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Compulsory Psychiatric Treatment: An Assessment of the Situation Four Years After the Implementation of the Act of 5 July 2011

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French law relating to compulsory psychiatric treatment was amended by the Act of 5 July 2011. It reaffirmed the rights of people receiving compulsory treatment and introduced two key measures: the intervention of the judge of freedom and detention (Juge des libertés et de la détention, or JLD), who monitors the need for compulsory treatment, and the possibility of compulsory ambulatory care as part of treatment programmes. In addition, a new form of admission 'in the case of imminent danger' (Acute Involuntary Admission or AIA) was introduced to facilitate access to care for isolated and socially excluded people.

Based on medico-administrative data, this study analyses the evolution in the use of compulsory psychiatric treatment since the introduction of the Act in 2011. 92,000 people received compulsory treatment in 2015, that is 12,000 more people than in 2012. This rise is explained by several factors: the extension of the duration of out-of-hospital compulsory care, as part of treatment programmes, and the rise in the treatment rates for people in imminent danger. Used to facilitate hospital admission in emergency situations and relieve third parties of this difficult process, this mechanism is used in a disparate manner, depending on the geographical area in France.

 Consent to care is a prerequisite for any therapeutic treatment (Article L.1111-4 of the Public Health Code (Code de la Santé Publique). Nevertheless, in the event of a severe psychiatric disorder affecting awareness of the disorder and the need for treatment, French law also provides for the use of compulsory treatment to prevent any deterioration in the patient due to a lack of treatment. Although it is now used in a small minority of cases, compulsory psychiatric treatment can be given in many countries (Kisely et al., 2011). In France,

the law concerning compulsory treatment was extensively amended by the Act of 5 July 2011, relating to the rights and protection of persons receiving psychiatric treatment and the treatment methods. It reaffirmed the rights of patients receiving compulsory psychiatric treatment: the duty to provide information on the patient's rights and review procedures, and the involvement of the patient in the decision-making process. Two key measures were introduced: on the one hand, the systematic monitoring of the need for compulsory hospitalisation by the judge

of freedom and detention, and the possibility for the hospitalised person to consult the judge; and, on the other hand, the possibility of compulsory ambulatory care as part of treatment programmes¹. Furthermore, the Act introduced a new form of admission 'in the case of immi-

¹ The treatment programmes, introduced by the Act of 5 July 2011, made it possible to provide involuntary outpatient and part-time care, which did not exist before. The programme sets out the treatment methods and their frequency in a written document, after an interview with the patient. The treatment programmes are similar to the notion of Compulsory community treatment (CCT) used in English literature.

SOURCES AND METHODS

The main source used is the Medical Information Database for Psychiatry (**Recueil d'Informations Médicalisé en Psychiatrie**, or Rim-P), diffused by the Agency for Information on Hospital Care (Agence Technique de l'Information sur l'Hospitalisation, or ATIH). Based on information provided by French public and private hospital-based psychiatric care facilities and introduced in 2007, this obligatory medical-administrative database comprises anonymous individual data: demographic, geographic, and clinical characteristics and data relating to the methods of full-time, part-time, and ambulatory treatment of persons receiving psychiatric care. In order to take into account the partial lack of response of certain institutions until 2013 (representing 1% of the activity), the rates and evolution graphs presented here only concern all the institutions that responded over the different years. The results include the French overseas départements, which explains some of the differences with the 2012 overview.

In relation to the specific issue of compulsory psychiatric treatment, the Rim-P database records the legal treatment procedure for each full-time or part-time sequence of treatment and each ambulatory act. The information about the care programme in the Rim-P is inferred from the pres-

ence of ambulatory acts or sequences of part-time treatments with a compulsory legal method. The absence of a precise indicator for the implementation of a care programme limits the analysis, particularly with regard to the duration of the programmes or failures leading to rehospitalisations.

Data was also provided by the Civil General repertoire of the French Ministry of Justice (**Répertoire Général Civil du ministère de la Justice**) relating to the interventions of the judges for freedom and detention concerning compulsory psychiatric treatment. This shows the evolution in the interventions of the judges of freedom and detention, the proportion of obligatory and optional judicial referrals, and the outcome of these consultations. This data is shown per court or département.

In addition, a regional monitoring committee was established to discuss the results and decide on the main areas of analysis. It comprised the representatives of users and families, psychiatric doctors, emergency doctors, medical information directors, centre directors, elected officials, a judge of freedom and detention, members of a local mental health board, and decision-makers from the Provence-Alpes Côte d'Azur Region (Paca).

CONTEXT

This study was carried out in conjunction with the Provence-Alpes Côte d'Azur Regional Emergency Observatory (Observatoire Régional des Urgences) and was funded by the General Directorate for Health (Direction Générale de la Santé, DGS) to monitor the Act of 5 July 2011 concerning the rights and protection of patients undergoing psychiatric care.

ment danger' to facilitate access to care for isolated and socially excluded people.

