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Involuntary Care and Coercion for Patients in Psychiatric Facilities: a Reduction Target that Remains to Achieve

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A reduction in the use of involuntary care, seclusion and restraint measures is one of the objectives of the Roadmap for "Mental Health and Psychiatry", in force 10 years after the implementation of the law of 5 July 2011, which modified procedures for resorting to involuntary care in psychiatric facilities, and five years after the law on the modernisation of the French healthcare system, which outlined a political will to regulate and reduce the use of coercion in psychiatry. In this context, this article presents a study on the use of these measures and their evolution at the national level, based on data from the Medical Information Database for Psychiatry (*Recueil d'Informations Médicalisé en Psychiatrie*, Rim-P).

In 2021, more than 5% of the people who received care in a psychiatric facility and 26% of those hospitalised full time in such facilities were treated without consent at least once during the year. There was a significant rise in the use of involuntary care between 2012 and 2021, despite a tailing off since 2015. Although the Covid-19 pandemic led to a sharp decrease in the overall use of psychiatric care in 2020 (with an 8% fall in the number of people hospitalised full time), the reduction in the use of involuntary care was lower (only a 1% fall in the number of people hospitalised full time).

The use of seclusion measures rose until 2018, with a slight decrease in 2019. However, there was a sharp increase in the use of these measures in 2020 and their extent, which decreased in 2021, remained higher than during the period prior to the Covid-19 crisis. Initial estimates on the use of mechanical restraint highlight that approximately 10,000 individuals were subjected to this type of coercion in 2021, representing more than one in 10 people who were involuntarily hospitalised. Continuous improvement in the quality, completeness, and dissemination of data on the use of coercion in psychiatry remains necessary in France to support the policy objective of reducing the use of such restrictive practices.

Since the implementation of the law of 4 March 2002, the French Public Health Code has affirmed that consent to care is a prerequisite for any therapeutic treatment (Article L1111-4 of the French Public Health Code). The possibility of imposing care in the absence of consent (involuntary care) is an exception exclusive to psychiatry. It aims to deal with situations in which individuals are unable to consent to care due to an altered awareness of their disorder or care needs, whereas their mental state requires immediate treatment and medical surveillance. Although it exists throughout the world (Rains et al., 2019), involuntary care in psychiatric facilities must remain an exception, as unanimously and repeatedly underlined in the international recommendations for good practice in mental health care (WHO, 2012, 2021).

In France, legislation governing the use of involuntary psychiatric care changed at the beginning of the 2010s (the law of 5 July

2011 concerning the rights and protection for individuals receiving psychiatric care, and the law of 27 September 2013 which made amendments to some part of the law of 5 July 2011). The new legislative provisions reaffirmed the obligation to inform patients seen in psychiatric facilities of their rights and the avenues of appeal, as well as of the need to involve them in decisions regarding treatment. They introduced a compulsory intervention of a liberty and custody judge (juge des libertés et de la détention or JLD) in monitoring the implementation of involuntary psychiatric care and a new legal admission procedure making it possible to provide treatment for people whose social ties are ruptured and isolated people (see Inset 1, "Care in the Case of Imminent Danger"). They also enabled healthcare professionals to provide involuntary ambulatory care –and not only during hospitalisation– as part of community treatment orders (see Inset 1). Furthermore, an initial 72-hour period of care and observation was introduced, during which a psychiatrist in the hosting institution has to issue certificates stating whether the person's state of health justifies the continuation of involuntary care.

Since 2012, significant regional disparities have been observed, as well as a rise in the use of involuntary care, which increased faster than the number of persons receiving psychiatric hospital care (Coldefy, Nestrigue, 2013; Coldefy et al., 2015; Coldefy et al., 2016; Coldefy et al., 2017). International research also shows that the use of involuntary care and its rate of increase over the last 10 years in France is amongst the highest in Europe (Rains et al., 2019). This increase is partly explained by the extension of the duration of ambulatory involuntary care, as part of community treatment orders, and the increase in the use of admissions under the imminent danger procedure (acute involuntary care), which facilitates admission in an emergency situation and relieves third parties of this difficult process (Coldefy et al., 2017).

As of 2018, the Roadmap for "Mental Health and Psychiatry", developed by the French Ministry of Health, advocated a reduction in the use of involuntary care and of seclusion and restraint measures (*Ministère des Solidarités et de la Santé*, 2022). Seclusion consists of placing a person –for protective purposes– in an enclosed space away from other patients during a critical phase in the person's therapeutic treatment. Mechanical restraint aims to limit a person's physical mobility in a situation in which the patient's behaviour is putting themselves or others at serious risk of harm, through the use of straps or specific clothing. These practices, which are often traumatic for the persons concerned, are only recommended as a last resort (see the 2016 Law on the modernisation of the French health system). Recent legislative changes aim to provide a stronger control and enable a regular assessment of the use of coercion in French psychiatry (compulsory traceability in a dedicated register, information of the liberty and custody judge in the event of an extension of

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Involuntary psychiatric care procedures in France

In France, hospitals responsible for providing involuntary psychiatric care, which is considered as a public service mission, are designated by the Regional Health Agencies (*Agences Régionales de Santé*, ARS) after consulting the Prefect. Involuntary care is only authorised for persons suffering from a mental disorder and whose state of health —assessed by physicians— means that they are unable to consent to treatment and requires continuous or regular medical surveillance.

