

**Any and all reproduction is prohibited
but direct link to the document is accepted:**
<http://www.irdes.fr/english/issues-in-health-economics/193-involuntary-psychiatric-hospitalisation-in-2010.pdf>

Involuntary Psychiatric Hospitalisation in 2010: First Exploitation of Rim-P and Overview of the Situation Prior to the Reform of July 5th 2011

Magali Coldefy, Clément Nestrigue (Irdes)

This first overview of involuntary psychiatric hospitalisation, based on recently available data from the Medical Information Database for Psychiatry (Rim-P), has several aims: to obtain a snapshot of persons forcibly interned in psychiatric hospitals together with the diversity of care modalities and care paths in 2010. The final objective is to monitor the effects of the mental health reform instituted by the Law of July 5th 2011 on the rights and protection of individuals under psychiatric care. Modified in September 2013, this Law aims at reforming compulsory psychiatric care practices by authorising alternatives to full-time hospitalisation, previously the only care modality, and provides for the intervention of a custodial judge (JLD – "juge des libertés et de la détention") within this framework.

What does the notion of compulsory psychiatric care refer to? How many mentally disordered patients were hospitalised without consent in France in 2010? Under what care modalities, in what type of establishments, for how long and for which mental disorders were they hospitalised? These are the main questions to which this first insight will provide some answers.

e Concerning the rights and protection of individuals under psychiatric care and the different care modalities, the Law of July 5th 2011, modified in September 2013, constituted a major reform. It extended the range of

possible care modalities, previously exclusively limited to full-time hospitalisation, and instituted the systematic intervention of a custodial judge (JLD) within the framework of involuntary hospitalisation. The intervention of a JLD reinforces the

rights of patients treated without their consent. Full-time hospitalisation can no longer be enforced without a prior JLD ruling following an audience with the patient. The judge may furthermore be called upon at any time to

order the prompt revocation of a compulsory psychiatric treatment order.

This overview meets two objectives: it will enable the future evaluation of the reform's impact by assessing the situation prior to its implementation and, for the first time in France, provide an overview of patients hospitalised in mental health facilities without their consent together with the variability of care modalities and care paths in 2010.

This first snapshot, made possible by the recent availability of the Medical Information Database for psychiatry (*Recueil d'informations médicalisées en psychiatrie* - Rim-P), contributes to gain-

ing better knowledge of particularly complex situations not only for the healthcare teams, but also for the patients and their families (Sources insert).

Compulsory treatment, a psychiatric exception

French legislation stipulates that consent to care is an essential prerequisite to any therapeutic treatment (article L.1111-4 of the Public Health Code). It also stipulates that, compulsory psychiatric care is authorised in cases of severe mental disorder rendering the patient temporar-

CONTEXT

This article falls within the framework of a research project aimed at describing and analysing the variability of involuntary treatment modalities and long-term psychiatric hospitalisations. Elaborated in response to a call for projects, this research was financed by the Public Health Research Institute (IRES). It forms part of more general research themes developed at IRDES on the variability of health care practices, the analysis of care paths and the organisation of psychiatric care.

ily unable to consent to care and where the absence of care would endanger public safety and the safety of the patient. Consent to treatment must always be privileged and care without consent must remain the exception. If compulsory psychiatric care is currently in the minority, it remains possible in numerous countries under certain conditions and in the case of severe mental disorders (Dressing and Salize, 2004; Kisely *et al.*, 2011). In France, until 2011, the Law of June 27th 1990 distinguished two modes of hospitalisation without consent: at the request of a third party or compulsory hospitalisation on the order of administrative authorities. Full-time hospitalisation was the only form of compulsory care authorised, and part-time hospitalisation or out-patient care was excluded except in cases of 'trial releases' from hospital. This was one of the major modifications instituted by the Law of 2011 which provided for alternative modalities of care to full-time hospitalisation.

Over 71,000 patients hospitalised in mental health facilities without consent in 2010, of which 80% at the request of a third party

In 2010, over 71,000 different¹ patients were hospitalised in French mental health

¹ A patient hospitalised in several establishments is only counted once. 4% of patients hospitalised without their consent were treated in several establishments in 2010. Less than 5% of health establishments had not transmitted data to the Rim-P in 2010. We estimate the under-estimation of the number of patients hospitalised without consent at less than 3% in the Rim-P compared with data produced by the Annual Hospital Statistics (*cf.* Sources insert).

* Terms or expressions followed by an asterisk are defined in the Definitions insert, page 5.

SOURCES QND METHODS

The sources of information on involuntary psychiatric hospitalisations: figures and players

Over the last few years, several sources of information have become available allowing the measurement of involuntary care procedures. More or less recent, of variable quality and comprehensiveness, and based on different concepts, these sources of information call for extreme prudence in their exploitation and interpretation. Three main sources of information were used in this study:

a. Activity reports from the Departmental Commissions for Psychiatric Hospitalisation (commissions départementales d'hospitalisation psychiatrique (CDHP)), now Departmental Commissions for Psychiatric Care (commissions départementales des soins psychiatriques (CDSP)), following the 2011 reform, constitute the oldest and most stable source of information on involuntary psychiatric hospitalisation. The CDHP were created within the framework of the Mental Health Act of 27th June 1990 on the rights and protection of persons hospitalised for mental health disorders and the conditions under which they are hospitalised. The CDHP activity reports are transmitted to the General Health Authority (Direction générale de la santé) who regularly publishes departmental data in the form of circulars. The activity reports list **new involuntary hospitalisation procedures during the year in question**. Procedures beginning in the previous year are not taken into account. When a patient is transferred to another hospital, it is the initial procedure that remains in vigour. Beyond these procedures, these reports count emergency admissions and the duration of hospitalisation measures. However, the numbers of individuals concerned are not recorded and the comprehensiveness of reporting information can vary from one year to the next.