This study follows on from the assessment conducted by the Irdes in the year following the implementation of the reform (Coldefy, Tartour, 2015). It aims to verify whether the trends observed have continued, by tracing the evolution in the use of compulsory psychiatric treatment since 2012 and the development of the treatment programmes. The study then looks at the intervention of the judge of freedom and detention, based on the data provided by the French Ministry of Justice. The approach adopted is essentially quantitative, based on the use of medico-administrative databases (Sources and methods' insert).

E

The legal procedures for compulsory psychiatric treatment, since the Act of 5 July 2011

All of them must meet three criteria: the presence of mental disorders; the patient's psychological orders make his or her consent impossible; and the patient's state requires immediate care combined with constant or regular surveillance in a hospital.

Hospitalisation at the request of a state representative (**Soins psychiatriques sur décision d'un représentant de l'Etat**, SDRE) replaced and extended obligatory hospitalisation (Hospitalisations d'office, HO) to include other forms of part-time and ambulatory treatment. A fourth criterion had to be met: persons who represent a danger to other persons or a serious menace to public order. The admission is ordered by the Prefect based on a detailed medical certificate from a psychiatrist who practises outside the psychiatric institution.

Hospitalisation at the request of a third party (**Soins psychiatriques sur demande d'un tiers**, SDT), previously called hospitalisation at the request of a third party (HDT), is based on the notion of a 'third party' who enables the patient to commence treatment. Any person (excluding the nursing staff) may be 'a third party' who can justify that they were close to the patient before their hospitalisation and act on the patient's behalf. The request for treatment must be hand written and accompanied by two detailed and complementary medical certificates. The first certificate must be issued by a doctor who has no connection with the hospital, whilst the second must be issued by a psychiatrist working in the hospital.

Acute involuntary admission (AIA) used in the case of imminent danger (**Soins psychiatriques en cas de péril imminent**, SPI) was introduced by the Act of 5 July 2011 in order to enable isolated and socially excluded people to receive treatment. The admission criteria are similar to those for persons

hospitalised at the request of a third party. In addition, the absence of a viable and contactable third party in the event of a serious and imminent threat to the health and/or life of the person is a fundamental prerequisite for his or her admission at the request of the hospital director on the basis of a medical certificate issued by a doctor who has no connection with the institution. The director must inform the patient's family or any other person acting on his or her behalf within twenty-four hours.

Both of the following treatment methods follow the same procedures as hospitalisations requested by a state representative: psychiatric treatment for persons who are not criminally responsible (**Soins psychiatriques à destination des personnes jugées pénalement irresponsables**, PJPI) is part of a specific measure complemented by intensive monitoring.

Psychiatric care for detainees (**Soins psychiatriques à destination des personnes détenues**, D398), preceding the implementation of the reform, specifically concerns incarcerated persons with severe mental disorders requiring hospital treatment and who cannot be incarcerated in a penitentiary establishment. The treatment is administered in a standard psychiatric unit. The programme to open specially adapted hospital units (Unités hospitalières spécialement aménagées, UHSA), implemented since 2010, means that it is now possible to 'freely' hospitalise detainees in specifically adapted conditions wherever these units exist in France.

Temporary treatment orders, or TTOs (**Ordonnances de placement provisoire**, OPP) concern minors, when the parents are opposed to indispensable therapeutic treatment. The doctor may refer the case to the public prosecutor, who brings the matter before the children's judge, in order to adjudicate on the issue.

Over 92,000 people received compulsory psychiatric treatment on at least one occasion in France, in 2015: the patients were largely young males suffering from severe psychiatric disorders

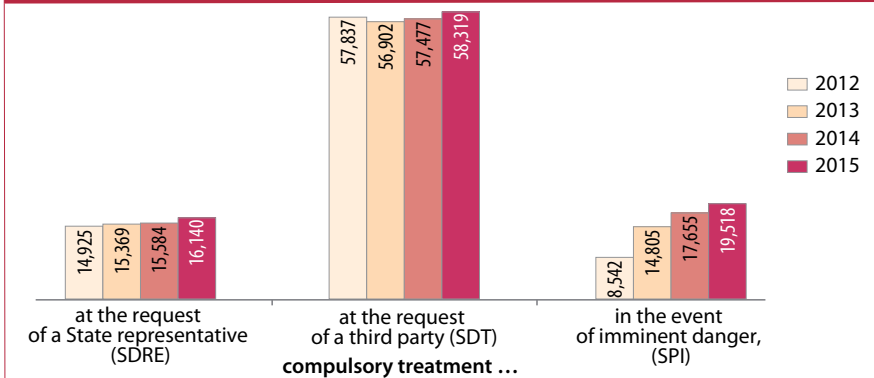
In 2015, authorised public and private psychiatric institutions gave compulsory treatment to over 92,000 people aged sixteen or over, that is 5.4% of the active patient list receiving psychiatric care². This patient category differed from the category of patients receiving voluntary psychiatric care in several respects:

- Men were over-represented: they represented 60% of the people receiving compulsory treatment, compared with 47% of all the people receiving psychiatric care;

² The total active patient list receiving psychiatric care corresponds to all the people treated on at least one occasion during a given year.