Involuntary psychiatric care may be used based on a decision taken by the director of a psychiatric facility after obtaining detailed medical certificates. This procedure may be implemented on the request of a third party (*Soins psychiatriques sur demande d'un tiers*, SDT): any individual likely to act in the patient's interests and who can justify a relationship with the person prior to admission, with the exception of the facility's healthcare personnel. The treatment request must be written and complemented by two detailed and concurring medical certificates, one of which must be drafted by a doctor working outside the facility. Involuntary care may also be administered without the request of a third party (*Soins psychiatriques en cas de péril imminent*, SPI) in the event of imminent danger and if there is an inability to elicit a request from a third party– particularly for isolated populations, whose social ties have been ruptured. Admission is justified by a single medical certificate established by a doctor who does not work in the facility and a justification for the absence of a contactable third party. Lastly, psychiatric treatment on the decision of a representative of the State (*Soins psychiatriques sur décision d'un représentant de l'Etat*, SDRE) is administered when an individual is identified as representing a threat to the safety of others or public order. This procedure requires a single detailed medical certificate from a doctor working outside the facility, without a request from a third party. The admission order is then issued by order of the Prefect. SDRE includes two additional and specific procedures: psychiatric treatment intended for persons declared criminally irresponsible (Article L13213-7 of the *Code de la Santé Publique*) complemented by reinforced surveillance, and psychiatric treatment aimed at detainees (Article L3214-1 of the *Code de la Santé Publique*). The latter specifically apply to detainees who suffer from severe mental health disorders who cannot be detained in a penitentiary establishment due to the hospital treatment they require, and which is administered in a conventional psychiatric department. Nevertheless, in some regions, specially equipped hospital facilities (*Unités hospitalières spécialement aménagées*, UHSA) make it possible to hospitalise detainees voluntarily or involuntarily for psychiatric treatment in specifically adapted conditions.

Historically limited to full-time hospitalisation, the use of involuntary psychiatric care may, since the law of 2011, be implemented in other forms of care (part-time hospitalisation, consultations in ambulatory centres (*Centres Médico-Psychologiques*, CMP), home visits, etc.) in the frame of community treatment orders. The latter make it possible to extend deinstitutionalisation to involuntary care with a varied palette of treatments. They include an involuntary treatment plan defined in advance in terms of procedures and periodicity, and can only be implemented after a preliminary full-time hospitalisation.

Context

This research project is part of a long series of studies conducted by IRDES into the use of involuntary psychiatric care in France (Coldefy, Nestrigue, 2013; Coldefy et al., 2015; Coldefy et al., 2016; Coldefy et al., 2017), and uses recent data to update previous studies. It is a preliminary step, part of a larger project aimed at exploring the determinants of the use of restrictive practice in psychiatry on a national scale. The latter will be conducted in collaboration with the PLAID-CARE research project, coordinated by Sébastien Saetta (Saint-Etienne University Hospital), which sets out to study hospitals characterised by a low use of coercion measures in psychiatry[1]. In this regard, a specific agreement with the Regional Health Agency (ARS) Provence-Alpes-Côte d'Azur (PACA) was implemented to explore the data relating to seclusion and mechanical restraint in the Medical Information Database for Psychiatry (*Recueil d'Informations Médicalisé en Psychiatrie*, Rim-P).

[1] https://www.health-data-hub.fr/projets/plaid-care-psychiatrie-et-libertes-individuelles-etude-detablissements-caracterises-par-un

the seclusion and restraint measures, etc.) (Decree of 23 March 2022 modifying the applicable procedure before a liberty and custody judge with regard to seclusion and restraint, implemented in the frame of involuntary psychiatric care). However, the General Controller of Places of Deprivation of Liberty (*Contrôleur Général des Lieux de Privation de Liberté*, CGLPL) –the independent administrative authority responsible for monitoring institutions that provide psychiatric care and are authorised to administer involuntary care– has repeatedly and regularly expressed concern about the increased use of this type of treatment (CGLPL, 2019, 2021, and 2022).

In this context, this study aims to provide an updated assessment of the use of involuntary psychiatric care on a national scale in France, 10 years after the publication of the law of 5 July 2011, and including the period affected by the Covid-19 pandemic. A preliminary description of the use of seclusion and mechanical restraint measures is also included, thanks to a recent collection of data enabled by the French Agency for Information on Hospital Care (*Agence Technique de l'Information sur l'Hospitalisation*, ATIH).