b. The Annual Health Establishment Statistics (statistique annuelle des établissements de santé (SAE)) [survey produced and disseminated by the DREES] collects health establishment data since 2006, **on the number of patients, admissions and health measures**, and the **number of days** (excluding trial releases) involuntary hospitalisation. In addition, the patient is counted in all the establishments frequented. From 2006 to 2009, the SAE provided a precise definition of **admission** that was different from the notion of 'measure' used in CDHP reports. The definition related to that used in the Rim-P was the following: 'The number of admissions corresponds to the number of full-time hospital stays according to legal procedure' (DREES, SAE 2008, completion guidelines). It concerns 'total', direct admissions or referrals in the given year; on-going hospital stays concerning admissions in the previous year are not counted. From 2010, the number of admissions was abandoned and replaced by the **number of measures, on-going as of January 1st (stock) and newly taken during the year (flux)**, without specifying what the concept of measure referred to. This **shift in concept** has had an impact on the quality of data and considerably limits progression analyses. Comparing data before and after 2010 in the SAE is impossible and we can question whether the change in concept in 2010 was taken into account by SAE respondent establishments. Furthermore, the number of health establishments providing information on these items in the SAE varies from one year to another and calls for extreme prudence in the analysis of observed events, notably during the first years of data collection.

c. Medical Information Database for Psychiatry (Rim-P) set up in 2007 (managed and disseminated by the Technical Agency for Hospital Information (*Agence technique de l'information sur l'hospitalisation* - ATIH)) can only be reasonably exploited since 2010. This data source provides the **number of patients, the number of hospital stays including** both new admissions and admissions initiated in the previous year and the **number of days' hospitalisation** (allowing the identification of trial releases). The Rim-P also provides information on the characteristics of patients' monitored and the totality of care delivered within the hospital. Finally, the existence of a national identifier makes it possible to avoid duplications in cases where patients are treated in several different establishments. The quality and comprehensiveness of this recent data source increases year by year.

The analyses presented in this study were conducted by the IRDES team with support from a working team made up of psychiatrists, DIM doctors, users and family representatives, DREES and ATIH representatives and social science researchers.

facilities without their consent (data not adjusted by data of establishment not-responding to Rim-P). Only a percentage of hospitals have inpatient psychiatric care accreditation (essentially public hospitals or private non-profit establishments participating in the sectorisation of psychiatric care*). Within these establishments, involuntary psychiatric patients represent 5% of the active patient list* and 29% of full-time hospitalisations in 2010 (see care modalities, Definitions insert).

In 80% of cases, hospitalisations without consent are admissions at the request of a third party *hospitalisation à la demande d'un tiers* (HDT) (Graph 1) and concerned close to 57,000 patients in 2010. Three criteria must be met before an HDT procedure can be applied: the presence of a mental disorder, the patients' incapacity to consent to their hospitalisation as a result of their disorder, and the need for immediate care and constant supervision in a hospital environment (HAS, 2005). First, a written request for hospital admission must be emitted by a third party, usually a relative or a person in the patient's social circle acting in their interest (excluding care providers in the admitting health establishment) and secondly, two detailed and concordant medical certificates must be established, one of which by a physician

who does not work in the admitting establishment. Exceptionally, and only in the case of imminent danger to self or to others, only one medical certificate is required. These emergency procedures have increased through time and represented half the HDT measures pronounced in 2009 (Source: *Commissions départementales d'hospitalisation psychiatrique* (CDHP) progress reports (Departmental Commissions for Psychiatric Hospitalisation) against 30% in 1997 (Coldefy, 2007). One of the frequently advanced hypotheses to explain this increase is the misuse of emergency procedures to simplify the admission process (it can be difficult in certain areas to find two physicians available to establish the certificates), an irregularity pointed out by the assessment panel rapporteurs for the Law of June 17th 1990 (Strohl, Clément, 1997).

Almost 15,000 patients were subject to a compulsory hospitalisation order (*hospitalisation d'office* - HO) in 2010; in other words 20% of patients hospitalised without consent in a mental health facility. The HO procedure is a medical-administrative measure delivered by the Prefect of Police (or Commissioner of Police in Paris), conditional on a detailed medical certificate established by a physician external to the admitting establishment. Beyond the medical criteria required for HDT, the HO procedure is applied in cases where the patient's state of health presents an immediate danger

to public safety and the safety of others (including self). In the case of 'immediate danger regarding the safety of others, confirmed by medical advice, or failing that public notoriety', an emergency procedure can be initiated by the local public administration authority (*maire*) or police commissioners in Paris. In the same way as HDT admissions, these emergency procedures have become the norm as in 2009 they concerned 64% of HO pronouncements (Source: CDHP activity reports). In 35 departments, they represented over 90% of the HOs delivered.