G1

Evolution (2012 to 2015) in the number of patients receiving compulsory psychiatric treatment per legal procedure



Note: The same patient may be treated according to different legal procedures over the course of one year.

Scope: France.

Source: Rim-P.

[Download the data](#)

active patient list hospitalised on an exclusively voluntary basis dropped by 4% during the period. In 2015, the active patient list hospitalised without consent represented 24% of the active patient list hospitalised full time (and 25% of the days) in the authorised psychiatric institutions, compared with 21% in 2012 (Graph 2).

An increase in the number of people receiving psychiatric care without consent, explained by the extension of treatment outside the psychiatric institution as part of the care programmes ...

- With an average age of 43, the people receiving compulsory treatment were younger than the people receiving general psychiatric care (an average age of 47);

- The people diagnosed with schizophrenic or psychotic disorders represented almost half of the people receiving compulsory care (11% of the people receiving psychiatric care). Bipolar disorders (11%) and personality disorders (8%) were also more frequent in patients receiving compulsory treatment. Hence, people suffering from the most severe psychiatric disorders were more likely to require compulsory care in the course of their treatment.

treatment sessions. This increase related to all the legal care procedures (insert p. 2), but was more significant with regard to treatment in the case of imminent danger (AIA), introduced by the Act of 2011 (Graph 1).

The increase in the number of people receiving compulsory treatment is also evident when the analysis is restricted to people who were hospitalised full time. Among the 92,000 people who received compulsory treatment in 2015, 80,000 were hospitalised full time on at least one occasion during the year, representing an increase of 13% compared with 2012. In parallel, the volume of the active patient list receiving full-time psychiatric treatment in hospitals (voluntary care or treatment without consent) remained stable (342,500 people aged 16 or over were hospitalised in 2015) and the volume of the

The primary factor underlying this increase is linked to the extension of compulsory medical treatment procedures to ambulatory care and part-time care, as part of the care programmes. The number of people receiving compulsory medical treatment rose because of the increased duration of out-of-hospital compulsory medical treatment. A study conducted in the Ile-de-France region two years after the implementation of the Act (Vidon et al., 2015) estimated that the average duration of these programmes, depending on the legal method of treatment, was between 12 and 22 months.

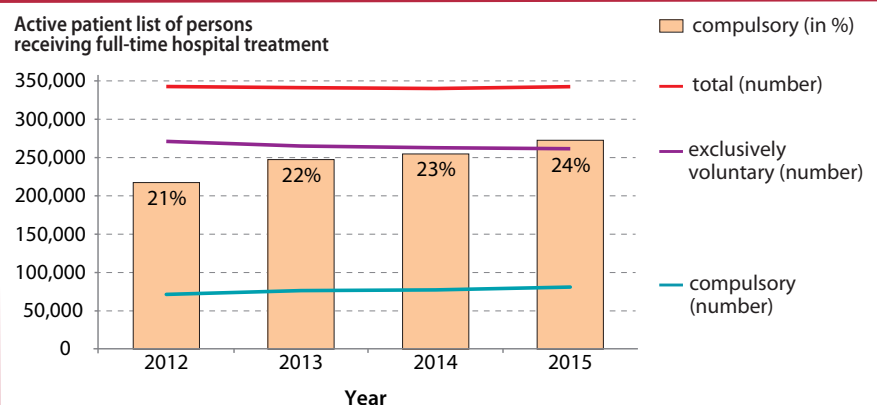
Among the 92,000 patients who received compulsory treatment in 2015, around 29,000 (31%) had already received compulsory treatment in the preceding year. This proportion has trended upwards since 2012. Among them, around

There has been a noticeable increase in the use of compulsory psychiatric treatment since 2012

In 2015, over 1.7 million people aged sixteen or over were treated in authorised public and private psychiatric institutions. Among them, over 92,000 people received compulsory care on at least one occasion (full-time, part-time, or ambulatory care), that is 15% more people than in 2012. This increase is higher than that of the total active patient list receiving psychiatric care (+ 5% over the period). While 4.8% of the patients received compulsory treatment in 2012, they represented 5.4% of the patients in 2015; hence, there was an increase in the use of compulsory psychiatric care, measured in terms of the patients concerned, days, or

G2

Evolution (2012 to 2015) of the active patient lists in full-time hospital psychiatric care per legal procedure



Scope: France.

Source: Rim-P.

[Download the data](#)

11,000 people had already received compulsory ambulatory care in the preceding year. It was this subcategory of patients in care programmes that increased significantly year after year (Graph 3).