Source and Method

This project was based on national data from the Medical Information Database for Psychiatry (Rim-P), produced by the hospitals (public or private, mono- or multidisciplinary) that are authorised to provide psychiatric care and managed by the French Agency for Information on Hospital Care (*Agence Technique de l'Information sur l'Hospitalisation*, ATIH). This systematic collection of administrative and medical data makes it possible to monitor annually care activities managed by hospitals (including out-patient care) in the psychiatric field. It includes data about the clinical (in terms of diagnostic groups that led to treatments), demographic, and socio-economic characteristics of the patients, as well as information about the full time, part time, and ambulatory care that they receive (length of stay, type of care, places of treatment…). The use of involuntary psychiatric care was identified via the variable relating to the legal form of treatment (including for the community treatment orders which existence was not specifically identified and therefore deducted from the presence of ambulatory contacts or part-time treatment with a legal form corresponding to involuntary care). Also identified for each full-time hospitalisation was the number of calendar days the patient had been secluded in accordance with the surveillance protocol of the National Health Authority (*Haute autorité de santé*, HAS) [HAS, 2017], for a continuous period equal to or longer than two hours. Since 2018, the Medical Information Database for Psychiatry (Rim-P) also includes mandatory and specific data relating to seclusion and mechanical restraint measures, which can only be accessed by the Regional Health Authorities (ARS). Its recent establishment means that it needs to be used with caution, pending a national assessment of the quality and exhaustivity of the data. The analysis of the use of mechanical restraint was thus restricted to an assessment of the order of magnitude of the number of persons concerned and was based on a collaboration with the ARS Provence-Alpes-Côte d'Azur (PACA).

First of all, we focused on 2021, the most recent available year, then we outlined the changes in the annual use of involuntary care and seclusion since 2012. We then specifically focused on the period affected by the Covid-19 pandemic, with an analysis of quarterly data in 2020 and 2021. With regard to the study of the changes in the number of persons hospitalised full time without their consent, the data from 2012 was not used as it was incomplete.

In 2021, more than 5% of the people who received psychiatric hospital care and 26% of those hospitalised full time in psychiatry received involuntary care at least once

In 2021, 1.84 million people aged 16 or over received psychiatric hospital care in France. Among them, 95,500 received involuntary care at least once (all forms of treatment combined), that is to say more than 5% of the people who received psychiatric care in 2021. The rate increased significantly when specifically considering the people hospitalised full time in a psychiatric facility during the year (303,658): 26% of them (78,400) received involuntary care at least once.

The people who received involuntary psychiatric care at least once, irrespective of the form of treatment, were more often male (60%) than the other people who exclusively received voluntary psychiatric treatment (46%). Nevertheless, variations were observed based on the legal form of admission, as men represented almost 80% of the individuals admitted for involuntary care as part of admission by decision of a state representative (*Soins Psychiatriques sur Décision d'un Représentant de l'État*, SDRE). The persons who received involuntary care were also younger (average age: 43 years old) than the population that received voluntary treatment in a psychiatric facility (average age: 46 years old). Again, variations were observed based on the legal form of admission with an average age of 34 years old for people who received psychiatric care for detainees, 41 for people who received psychiatric care for the criminally irresponsible, 42 for the other persons admitted by decision of a state representative (SDRE), and 44 for persons admitted for psychiatric care at the request of a third party (*Soins Psychiatriques sur Demande d'un Tiers*, SDT) and in the event of imminent danger (acute involuntary care, SPI).

The persons who received involuntary psychiatric care at least once in 2021, irrespective of the form of treatment, largely received treatment for severe mental health disorders (in particular, psychotic or bipolar disorders) and were over-represented in this population compared with persons who exclusively received voluntary psychiatric care (71% versus 17%).

The clinical and demographic characteristics of the persons who received involuntary psychiatric care at least once remained unchanged over time: in 2015, the population was also largely male, young, and suffering from severe mental health disorders (Coldefy et al., 2017).

Lastly, the use of data relating to the billing of hospital stays made it possible –for people hospitalised full time– to characterise the social situation of the individuals through the use of the Complementary Health Solidarity (*Complémentaire Santé Solidaire*, C2S) for people with low incomes–which has replaced the free Complementary health insurance scheme (*Couverture Maladie Universelle Complémentaire*, CMU-C) and the Health Insurance Vouchers Plan scheme (*Aide à l'acquisition d'une complémentaire santé*, ACS) since 2019. The data showed that the people who were hospitalised full time without their consent were almost twice as likely to be beneficiaries of the CSS than the people who were voluntarily hospitalised full time in a psychiatric facility (33% were beneficiaries versus 17% amongst the people who received voluntary psychiatric care).