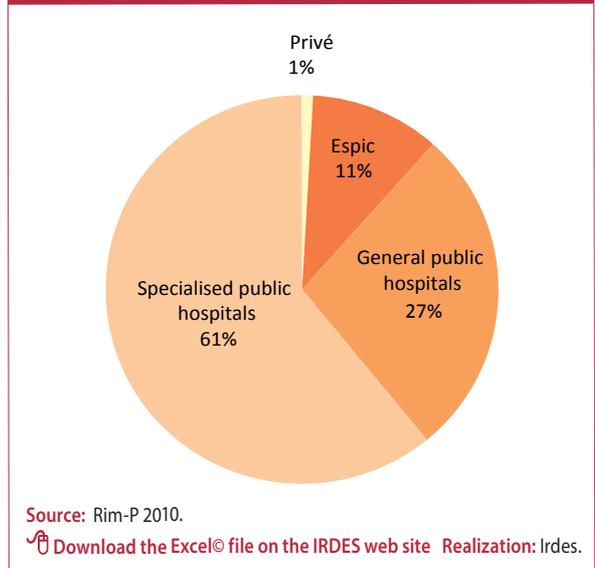
Beyond the HO and HDT procedures, there exist other forms of hospitalisation without consent that concern a minority of individuals. In 2010, the Rim-P thus registered 1,300 criminal offenders detained in psychiatric hospitals, a little under 400 offenders judged not criminally responsible, and 100 minors subject to an *ordre de placement provisoire* (provisional placement order (OPP))*.

Care essentially provided in public health establishments

Patients hospitalised without their consent are in the majority (88%) treated in public health establishments, often specialised in mental health care, 11% in private non-profit establishments (ESPIC),

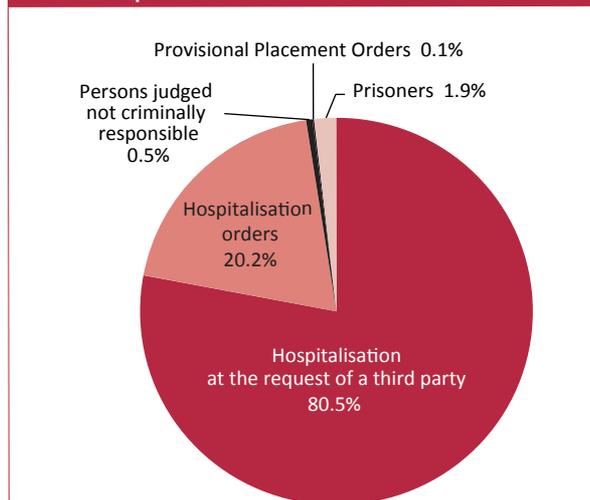
G2

Distribution of involuntary psychiatric inpatients by type of health establishment



G1

Distribution of legal modes of psychiatric hospitalisation without consent in 2010



Reading: As a patient can be hospitalised under different legal procedures during the course of a given year, total percentages are above 100.

Source: Rim-P 2010

[Download the Excel® file on the IRDES web site](#) Realization: Irdes.

and 1% (less than 800 patients) in private for-profit establishments (Graph 2). The list of health establishments authorised to receive involuntary psychiatric patients is decreed by the Regional Health Agency (ARS) and essentially concerns establishments participating in the sectorisation of psychiatric care. Only four private clinics in France are also authorised to receive involuntary patients. Among the authorised establishments, specialised public hospitals receive the majority of involuntary patients (32% of inpatient hospitalisations without consent, against 26% in non-specialised establishments or authorised private non-profit establishments).

A relatively young and in the majority male population, particularly for compulsory hospitalisation orders (HO)

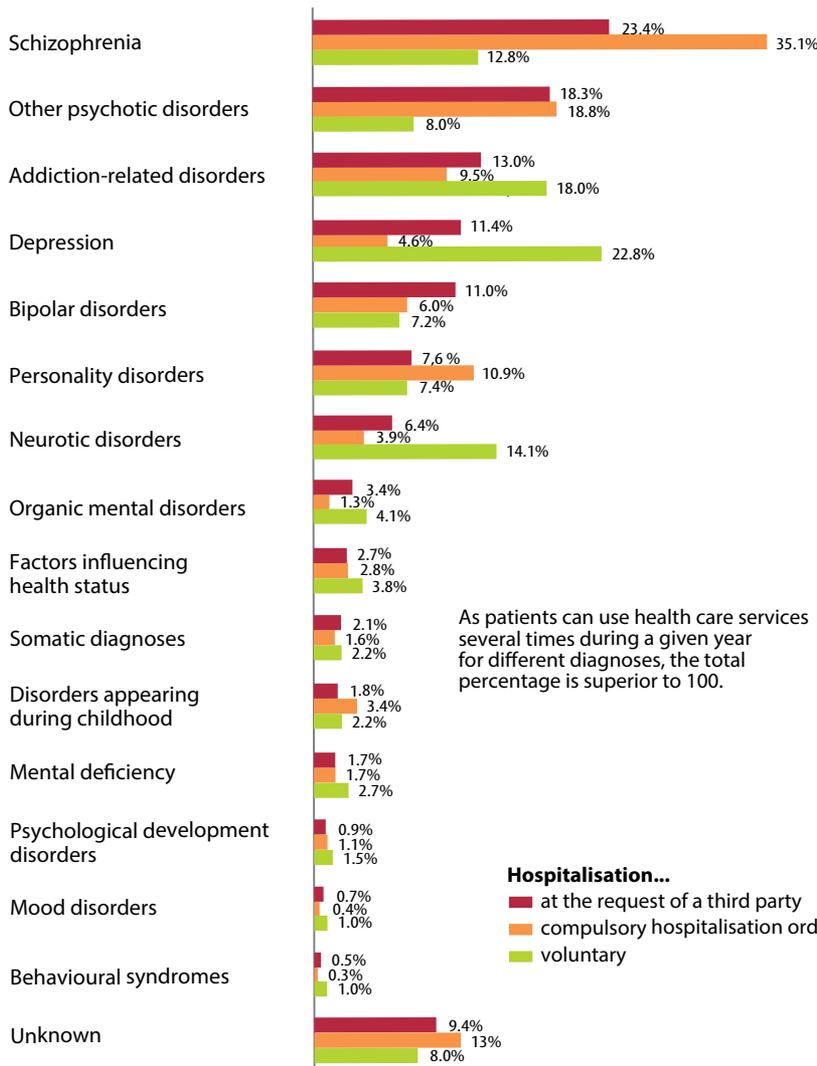
With 60% of patients hospitalised in mental health facilities without their consent (against 47% of patients hospitalised with consent), the majority are men. These results are consistent with those observed in the international literature (Brophy *et al.*, 2006; Hustoft *et al.*, 2013; Lorant *et al.*, 2007). This male