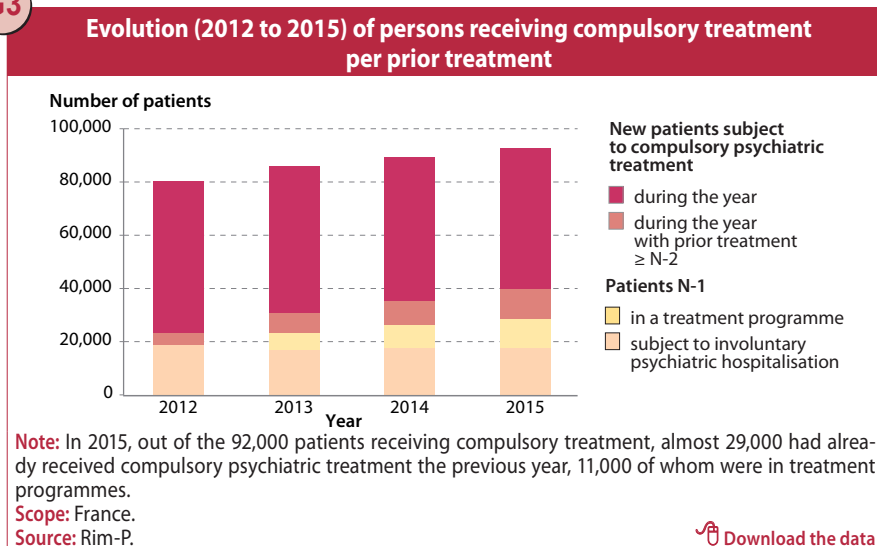
Furthermore, the category of patients who received compulsory medical treatment grew by more than half each year. In 2015, 64,000 patients who received compulsory medical treatment had not received this type of treatment in the preceding year, and 52,000 patients had not received this type of treatment in the three preceding years.

... and the rise in the number of Acute Involuntary Admissions (AIAs)

The various legal admission procedures were affected in different ways by the rise between 2012 and 2015. As in 2010, the majority of cases involved treatment at the request of a third party (French: Soins à la demande d'un tiers, SDT; 64% of the patients in 2015), followed by treatment in the case of imminent danger (21%), and treatment at the request of a state representative (18%). The other procedures (the hospitalisation of inmates, governed by Article D398 of the French Penal Procedure Code, people deemed to be not criminally responsible, and provisional detention orders for minors) remained in the minority, representing less than 4% of the people who received compulsory medical treatment³.

The number of people who received treatment at the request of a third party (59,000 people in 2015) increased by 1% between 2012 and 2015, representing a clear slowdown since the Act of 2011 (Graph 1). During the same period, the number of people receiving treatment at the request of a state representative (Soins à la demande du représentant de l'Etat, SDRE) increased by 8%, reaching a little over 16,000 people in 2015. The highest increase concerned the new type of hospital admission for treatment in the case of imminent danger, introduced by the Act of 2011. The number of people admitted in the case of imminent danger (AIA) more than doubled since the intro-

G3



duction of the procedure in 2011–2012. 19,500 people were admitted in the case of imminent danger in 2015, compared with 8,500 in 2012 (i.e. + 128%). Acute Involuntary Admissions (AIAs) now represent 21% of the compulsory medical treatment. Initially aimed at isolated and socially excluded people, for whom a third party cannot be found, the procedure has seen a significant increase in numbers that exceeds exceptional procedures.

Most of the AIAs were initiated by the emergency services

The patients admitted as AIAs in 2015 had clinical and demographic characteristics⁴ that were relatively similar to those of the patients admitted at the request of a third party. The majority of cases involved psychotic disorders (including schizophrenic disorders), but the people admitted in the case of imminent danger were somewhat different because of a higher incidence of personality disorders and addiction-related disorders, and neurotic disorders. Lastly, the people admitted in the case of imminent danger were characterised by periods of hospitalisation that were on average shorter than those admitted at the request of a third party. 27% (of the hospitalisation periods in the year) of the AIAs in 2015 had a duration less than or equal to 72 hours (the initial period of treatment and observation introduced by the Act of 2011) and 56% of the AIAs had a duration of less than 12^e days (the time limit for the intervention of the judge of freedom

and detention): 16% of the AIAs left the hospital after 72 hours, 10% of the cases became voluntary hospitalisations, and 1% became another form of legal involuntary hospitalisation. In comparison, 23% of the admissions at the request of a third party had a duration of less than 72 hours, and 51% less than 12 days. The difference is primarily due to the fact that a higher rate of the AIAs became voluntary hospitalisations (10% patients admitted in the case of imminent danger became cases of voluntary treatment after 72 hours, compared with 6% patients admitted at the request of a third party).

With a shorter period of treatment, one of the most distinguishing factors relating to AIAs was that they were initially treated by the emergency services. 63% of the patients admitted in the case of imminent danger in 2015 were dealt with by an emergency service⁵ before being admitted as AIAs; 6% were transferred from another department, and only 31% came directly from their homes. In comparison, 53% of the patients admitted at the request of a third party were dealt with by the emergency services; 7% of the

³ The sum of the percentages exceeds 100, as a person may be admitted via several legal procedures during a given year.

⁴ The Rim-P (Medical Information Database for Psychiatry) data does not, however, make it possible to identify the person's social environment, which may explain the difficulty in finding a viable third party.

