n. 96, conducted a study among elderly who were uninterested in modern technology.
165. A. Bener and S. Ghuloum, 'Gender Difference on Patients' Satisfaction and Expectation Towards Mental Health Care', 16 *Nigerian Journal of Clinical Practice* 285, at 290 (2013) in H. Jefee-Bahloul, 'Telemental Health in the Middle East: Overcoming the Barriers', 2 *Frontiers in Public Health* 1 (2014).
166. *See e.g.* A. Burghouts, N. Beekers, J. Krijgsman, S. Ottenheijm, K. Oost, F. Beenkens & J. Jacobs, *Spelen met de zorg van morgen. Trendboek eHealth in de eerste lijn.Trendition* (2014), at 18-21.
167. Para. 12 (d) General Comment no. 14, (CESCR).
168. European Commission (2012), above n. 5, at 4-5; WHO (2005), above n. 5, at 2, para. 7.
169. Jefee-Bahloul, above n. 165.
170. D.M. Hilty, D.C. Ferrer, M.B. Parish, B. Johnston, E.J. Callahan & P.M. Yellowlees, 'The Effectiveness of Telemental Health: A 2013 Review'. 19 *Telemedicine and e-Health* at 444 (2013); F. Garcia-Lizana and I. Munoz-Mayorga, 'What About Telepsychiatry? A Systematic Review'. 12 *Primary Care Companion to the Journal of Clinical Psychiatry* (2010), available at: <www.psychiatrist.com/_layouts/PPP.Psych.Controls/ArticleViewer.ashx?ArticleURL=/pcc/article/Pages/2010/v12n02/09m00831whi.aspx> (last visited 6 June 2016), as cited by Jefee-Bahloul, above n. 165, at 1.
171. Timmer, above n. 58, at 27-66.
172. American Telemedicine Association, *State Medicaid Best Practice, Telemental and Behavioural Health* (August 2013), at 1-7, available at: <www.americantelemed.org/docs/default-source/policy/state-medicaid-best-practices-telemental-and-behavioral-health.pdf?sfvrsn=4> (last visited 6 July 2016).
173. Art. 3 Draft international convention on telemedicine and telehealth of the International Bar Association Section on Legal Practice, Committee 2 (Medicine and Law) 22 July 1999.
174. Art. 2 (2) Draft international convention on telemedicine and telehealth.

are lacking in an online environment.[175] Other examples include distance as a complicating factor for the professional to give his or her diagnosis. A physician might experience difficulties in diagnosing the patient because of the distance. Additional problems occur when the communication is asynchronous and the time between the patient's question and the physicians' reaction is considerable.[176]

Furthermore, for an e-mental health system to work properly, a fruitful clinical supervision should be provided.[177] Another important issue of using ICTs is the liability of Internet web-based mental health care services. Liability concerns are linked with the numerous stakeholders involved,[178] poor quality information of websites, inappropriate use of information or the use of websites created by non-professional mental health specialists.[179] Clear liability rules for e-mental health in case of damage are needed.

6 Conclusion

This study aimed to answer the question under what conditions e-mental health can contribute to realising the right to the highest attainable standard of mental health. This was done by analysing the impact of e-mental health on mental health care regarding the AAAQ framework.

E-mental health can make health care more available as long as an ICT infrastructure is present. To make optimal cross-border e-mental health care available for everyone, interoperability between the various e-mental health systems should be realised.[180] This should be taken into account in the development process of e-mental health applications. Furthermore, the ICT has to be available itself around the country. The digital divide still exists and can cause inequalities in the availability of e-mental health care worldwide.[181]

E-mental health has the potential to increase the accessibility of e-mental health care. However, measures have to be taken in order to prevent exclusion of the digitally illiterate or those who are otherwise digitally excluded.[182] The first step in preventing this problem could be to design e-mental health applications with the needs of these people in mind;[183] E-health should be need-driven instead of technology-driven.[184] Proper reimbursement of e-mental health services is another requirement for e-mental health to increase the access to mental health care.[185]

The third condition to realise the right to health is the acceptability of the services. This entails that services respect medical ethics and are culturally appropriate. Several national and international guidelines on medical ethics and e-health exist.[186] When these guidelines are followed, e-mental health can be acceptable. E-mental health should be culturally acceptable as well;[187] however, further research on this matter is needed to determine whether a particular e-mental health intervention is culturally acceptable. Finally, e-mental health has the potential to contribute to mental health care of good quality,[188] but only when quality standards are followed and clear liability rules are established. E-mental health can enhance the realisation of the right to the highest attainable standard of mental health for everyone in case the aforementioned conditions are met. Because of the large expansion and impact of e-mental health, there are still efforts to be made in order to overcome the aforementioned barriers.