predominance was validated for each legal procedure. Men are thus in a large majority regarding compulsory hospitalisation orders (80%), mentally disordered offenders judged not criminally responsible (91%) and hospitalised prisoners (93%). Men represent 54% of hospitalisations at the request of a third party, and 65% of minors under provisional placement orders.

The average age of patients hospitalised without consent is 43 years old (against 47 years old for voluntary inpatients). It varies from 44 years old for patients admitted under the HDT procedure, to 40 years old for those admitted under the HO procedure or offenders judged not criminally responsible and on average 33 years old for prisoners.

G3

Principal diagnoses for persons hospitalised full time in mental health facilities, according to legal procedure



Reading: 35.1% of persons hospitalised under a legal procedure in 2010 received a principal diagnosis of schizophrenia, against 13% of persons hospitalised voluntarily.

Source: Rim-P 2010.

Download the Excel® file on the IRDES web site

Realization: Irdes.

Hospitalisation without consent is most frequently associated with psychotic disorders

Psychotic disorders (schizophrenia and other psychotic disorders) represent over half the principal diagnoses observed among patients hospitalised without consent against 21% of diagnoses among voluntary inpatients in the establishments concerned. Addiction-related disorders are the second most frequent cause of involuntary hospitalisation but are not more highly represented among voluntary inpatients. Diagnosed in 10% of patients, depressive disorders are in third position but are under-represented in comparison with voluntary inpatients in the same way as neurotic disorders (registered in 6% of hospitalisations without consent). Bipolar and personality disorders are on the contrary twice as frequent among patients hospitalised without consent (respectively 10% and 9% of patients). Here again, the results are consistent with findings in the international literature (Hansson *et al.*, 1999; Hustoft *et al.*, 2013; Lorant *et al.*, 2007; Riecher *et al.*, 1991; Spengler, 1986; Webber & Huxley, 2004).

We also note differences between the different legal modes of admission (Graph 3). Psychotic disorders (schizophrenia and others) represent 54% of principal diagnoses for HO admissions against 42% of

HDT admissions. Personality disorders are in second position for HO (11%). For HDT admissions, the most frequent principal diagnosis is addiction-related disorders (13%), followed by depressive and bipolar disorders (11% each). We also note the higher prevalence of suicide attempts in patients hospitalised under HDT (2.9%) compared with HOs (1.1%).

For 28% of patients, hospitalisation without consent is the only available form of treatment in a given year

Hospitalisation without consent constitutes a singular episode in psychiatric care; it can be a means of entering into care for new patients, or constitute a treatment

DEFINITIONS

The modalities of hospital-based psychiatric care: There are three main forms of care provision in adult psychiatry; outpatient care, full-time and part-time care. **Outpatient care** defines all forms of care delivered outside a hospital structure. **Full-time care** essentially refers to full-time hospitalisation in care structures providing constant patient supervision. **Part-time care** is delivered in hospital structures without inpatient facilities, with the exception of night hospitals (cf. Coldefy, Nestrigue, 2013).

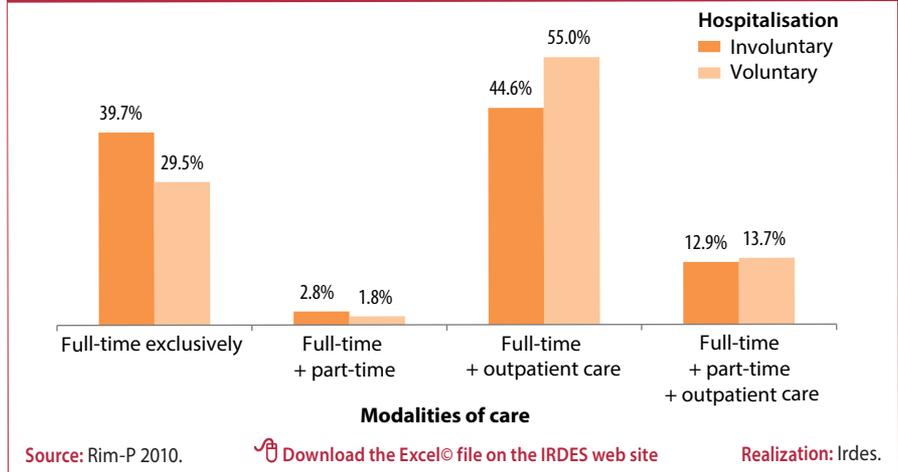
The sectorisation of psychiatric care is based on the network organisation of public sector hospital care supply. The psychiatric sector, created by the circular of March 1960, constitutes the base unit in the delivery of public sector psychiatric care. Made up of multi-professional teams, it delivers and coordinates the care and services necessary to meet global care needs: prevention, hospital and ambulatory care supply, post-cure and re-adaptation.