There has been a general increase in the use of involuntary care since 2012, despite a tailing off in recent years, which has been relatively unaffected by the general decrease in the use of healthcare during the Covid-19 pandemic

Between 2012 and 2021, the annual number of people who received psychiatric care in a healthcare facility increased by 9%. The increase was more significant amongst the people who received involuntary care at least once; their number increased by 14% during the period (versus + 9% for the people who exclusively received voluntary psychiatric care). Nevertheless, contrasting patterns were observed during the study period, with a significant increase until 2015 and then a decrease with a relative stabilisation of the annual rates of increase (see Graph 1).

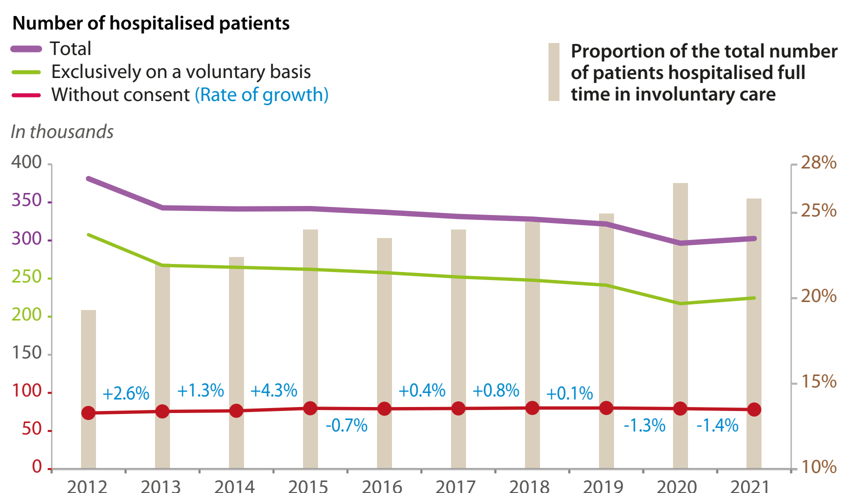
The lockdown measures implemented to curb the spread of the Covid-19 pandemic in 2020 limited access to psychiatric care, as they did in other medical specialties. A break was thus observed in the continual growth in the number of persons who received psychiatric care in a healthcare facility–a change that was less significant in involuntary psychiatric care (see Inset 2): that is to say a 5% decrease in the number of persons who received psychiatric care in a healthcare facility between 2019 and 2020, whereas the decrease was only 1% with regard to the number of persons who received involuntary care at least once during the year. The decrease was more significant for the admissions by decision of a state representative (SDRE) [including admissions of detainees and persons declared criminally irresponsible], whereas admissions in the event of imminent danger (SPI) continued to increase. In 2021, the number of persons who solely received voluntary psychiatric care increased significantly (+ 6%), a form of "catching-up" compared with 2020, but the number of persons who received involuntary psychiatric care at least once remained stable during the period. Several hypotheses may explain these findings. The Covid-19 pandemic resulted in an increase in the prevalence of mild to moderate mental health disorders (Gandré, Hazo, 2021), which, although they required psychological or psychiatric care, particularly ambulatory care, were unlikely to lead to an alteration of the ability to consent to care. Furthermore, as in the other medical specialties, the treatment of the more severe mental health disorders, which required urgent care that could not be postponed, were presumably prioritised in psychiatric facilities, and, in particular, involuntary care, for which a catching-up the following year was therefore not observed.

The proportion of people hospitalised involuntarily full time at least once also tended to increase during the study period (see Graph 1). While the overall number of individuals hospitalised full time in a psychiatric facility has steadily decreased in France (- 12% since 2013), the number of persons hospitalised full time without their consent tended to increase: + 3% since 2013. The year 2020, particularly affected by the Covid-19 pandemic, saw a break in this trend (see Inset 2). A 1% decrease in the number of persons hospitalised full time without their consent in a psychiatric facility at least once was thus observed. However, the decrease was less marked than that observed for people hospitalised full time who solely received voluntary psychiatric care, which was - 10% during the same period, which suggests that involuntary treatment, corresponding to emergency care, was prioritised. In 2021, there was a slight increase in the number of persons voluntarily hospitalised full time in a psychiatric facility compared with 2020 (+ 3%), whereas the number of persons hospitalised full time without their consent at least once decreased by 1%. This trend should be monitored over time in order to determine whether it is a temporary or persistent trend and assess the commitment to reduce the use of involuntary psychiatric care.