175. ISMHO/PSI Suggested Principles of Professional Ethics for the Online Provision of Mental Health Services, version 3.15.psi, 9/13/00, section A, Art. 1 (a).
176. KNMG, *Richtlijn online arts-patient contact* (2007), at 15, available at: <http://knmg.artsennet.nl/Publicaties/KNMGpublicatie/62422/Richtlijn-online-artspatient-contact-2007-met-aanvulling-Handreiking-Artsen-en-Social-Media-2011.htm> (last visited 29 June 2016).
177. Jefee-Bahloul, above n 165.
178. European Commission (2014), above n. 78, at 16
179. Christensen *et al.*, above n. 75, at 5.
180. Gaddi and Capello, above n. 82, at 6.
181. International Telecommunication Union, *What is the Digital Divide?*, available at: <https://www.itu.int/net/wsis/basic/faqs_answer.asp?lang=en&faq_id=43> (last visited 21 October 2015); International Telecommunication Union, *Measuring the Information Society Report 2014*, at 55 (2014); International Telecommunication Union, *World Information Society Report 2007*, at 21 (2007).
182. Coleman *et al.*, above n. 97, at 176.
183. Lind and Karlsson, above n. 96, at 353-57.
184. Cunningham *et al*., above n. 95, at 26-27.
185. Jefee-Bahloul, above n. 165 and Christensen *et al.*, above n. 75, at 4-7.
186. Such as the International Code of Medical Ethics, Adopted by the 3rd General Assembly of the World Medical Association, London, England, October 1949 and amended by the 22nd World Medical Assembly Sydney, Australia, August 1968 and the 35th World Medical Assembly Venice, Italy, October 1983 and the WMA General Assembly, Pilanesberg, South Africa, October 2006; ISMHO/PSI Suggested Principles of Professional Ethics for the Online Provision of Mental Health Services, version 3.15.psi, 9/13/00, WMA Statement on Guiding Principles for the Use of Telehealth for the Provision of Health Care, Adopted by the 60th WMA General Assembly, New Delhi, India, October 2009, National Board for Certified Counselors, *Policy Regarding the Provision of Distance Professional Services* (2012), available at: <www.nbcc.org/Assets/Ethics/NBCCPolicyRegardingPracticeofDistanceCounselingBoard.pdf> (last visited 29 June 2016); American Telemedicine Association, *Practice Guidelines for Videoconferencing-Based Telemental Health* (2009), available at: <www.americantelemed.org/docs/default-source/standards/practice-guidelines-for-videoconferencing-based-telemental-health.pdf> (last visited 29 June 2016); American Telemedicine Association, *Practice Guidelines for Video-Based Online Mental Health Services* (2013), available at: <www.americantelemed.org/docs/default-source/standards/practice-guidelines-for-video-based-online-mental-health-services.pdf?sfvrsn=6> (last visited 29 June 2016); American Telemedicine Association, *Core Operational Guidelines for Telehealth Services Involving Provider-Patient Interactions* (2014), available at: <www.americantelemed.org/docs/default-source/standards/core-operational-guidelines-for-telehealth-services.pdf?sfvrsn=6> (last visited 29 June 2016), KNMG, *Richtlijn Online Arts-Patient Contact* (2007), available at: <http://knmg.artsennet.nl/Publicaties/KNMGpublicatie/62422/Richtlijn-online-artspatient-contact-2007-met-aanvulling-Handreiking-Artsen-en-Social-Media-2011.htm> (last visited 29 June 2016); NHG, *NHG-Checklist e-Consult* (2014), available at: <https://www.nhg.org/sites/default/files/content/nhg_org/uploads/nhg-checklist_e-consult_1.3_-_februari_2014.pdf> (last visited 29 June 2016).
187. Ye *et al.*, above n. 162.
188. Jefee-Bahloul, above n. 165.