⁵ These patients are identified via their form of admission and their entry in the Rim-P database, an associated stay, or emergency treatment invoiced in the framework of the PMSI MCO (Medicalisation Programme for Acute Healthcare Information Systems in Medicine, Obstetrics and Dentistry).

patients were transferred, and 41% were admitted from their homes.

The actors on the ground, medical professionals, and representatives of patients' families point to two factors to explain the increase in the use of this procedure. The AIAs are a simplification of the admission procedure for psychiatric care under emergency conditions. Gobillot et al. (2015) have revealed a more frequent use of the procedure by the emergency services and SOS doctors, non-psychiatric doctors, emergency doctors, and general practitioners. The use of this form of care is therefore justified by the difficulty of waiting in the emergency department for a third party to be found, or for the consent of patients suffering from acute mental illness. The AIAs can also be used to protect a third party (Klifa, 2014). The request by a third party for compulsory treatment is often very difficult for the party concerned (a member of the family or friend) and may have an adverse effect

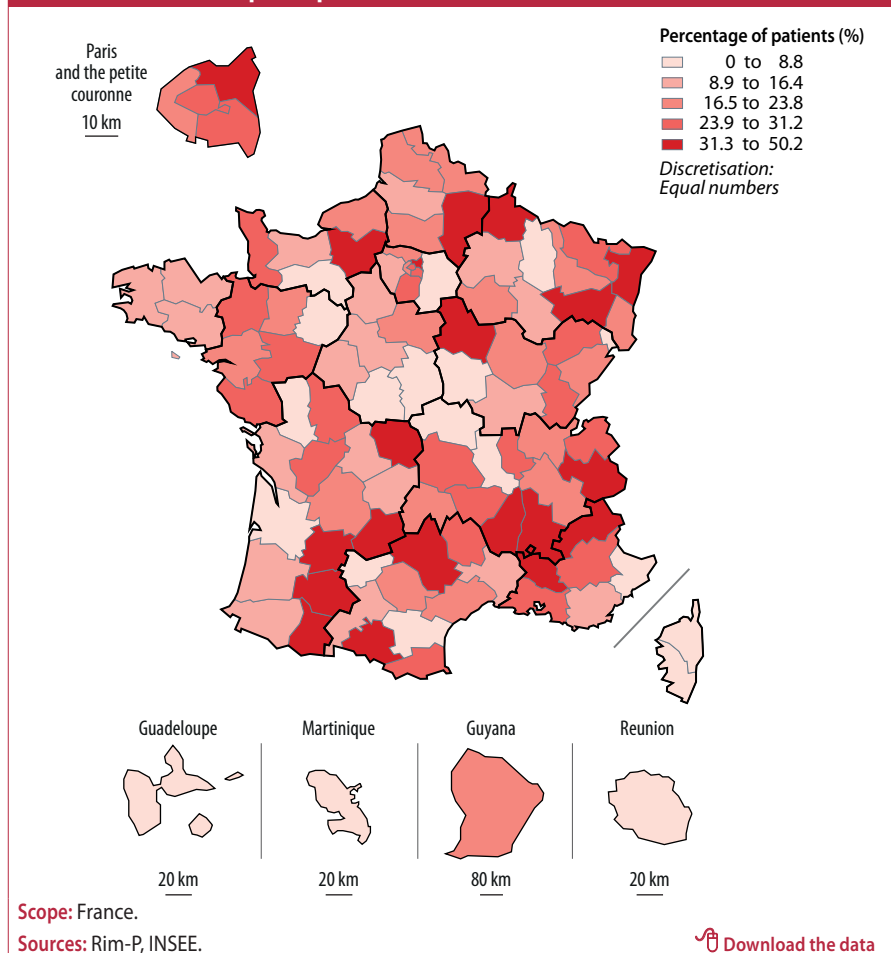
on his or her relationship with the person. In the case of AIAs, the doctor bears sole responsibility – morally and medically – for the decision. Since 2012, the number of people admitted at the request of a third party stabilised (+ 0.5% of people hospitalised in this way, i.e. 51,256 people in 2015), confirming that some patients admitted at the request of a third party became AIAs. However, the doubling in the number (since 2012) of people admitted as AIAs (over 18,000 people hospitalised in 2015) was due more specifically to the simplified entry into the mental health system offered by this procedure.

The use of AIAs varies greatly according to the region

The proportion of AIAs in compulsory treatment varies greatly according to the départements (Map), which raises questions about the practices and the ways

in which emergency treatment is organised in health institutions and by other regional actors. While at national level, two out of every ten patients receiving involuntary care were admitted as AIAs on at least one occasion in 2015, this was the case with less than one out of ten patients in 22 départements, but more than four out of ten patients in the Ariège, Ardèche, Creuse, Lot, Eure, Savoie, Drôme, and Bas-Rhin départements. Within the départements, the practices vary greatly from one institution to another, and even from one department to another. In 2015, among the 260 authorised public psychiatric institutions, 40 declared that they had had no AIAs. By contrast, 40 institutions declared that over 35% of their patients who received involuntary treatment were AIAs. These institutions dealt with 36% of the patients admitted as AIAs, and treated 19% of the patients admitted for involuntary treatment and 16% of the active patient list receiving general psychiatric care in France.