The active patient list in psychiatry refers to the total number of patients seen at least once in the given year either in hospital, in consultations or home visits.

Provisional Placement Order (OPP) is a measure enabling a juvenile court judge to place minors in a structure habilitated to receive and accommodate them, whether a judicial, social, medical-social or health care structure. This can be extended to include mental health facilities if a judge considers it necessary for purposes of assessment or specialised treatment. In the case of minors, it thus constitutes a specific mode of hospitalisation without consent outside the general framework of hospitalisations without consent provided for by the Law of June 27th 1990.

G4

Diversity of modalities of care for involuntary psychiatric hospitalisations in 2010



phase following a relapse or sudden exacerbation of a disorder. For 28% of patients, hospitalisation without consent constitutes the only form of care delivered during the year. However, care delivered by private practice psychiatrists or general practitioners are not taken into account in this study.

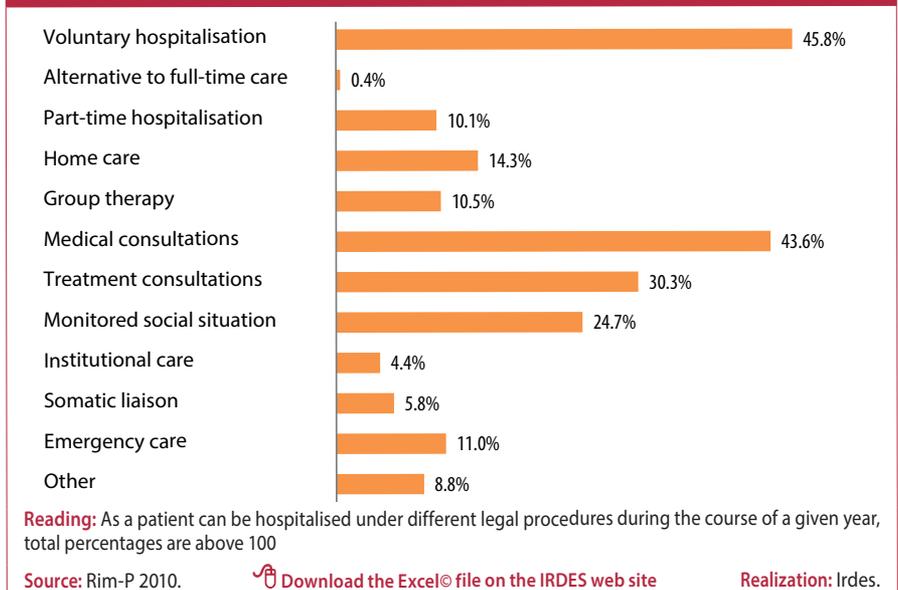
Over seven out of ten patients also benefitted from other forms of full-time, part-time or outpatient care. In addition to their hospitalisation without consent, 12% of patients had also been admitted as voluntary inpatients. For 40% of patients hospitalised without consent in 2010, the care provided was exclusively administered on the basis of full hospitalisation (outside office-based care not

accounted for here). In addition to full hospitalisation, 3% of patients moreover received additional part-time care in a day or night hospital, for example. The most common combination remains full-time hospitalisation associated with outpatient care (45%). Finally, 13% of patients benefitted from the three forms of care: full-time hospitalisation, part-time hospitalisation and outpatient care. Full-time hospital care on its own is more frequent among patients hospitalised without consent than among voluntary inpatients in the same establishments (Graph 4).

Almost half the patients hospitalised without consent consulted a physician during the course of the year (5 medical

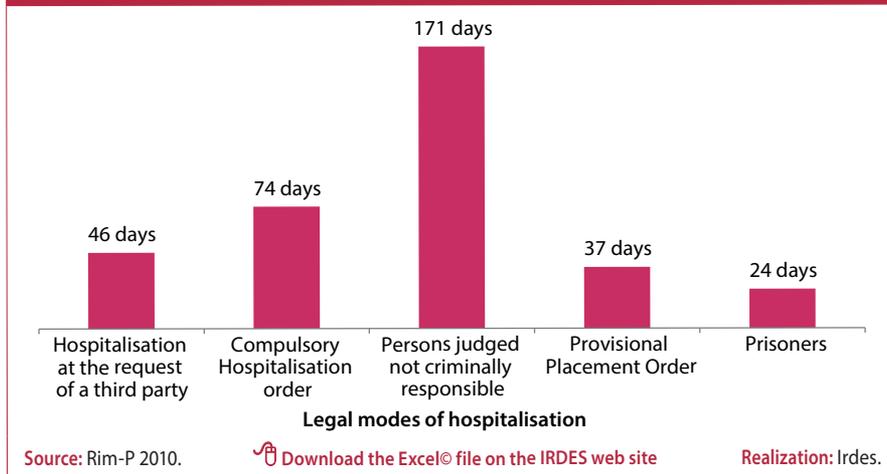
G5

Modalities of care for patients hospitalised without their consent



G6

Average number of days' hospitalisation per year by legal procedure



talisation is less than 11 days, whereas for another 25% it amounts to over 83 days in the year. The situation is very different for mentally disordered offenders judged not criminally responsible of which half are hospitalised full time for over 140 days during the year, and 30% for over 300 days (Graph 7).