Care in the event of imminent danger– a practice that continues to go beyond the scope of the exceptional measures

A quarter of the people who received involuntary psychiatric care at least once in 2021 were admitted in the event of imminent danger (acute involuntary care, SPI) [see Graph 2]. Since its implementation under the law of 2011, the number of persons admitted in the event of imminent danger has continued to increase and was the second most frequently used legal form of involuntary care in 2021 (+ 186% since 2012), after psychiatric care at the request of a third party (SDT), which has decreased slightly since 2012 (- 6%). In 2020, at the height of the Covid-19 pandemic, admission in the event of imminent danger (SPI) was the only legal form of admission which use (in terms of the number of persons concerned) increased, whereas a decrease was observed for all the other forms of admis-

G1 Evolution in the number of persons hospitalised full time, treated at least once without consent or solely on a voluntary basis, in a psychiatric health facility between 2013 and 2021



Source: The Medical Information Database for Psychiatry (Rim-P), years: 2013 to 2021.

Scope: People aged 16 years old or over receiving psychiatric care in a mental health facility in France; the people receiving involuntary care includes all the people treated at least once a year in the frame of psychiatric care on the decision of a representative of the State (SDRE), psychiatric care at the request of a third party (SDT) or "Care in the Case of Imminent Danger" (SPI).

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sion (see Graph 2). These findings suggest, as did previous studies (Coldefy et al., 2015; Coldefy et al., 2017), that admission in the event of imminent danger (SPI) could be used in situations other than those it was initially intended for, for example when the patient's relatives do not wish to be involved in a request for involuntary treatment (the admissions for psychiatric care at the request of a third party (SDT) decreased in parallel with the increase in admissions in the event of imminent danger (SPI)) or with the emergency services where the medical teams are less familiar with the patients and do not always have the necessary resources to find third parties to contact (Coldefy et al., 2015). Hence, the use of admissions in the event of imminent danger (SPI) probably includes different practices and continues to go beyond the scope of the exceptional measures initially proposed by the law of 2011.

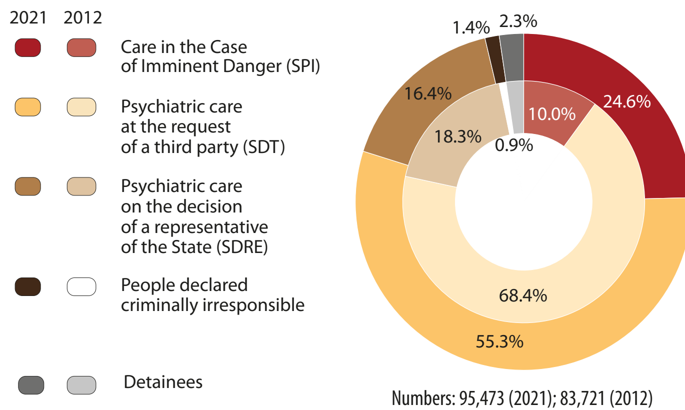
Between 2012 and 2021, an increase in the number of individuals receiving psychiatric care for persons declared criminally irresponsible was also observed. This increase, which remained marginal, appeared to be primarily due to the high proportion of persons admitted in this way and who were subsequently treated in more long-term community treatment orders (63%). Around 1,400 people received psychiatric care through this legal form of admission in 2021, whereas the number of persons declared criminally irresponsible was 203 in 2020 (French Ministry of Justice, 2020). Moreover, this legal form of treatment most frequently results in the use of community treatment orders.

A rise in the use of community treatment orders that seems to have stabilised in recent years

The law of 5 July 2011 extended the possibility to provide involuntary treatment to ambulatory care through community treatment orders. In 2021, more than 39,000 people received involuntary ambulatory psychiatric treatment in this context, representing 41% of the people who received involuntary psychiatric care. Although the number of persons who benefited from community treatment orders significantly increased until 2018 (+ 67%), it since seems to have reached a threshold and stabilised, and even decreased (see Graph 3).

G2

Evolution in the use of different legal forms of involuntary psychiatric care between 2012 and 2021



Numbers: 95,473 (2021); 83,721 (2012)

Source: The Medical Information Database for Psychiatry Rim-P, years: 2012 to 2021.

Scope: People aged 16 years old or over receiving psychiatric care in a mental health facility in France; the people receiving involuntary care includes all the people treated at least once a year in the frame of psychiatric care on the decision of a representative of the State (SDRE), psychiatric care at the request of a third party (SDT) or "Care in the Case of Imminent Danger" (SPI).

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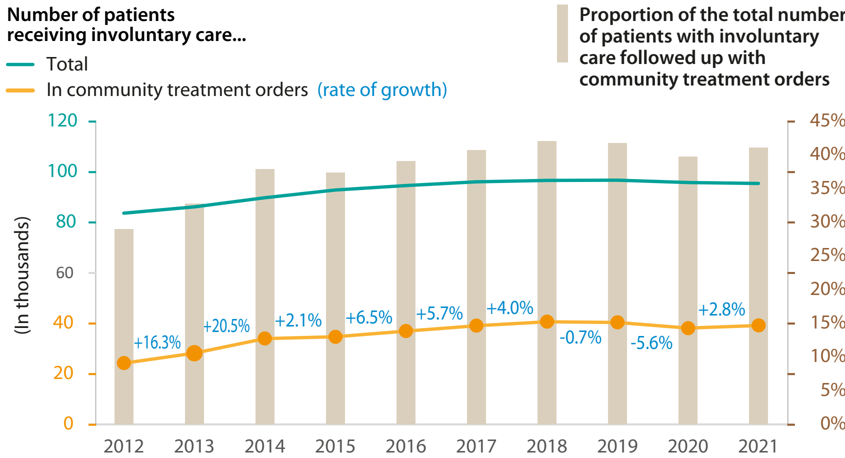
Change in the resort to mental healthcare facilities during the Covid-19 pandemic