C Proportion of AIA patients out of patients receiving compulsory psychiatric treatment in 2015 per département where the treatment was administered



The increase in the use of this procedure and the considerable variations in its application in different regions and institutions raise questions about its purpose. To what degree do the AIAs facilitate access to care in complex situations and emergency situations, or do they infringe upon the patient's freedom because of the simplification of the admission procedure?

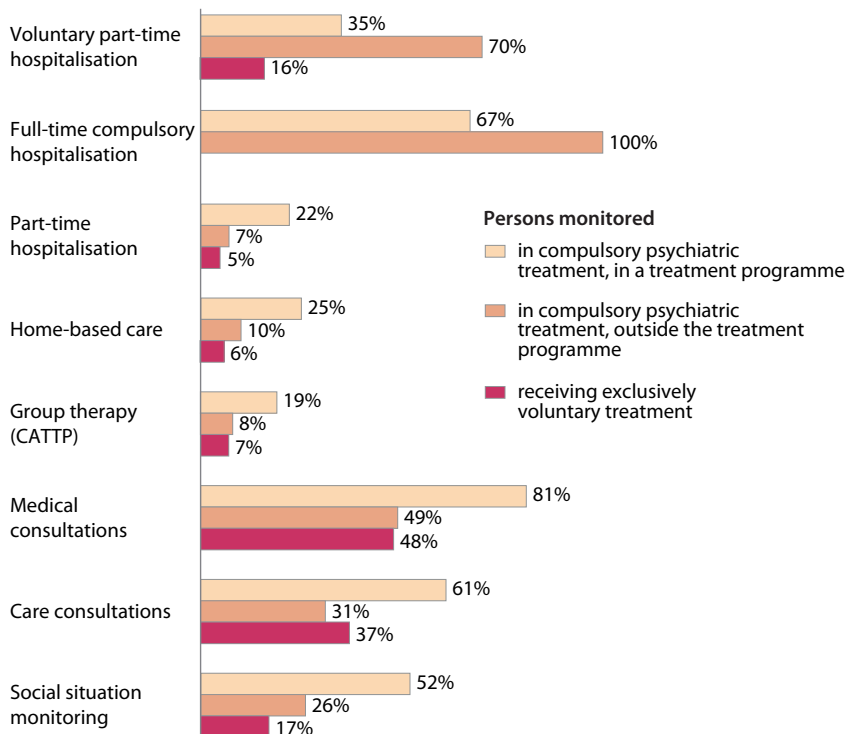
The treatment programmes: an assessment of the situation four years after their introduction

The treatment programmes, introduced by the Act of 5 July 2011, made it possible to provide involuntary outpatient and part-time care, which did not exist before. The programme sets out the treatment methods and their frequency in a written document, after an interview with the patient: part-time hospitalisations (during the day or night), outpatient care (in a medico-psychological centre or a part-time therapy centre), home care, and, in certain cases, drug therapy. Hence, the treatment programmes extend the principles of the deinstitutionalisation of psychiatric care to involuntary care.

G4

Access to treatment methods for persons receiving compulsory psychiatric treatment compared with those receiving voluntary treatment in 2015

Proportion of monitored persons



Note: 16% of the patients followed in free care exclusively were hospitalized full-time.
 Scope: France.
 Source: Rim-P.

[Download the data](#)

treatment methods implemented by the sector policy for the various phases of the pathology. Hence, 81% of the persons in treatment programmes had medical consultations and 61% paramedical consultations (Graph 4). More than half also benefited from social aftercare and 25% were treated at home. These rates were almost two times higher than those observed for persons undergoing compulsory hospital admission but who were not in a treatment programme. They were also much higher than those observed for patients receiving voluntary care that comprises a broad range of pathologies and various levels of severity.

The increased access to all of the treatment methods was complemented by a greater intensity in these treatments, represented by the average number of medical acts or treatment days over the year (Graph 5). Therefore, the treatment programmes constitute a form of intensive treatment for persons suffering from severe psychic disorders who require compulsory psychiatric treatment. The intensity of treatment was also evident in full-time hospital care, whether in terms of the duration of the hospitalisations or the frequency of hospital stays over the year. Although a third of the patients in treatment programmes had never been hospitalised full time during the year (having begun their care programme the previous year), two thirds stayed in hospital for longer periods and more frequently than for the others receiving voluntary or compulsory psychiatric care.

In 2015, around 37,000 people received involuntary outpatient or part-time care⁶, representing 40% of the people who received involuntary treatment. Their number increased but less significantly than that of people hospitalised without consent. This limited increase is partly due to the difficulty of implementing the programmes on the ground. The treatment programmes are most commonly used for patients receiving treatment at the request of a state representative (53% of the patients received such treatment in 2015), where there is a possibility of police involvement if the patient ceases to follow the treatment programme. In the case of patients admitted at the request of a third party, where it is more difficult to ensure compliance with an outpatient programme, the treatment programmes have declined slightly in number since 2014 (40%).