'Trial releases' concern about 25% of patients hospitalised without consent, with an annual average number of days stay ranging from three months for HDTs, to five months for HOs

consultations on average). Furthermore, 30% had consulted nurses or psychologists (10 on average during the year). A quarter also benefitted from social situation monitoring (6 procedures on average during the year). Part-time or out-patient follow-up care in addition to hospital care is similar in nature and intensity as that delivered to voluntary inpatients in the same establishments. Finally, 11% of patients were treated in hospital emergency units (Graph 5).

which the patient is detained. For patients hospitalised under the HDT procedure, it amounts to an average 46 days in a given year, 74 days for HOs and 171 days for offenders judged not criminally responsible (Graph 6). The average lengths of stay reflect a variety of situations according to type of order. Most HDT hospitalisations are relatively short with an annual average of less than 20 days for half these patients and less than 7 days for a quarter of them. For another 25% the annual length of stay is equal to or above 44 days and for HOs, the median is higher at 31 days. For a quarter of patients under HO, the annual number of days' hospi-

Before the reforms instituted by the Law of July 5th 2011 regarding psychiatric treatment without consent, full-time hospitalisation was the only form of care available for involuntary patients. A patient requiring psychiatric care but refusing non-hospital care could not be monitored in an ambulatory or part-time framework in hospital without consent. Health care teams could nevertheless propose a 'trial release' from hospital and out-patient follow-up care after a period of hospitalisation without consent. "Trial releases" constitute an adjustment in the modalities of compulsory care provision (article L3211-11 of the Public Health Code) with

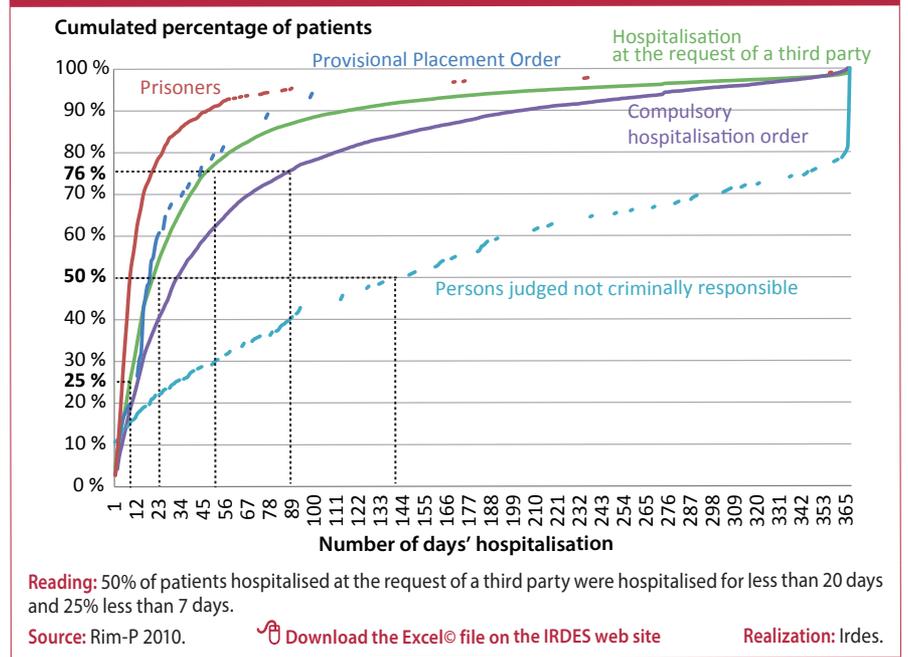
In psychiatry, the annual number of days' hospitalisation for patients hospitalised without consent is almost double compared to voluntary inpatients

In 2010, individuals hospitalised without consent for psychiatric disorders spent an average 53 days in hospital during the year. To these episodes of hospitalisation can be added episodes of voluntary psychiatric hospitalisation. When the number of full hospitalisation days during the year (both voluntary and involuntary hospitalisations) are added together, the annual number of days hospitalisation amounts to an average of 76 days. In comparison, the average annual number of days' full hospitalisation for voluntary inpatients in the same establishments is 43 days.

The annual duration of involuntary psychiatric hospitalisations vary considerably according to the legal procedure under