The use of data from the Medical Information Database for Psychiatry (Rim-P) per quarter in 2020 and 2021 (the years that were the most affected by the Covid-19 pandemic and related measures to manage the health crisis) highlighted a significant reduction in the total annual number of persons receiving psychiatric care in a hospital (-5% while the trend over recent years has been a rise in the total number of patients). This was particularly notable in the second quarter of 2020, i.e., during the lockdown, compared with the first quarter of 2020: -13%, that is more than 100,000 people less, with a clear reduction for part-time activity. This reduction was similar to that observed in all the medical specialties, as the lockdown significantly reduced access to healthcare, but more moderately for mental health treatments (CNAM, 2020). The total annual number of persons treated in a psychiatric facility then rose steadily and more significantly in the first and second quarters of 2021, exceeding the numbers of the first quarter of 2020. This is probably linked to the catch-up effect and an increase in the demand for psychiatric care following the mental health consequences of the health crisis (Gandré, Hazo, 2021). With a specific focus on people hospitalised full time in psychiatric facilities, a significant reduction was also noted in the second quarter of 2020 (down 12% compared with the first quarter), but it rose more rapidly than that of the total number of patients followed up in such facilities as of the third quarter of 2020. Furthermore, the reduction in the number of people hospitalised full time observed in the second quarter of 2020 was more marked than that of the total number of days of full-time hospitalisation, reflecting a significant increase in the average duration of hospitalisation over this period, perhaps in relation to the difficulty of planning downstream solutions during the lockdown. Concurrently, the number of persons hospitalised in involuntary care remained stable and was virtually unaffected by the lockdown measures, and even increased slightly in the second and third quarters of 2020, possibly due to a lesser capacity of the healthcare system to manage mental crisis situations during this complicated period or due to an increase in critical situations in the context of a pandemic. Within community treatment orders, while part-time activities decreased during the first lockdown as they did for the total number of patients followed up, ambulatory care without consent continued, which may be linked to the effects of demand. Indeed, while certain patients decided to reduce their psychiatric treatment during the pandemic, the people in community treatment orders had no choice in the matter. However, the reduction in part-time activity may have been linked to the deprogramming of group activities likely to facilitate contaminations by Covid-19, and which are common in this type of care. Mental health care aimed at detainees was the only form of involuntary care for which a significant decrease in numbers was observed during the second quarter of 2020 (down 16% compared with the first quarter) –perhaps the sign of a less urgent use than for the other forms of treatment without consent. Lastly, the numbers of people secluded and seclusion days increased significantly in the second quarter of 2020 and remained high throughout 2020, but decreased in 2021.

G3 **Evolution in the use of community treatment orders between 2012 and 2021**



Source: The Medical Information Database for Psychiatry Rim-P, years: 2012 to 2021.

Scope: People aged 16 years old or over receiving psychiatric care in a mental health facility in France; the people receiving involuntary care includes all the people treated at least once a year in the frame of psychiatric care on the decision of a representative of the State (SDRE), psychiatric care at the request of a third party (SDT) or "Care in the Case of Imminent Danger" (SPI).

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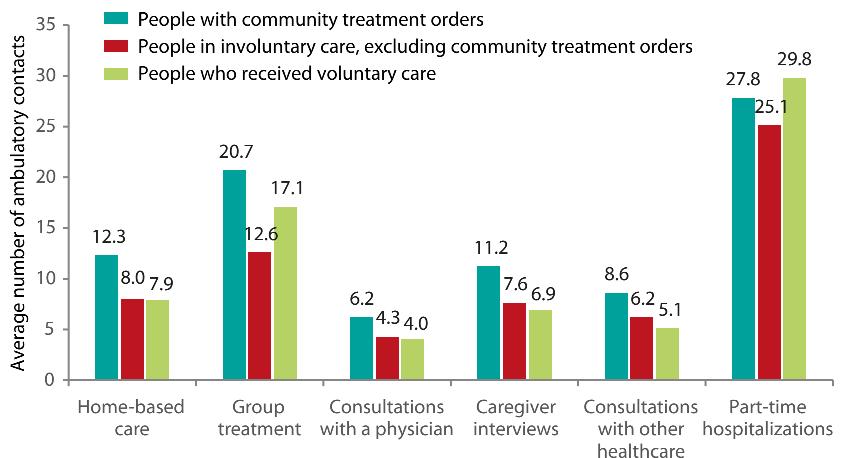
In 2020, the Covid-19 pandemic and the associated measures to restrict travel appear to have made it more difficult to implement community treatment orders, from which less people benefited than in 2019 (- 6%); fewer new community treatment orders were probably initiated, because the number of persons who were involuntarily hospitalised without a community treatment order increased in that year (+ 2%).