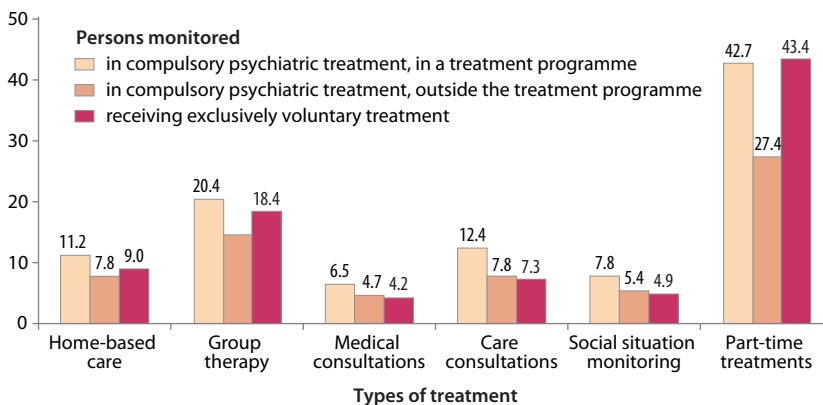
⁶ The Rim-P does not make it possible to directly identify the care programmes. They are indirectly identified via the presence of at least two ambulatory treatment sessions or part-time treatment sessions with a legal involuntary treatment procedure.

Compulsory ambulatory and part-time care mainly concerned persons with psychotic disorders (59% of patients in care programmes), whatever the legal treatment procedure. The availability of ambulatory care for persons suffering from a severe psychiatric disorder that requires compulsory psychiatric treatment enabled the patients to benefit from all the necessary

G5

Intensity of ambulatory and part-time treatment of persons receiving psychiatric care in 2015

Average number of interventions or days of treatment

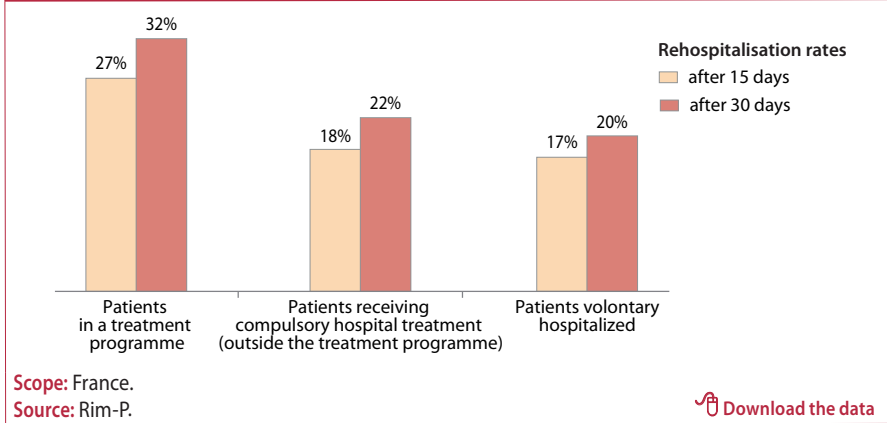


Scope: France.
 Source: Rim-P.

[Download the data](#)

G6

Rehospitalisation rates after 15 and 30 days for persons in treatment programmes, compared with patients receiving psychiatric treatment in hospitals in 2015



(Guibet-Lafaye, 2014) are important and need to be studied to assess their effectiveness and convey the viewpoints of the persons directly concerned. Rare indeed are the studies that have analysed the perception of these programmes by the patients themselves.

The Intervention of the Judge of Freedom and Detention

In order to improve the rights of persons receiving compulsory psychiatric treatment, the Act of 2011 introduced a new actor in the treatment process—the judge of freedom and detention (Juge des libertés et de la détention, or JLD). The judge of freedom and detention has to decide whether the infringement of individual freedom constituted by compulsory psychiatric hospitalisation is necessary and proportional (Senon et al., 2012). In proportion to the rise in the number of persons receiving compulsory treatment, the total number of referrals rose steadily. This increase was even greater after the amendment of the Act in 2013, which reduced the length of time – within 12 days, compared with 15 days in 2011, of the person’s admission – for a judicial review of the need to keep the patient in full-time hospital care. This rise was mostly due to so-called ‘obligatory’ referrals, which represented 96.8% of all the referrals in 2015, compared with 94.4% in 2013, and which were accompanied by an overall reduction in optional referrals (respectively by 5.2% in 2013 compared with 3.1% in 2015); this may be partly explained by the reduction in the length of consultations with the judge of freedom and detention. Patients being better informed about their rights and the introduction of the judge of freedom and detention were significant improvements on the Act of 2011 with regard to the rights of persons requiring compulsory psychiatric care at some point in their treatment programme. However, the low proportion of optional referrals raises doubts about the effectiveness of the patient’s access to rights and review procedures.