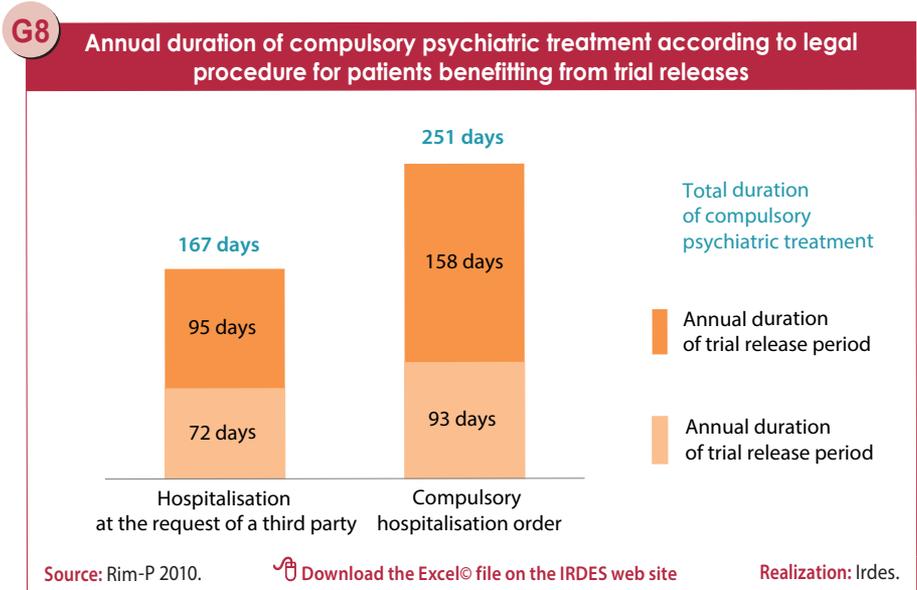
G7

Distribution of annual hospital stays by legal procedure



the aim of promoting the healing, re-adaptation or social reintegration of persons that had been subject to a HDT or HO procedure. Patients leave the hospital but receive outpatient care or part-time care within the hospital as the compulsory treatment order remains effective. In certain respects, the Law of 2001 regularised this practice. A quarter of patients hospitalised without consent in 2010 benefitted from a trial release (28% for HOs and 24% for HDTs).

The trial release lasts three months on average (95 days) for patients hospitalised at the request of a third party and longer for HOs with an average of five months (158 days) in the year. The duration of compulsory treatment can thus be calculated by adding together periods of hospitalisation without consent with the duration of a trial release. For patients benefitting from a trial release, if the annual average number of days hospitalisation under HDT is 72 days, the total duration of compulsory treatment is on average 167 days. For patients under HO benefitting from a trial release, the duration of involuntary hospitalisation as such is 93 days on average, but the total duration of compulsory treatment is 251 days (Graph 8). For these patients, compulsory hospitalisation days represent less than half the total compulsory care requirements in a given year.



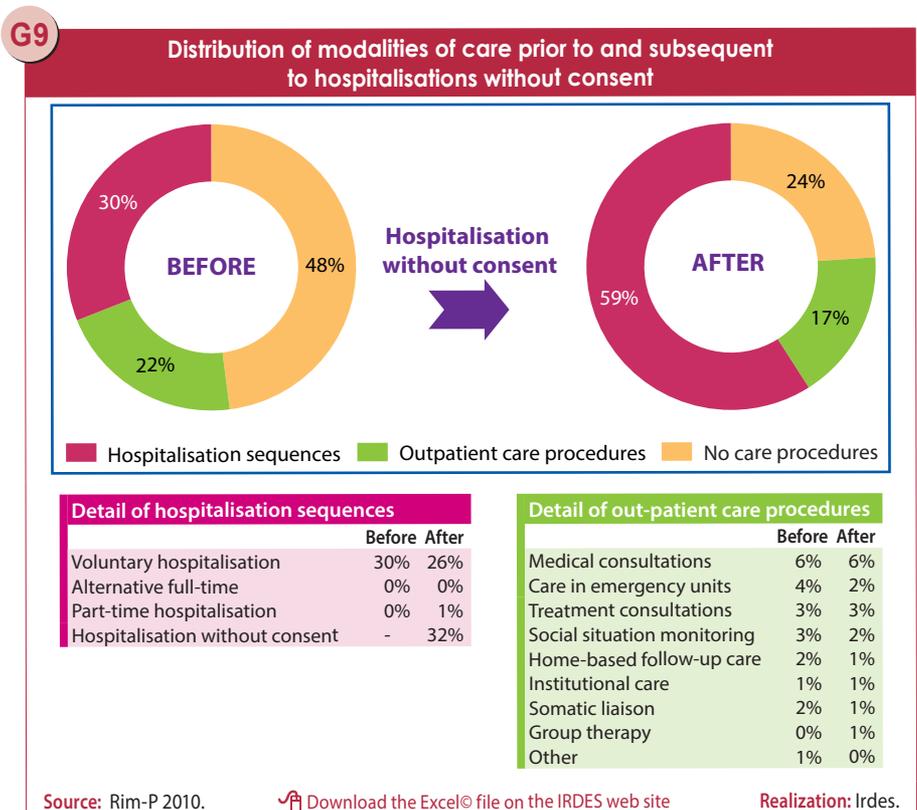
from an involuntary hospitalisation episode between January and September 2010 allowing us to analyse follow-up care provision over the three month period following hospitalisation without consent (Graph 9).

Half the patients hospitalised without consent in 2010 had not received care in a health establishment in the three months prior to their hospitalisation without consent. For some of these patients, involun-

tary hospitalisation was thus their first entry into care, or a return to psychiatric care. For 30% of these patients, involuntary hospitalisation follows a first episode of voluntary hospitalisation. This could indicate an exacerbation in the patient's disorder calling for a legal form of care provision. For less than one out of four patients, the provision of outpatient care in a public sector establishment preceded an episode of hospitalisation without consent.

Half the patients hospitalised without their consent did not received hospital-based mental health care three months prior to their hospitalisation...