As underlined in previous studies (Coldefy et al., 2015; Coldefy et al., 2017), community treatment orders appeared to have facilitated access to various forms of treatment and support for people who were treated for severe mental health disorders in 2021. The people followed up within community treatment orders were thus more likely to have access to the various forms of psychiatric care provided in healthcare facilities, with the exception of full-time hospitalisation (part-time hospitalisation, home-based care, group therapy, consultations with physicians or other healthcare professionals, social situation monitoring), than the people treated without their consent and without a community treatment order. Beyond the diversity of the treatment and support, the intensity of care received (measured in number of ambulatory contacts) was also significantly higher for people followed up in community treatment orders in 2021. This was particularly pronounced for the consultations with physicians or other health professionals, as well as for the care and support provided in the patient's home (see Graph 4). The community treatment orders therefore seemed to be used as a form of intensive care for people suffering from severe mental health disorders requiring involuntary treatment. This measure could be extended to voluntary care, with the same intensity and the same mobilisation of healthcare professionals, thus limiting breaks in treatment continuity and the use of restraint.

The annual exploitation of data from the Medical Information Database for Psychiatry (Rim-P) remains too limited to reach a conclusion about the benefits of involuntary ambulatory care for patients, such as those made possible by the law of 2011 as part of community treatment orders. However, the data shows that the proportion of people who were also hospitalised full time amongst the people in community treatment orders seems to be decreasing. Nevertheless, their average annual duration of hospitalisation (full-time) was longer than that of people hospitalised without their consent and without a community treatment order, and that of people who were solely hospitalised on a voluntary basis, and they were more likely to be rehospitalised after 15 or 30 days. Although these elements raise questions about the benefits of community treatment orders, they could be partly related to the severity of the patients' disorders and the implementation of a treatment strategy of regular planned rehospitalisations. Hence, these findings encourage support for the development of longitudinal and controlled research, based on extensive clinical data, to assess the impact of community treatment orders on the health outcomes of individuals who receive care in this frame, in a national

G4 **Intensity of psychiatric care in a mental health facility in 2021, according to involuntary care and community treatment order status**



Source: The Medical Information Database for Psychiatry (Rim-P), year: 2021.

Scope: People aged 16 years old or over receiving psychiatric care in a mental health facility in France; the people receiving involuntary care includes all the people treated at least once a year in the frame of psychiatric care on the decision of a representative of the State (SDRE), psychiatric care at the request of a third party (SDT) or "Care in the Case of Imminent Danger" (SPI).

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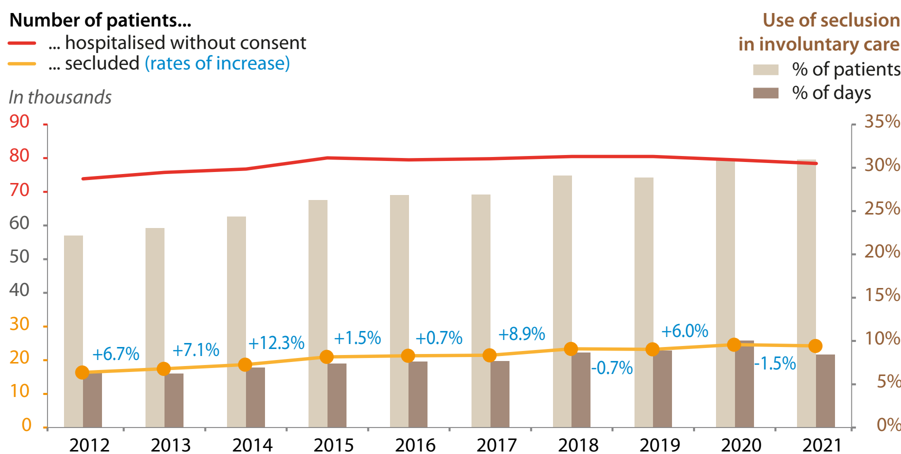
G5

Evolution in the use of seclusion between 2012 and 2021



Source: The Medical Information Database for Psychiatry (Rim-P), years: 2012 to 2021.

Scope: People aged 16 years old or over receiving psychiatric care in a mental health facility in France; the people receiving involuntary care includes all the people treated at least once a year in the frame of psychiatric care on the decision of a representative of the State (SDRE), psychiatric care at the request of a third party (SDT) or "Care in the Case of Imminent Danger" (SPI).