Almost one out of ten consultations with the judge resulted in the lifting of the compulsory measures (statistics provided

Persons in treatment programmes who were admitted to hospital on a full-time basis (either at the beginning of the programme, or subsequently during the treatment, or in the event of the patient’s reintegration after an interruption in the treatment programme) were hospitalised for an average of 75 days over the year (of which 61 days were compulsory) compared with 68 days (of which 45 days were compulsory) for the persons receiving compulsory treatment outside the treatment programme. This duration was far higher than that observed for persons exclusively hospitalised on a voluntary basis over the year (49 days on average). Furthermore, the periods of ‘compulsory’ hospitalisation were higher than those of patients who were not in treatment programmes.

By improving ambulatory treatment, the treatment programmes could limit the number of hospitalisations. Yet, the rehospitalisation rates at 15 and 30 days were higher for persons in treatment programmes (Graph 6). However, the statistics provided do not indicate if these rehospitalisations were an integral part of the programme (sequential hospital admissions) justified by the severity of the disorders, or if they corresponded to relapses or reintegrations into hospital after noncompliance.

Implemented in many countries, sometimes many years ago (as early as the 1980s in the United States and Australia, and since 2008 in England) (Kisely et al., 2014. Churchill et al., 2007), the ethical and medical aspects of compulsory ambulatory care have generated much

controversy. Studies conducted outside France with the intention of assessing their impact have mostly produced controversial results or the absence of significant conclusions in terms of reducing hospitalisation rates, the use of the health services, and, more generally, benefits for the patient (Burns et al., 2016; Molodynski et al., 2010; Castelles-Aulet et al., 2015; Maughan et al., 2014; and Dawson, 2005).

The Rim-P data is limited as a means of analysing the effectiveness of treatment programmes. Complementary studies, such as longitudinal surveys and randomised controlled trials, are required to assess (in France) the benefits of these programmes, both in terms of the reduced hospitalisation rates, compliance with treatment, and above all improvements in the health status, degree of recovery, and quality of life of the patients, and their level of satisfaction. From a legal standpoint, treatment programmes extend involuntary out-of-hospital psychiatric treatment to the patient’s home, sometimes over extended periods, thereby increasing the number of persons receiving this care. Although the 2013 amendment to the Act specified that a patient receiving treatment as part of a treatment programme can in no way be placed under any constraint, the threat of readmission to hospital in the event of noncompliance with the treatment programme may be perceived as an infringement of freedom for the person receiving treatment in these programmes. The ethical issues relating to the extension of compulsory out-of-hospital psychiatric treatment in the framework of treatment programmes

by the French Ministry of Justice), with significant variations between départements (between 0 and 38% in 2015 for the obligatory procedures carried out by the judge of freedom and detention). The proportion of discharges was higher but remained limited in the event of optional referrals by the persons or their relatives (13.5%). It was higher in the case of disagreements between the psychiatrists and the Prefect (25% of the referrals resulted in the lifting of the measure, and only 72 measures were recorded in 2015). To rule on the necessity, appropriateness, and relation between the treatment measures and the deprivation of individual freedom, the judges based their decisions on a limited range of documents – the decision to hospitalise the patient made by the director of the psychiatric institution and detailed medical certificates – and in tight deadlines. The main reasons for contesting the measure related to procedural flaws (59%) noncompliance with regard to the notification of the patient's rights, the author of the psychiatric certificate, the third party's viability, and failure to adhere to the legal requirements for timelines), technicalities (24%) relating to the failure to state adequate

reasons to justify the patient's hospitalisation, or doubts about the competence of the author of the administrative act (17%) (Legohérel, 2014).

* * *

Since the implementation of the Act of 5 July 2011, the number of persons receiving compulsory psychiatric treatment increased more quickly than the active patient list receiving psychiatric care. This increase resulted from several factors. The first was related to the development of treatment programmes, which extended compulsory medical treatment outside the period of the patient's hospitalisation. The proportion of patients receiving compulsory treatment over several years increased after 2012, as the treatment programmes continued over a long period. Consequently, the number of persons receiving compulsory psychiatric treatment systematically increased every year. The second factor was the rise in the treatment rates for people in imminent danger, implemented by the Act in order to facilitate access to care for isolated and socially excluded people, for whom the request of a third party was difficult to obtain. This

scheme, which was implemented in a heterogeneous manner in France, appears to be used both to facilitate the admission system in emergency situations and to protect the third party from the difficult process of requesting treatment for a relative against their wishes.

These results, provided by statistics from the Medical Information Database for Psychiatry (Recueil d'Informations Médicalisées en Psychiatrie, or Rim-P), require complementary studies and an improvement in the information systems to enable a real assessment of the measures introduced by the Act of 5 July 2011. An evaluation would be even more crucial as the new measures affect people's individual freedoms. The extension of an undefined form of constraint to the patient's living areas may infringe on the rights and freedom, which must be monitored. These exceptional measures must be proportional to the anticipated benefits for the patient, and this is even more important in a context in which the recommended relationship between doctors and patients is shifting towards greater participation by the patients in the choice of their treatments. ♦

FOR FURTHER INFORMATION

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