In order to provide a more detailed analysis of the place occupied by involuntary psychiatric hospitalisation in a person's care path, we constructed two sub-groups of involuntary patients. The first sub-group (N=40 644 patients) was made up of patients having had a first experience of involuntary hospitalisation between April and December 2010. It allowed us to identify a hospitalisation episode in the three months preceding hospitalisation without consent. The second sub-group (N=40 767 patients) was made up of patients first discharged



... and a quarter of patients did not receive hospital-based follow-up care in the three months following discharge

After an involuntary hospital stay, 25% of patients did not receive any form of follow-up care following their discharge, whether in the same hospital or not. Another 25% were subsequently hospitalised voluntarily whereas a third were re-admitted to hospital without their consent. If readmission rates in the same establishment are equivalent for involuntary and voluntary psychiatric inpatients, the rate almost doubles if one takes into account readmissions in a different health establishment, indicating a high rate of patient transfers between establishments. This situation can be partially explained by the transferral of patients to a structure

more adapted to their needs, or their sector, after an initial admission via hospital emergency units. Post-hospitalisation outpatient care provision in the public sector (the only form of ambulatory care covered by the Rim-P) remains limited as only 17% of patients received outpatient care after an episode of involuntary hospitalisation.

* * *

Even if a percentage of patients were monitored by private practitioners after their involuntary hospitalisation (private psychiatrists or general practitioners) the low rate of follow-up psychiatric care in a mental health facility in the three months following involuntary hospitalisation for a quarter of these patients raises questions regarding the quality of follow-up care and the continuity of care proposed for this particularly vulnerable population whose

maintenance in care is difficult. After a first episode of involuntary treatment, the provision of care remains essentially hospital-based. To what extent has the reform of the Law of July 5th 2011 authorising compulsory outpatient care modified these observations? This first overview followed by the analysis of data subsequent to the reform would provide partial answers to this question. The constant improvement of psychiatric information systems and the current possibility of data matching with office-based care provision would enable the analysis of psychiatric care paths over several years. In the short term, it would also make it possible to conduct a quantitative evaluation and complete this first overview of the situation. ♦

The authors would like to thank Nadia Younès and Gilles Vidon, hospital psychiatrists, for their careful, constructive, and stimulating review of our text.

FOR FURTHER INFORMATION

- Brophy L.M., Reece J.E., McDermott F. (2006). "A Cluster Analysis of People on Community Treatment Orders in Victoria, Australia". *International Journal of Law and Psychiatry*, 29 469-481.
- Coldefy M. (2007). « Les hospitalisations sans consentement en psychiatrie : évolutions et disparités géographiques départementales », in *La prise en charge de la santé mentale* (Coord. Coldefy M.), La documentation française, pp.205-222
- Coldefy M., Nestrigue C. (2013). « La prise en charge de la dépression ». *Irdes, Questions d'économie de la santé* n° 191, octobre.
- Dressing H., Salize H.J. (2004). "Compulsory Admission of Mentally Ill Patients in European Union Member States". *Soc Psychiatry Psychiatr.Epidemiol*, 39 : 797-803.
- Hansson L., Muus S., Saarento O., Vinding H.R., Gostas G., Sandlund M., Zandren T., Oiesvold T. (1999). "The Nordic Comparative Study on Sectorized Psychiatry: Rates of Compulsory Care and Use of Compulsory Admissions during a 1-year Follow-Up". *Soc Psychiatry Psychiatr.Epidemiol*, 34 (2) : 99-104.
- HAS (2005). « Recommandations pour la pratique clinique : modalités de prise de décision concernant l'indication en urgence d'une hospitalisation sans consentement d'une personnes présentant des troubles mentaux ».
- Hustoft K., Larsen T.K., Auestad B., Joa I., Johannessen J.O., Ruud T. (2013). "Predictors of Involuntary Hospitalizations to Acute Psychiatry". *Int J Law Psychiatry*, 36 (2) : 136-143.
- Kisely S.R., Campbell L.A., Preston N.J. (2011). "Compulsory Community and Involuntary Outpatient Treatment for People with Severe Mental Disorders (Review)". *The Cochrane Library*, Issue 2.
- Lorant V., Depuydt C., Gillain B., Guillet A., Dubois V. (2007). "Involuntary Commitment in Psychiatric Care: What Drives the Decision?" *Social Psychiatry and Psychiatric Epidemiology*, 42 (5) : 360-365.
- Riecher A., Rossler W., Loffler W., Fatkenheuer B. (1991). "Factors Influencing Compulsory Admission of Psychiatric Patients". *Psychol.Med*, 21 (1) : 197-208.
- Spengler A. (1986). "Factors Influencing Assignment of Patients to Compulsory Admission". *Soc Psychiatry*, 21 (3) : 113-122.
- Strohl H., Clément M. (1997). « Rapport du groupe national d'évaluation de la loi du 27 juin 1990 ».
- Webber M., Huxley P. (2004). "Social Exclusion and Risk of Emergency Compulsory Admission. A Case-Control Study". *Soc Psychiatry Psychiatr. Epidemiol*, 39 (12) : 1000-1009.

IRDES

INSTITUT DE RECHERCHE ET DOCUMENTATION EN ÉCONOMIE DE LA SANTÉ •
10, rue Vauvenargues 75018 Paris • Tel. : 01 53 93 43 02 • Fax : 01 53 93 43 07 •
www.irdes.fr • Email : publications@irdes.fr •

Director of the publication: Yann Bourgueil • Technical senior editor: Anne Evans • Associate editor: Anna Marek • Reviewers: Véronique Lucas-Gabrielli, Camille Regaert • Translator: Véronique Dandeker • Copy Editing: Anna Marek • Layout compositors: Damien Le Torrec • ISSN : 1283-4769.