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context in which they are used for more than two out of five people who receive involuntary treatment.

A significant use of seclusion measures in 2021 following a trend increase since 2012 and an exceptional use in 2020 during the Covid-19 pandemic

In 2021, around 29,000 people hospitalised full time in a psychiatric facility were subjected to seclusion, almost 85% of whom were hospitalised without their consent. Hence, more than 30% of the people hospitalised without their consent in that year were subjected to this form of coercion–a practice that is therefore far from uncommon. These seclusion measures can sometimes be accompanied by mechanical restraint measures. The recent compilation of such data is not yet completely exhaustive, but already indicates that around 10,000 people were hospitalised full time in a psychiatric facility and were subjected to mechanical restraint measures in 2021, i.e., around a third of the patients placed in seclusion, and more than one individual in ten hospitalised without their consent. These preliminary figures, as well as the observations of the General Controller of Places of Deprivation of Liberty (CGLPL) [CGLPL, 2022], indicate significant disparities between healthcare facilities, as some of them do not implement any mechanical restraint measure. A reduced use or absence of these practices may be well established and part of a care culture within a given facility, or may have been instituted in response to recommendations put forward by the General Controller of Places of Deprivation of Liberty (CGLPL). It is important to encourage an exhaustive compilation of data on the use of seclusion and restraint in psychiatry on a national scale, as well as making it accessible and available to the public in order to help healthcare providers assess their practices, as recommended in the Six Core Strategies for Reducing Seclusion and Restraint Use –an action plan developed in the United States to reduce the use of coercion in psychiatric facilities, and underlined by the French National Health Authority (HAS, 2017)–, and to gauge the achievement of health policy objectives in this area.

This is all the more important because the use of seclusion has increased significantly since 2012 (see Graph 5). Indeed, the number of persons who were subjected to seclusion during full-time hospitalisation in a psychiatric facility increased by 19% between 2012 and 2021, and by 48% when only the persons hospitalised without their consent were considered. It is however possible that part of the increase observed was due to a higher completeness of seclusion data reported in the Medical Information Database for Psychiatry (Rim-P) following a progressive awareness of the need to document the use of this practice in recent years.

The use of seclusion was particularly significant in 2020, and notably during the lockdown following the Covid-19 pandemic (see Inset 2). While, at the same time, the number of people hospitalised full time in a psychiatric facility and the number of hospitalisation days decreased, the number of people subjected to seclusion and the number of days of seclusion increased significantly compared with 2019 (6% and 14% respectively). There are several possible explanations: a lack of staff due to sick leave or staff whose time was taken up with childcare as a result of the Covid-19 pandemic may have led to difficulties in dealing with complex clinical situations as well as a greater occurrence of crisis situations that lead to restrictive practices following the combined effect of breaks in treatment continuity (ambulatory care in particular), limitations in access to healthcare services, and the psychological impact of the pandemic and the lockdown on people suffering from severe mental health disorders.

The year 2021 confirmed the exceptional nature of the use of seclusion in 2020: the number of persons who were secluded decreased by 1.5% between 2020 and 2021, thereby returning to the level observed in 2019, while the number of days of seclusion, which decreased by 17% between 2020 and 2021, even reached a lower level than that observed in 2019. As with the use of involuntary care, this recent downward trend deserves to be observed closely over the coming years. Healthcare professionals' awareness of issues relating to restrictive practices in psychiatric facilities, as well as the development of treatment models based on a greater participation of the people concerned, may eventually lead to a reduction in the use of these practices.

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Ten years after the law of 2011 that reformed involuntary care procedures in psychiatric facilities in France, the use of this form of

treatment increased over the period despite a rate of growth that has plateaued over recent years and the start of a decrease since 2020, which needs to be monitored over time to determine whether this trend is continuing. At the same time, a use of seclusion and restraint that was far from marginal during involuntary care has been observed, while it is likely to still be underestimated in the data used. These observations do not suggest that the political goals of a reduction in the use of these treatment methods (*Ministère des Solidarités et de la Santé*, 2022), or the international recommendations of good mental health practices (OMS, 2012, 2021), are actually met in the French context. Furthermore, these results on a national scale probably mask significant disparities in use depending on the regions and support the need to further study the individual, organisational, and contextual determinants of the use of involuntary care and restrictive practices that deprive individuals of their freedom in psychiatric facilities. This descriptive and updated study is therefore an indispensable prerequisite for the development of complementary research to identify factors, not only related to the healthcare needs of individuals, that play a role in the use of controversial practices in psychiatry and which could be targeted by public policies to develop more ambitious actions aiming at attaining national objectives relating to the reduced use of such practices. A greater availability of seclusion and restraint data for research purposes would make it easier to carry out such projects.

Our results highlight the fact that ethical issues (respect for the dignity and freedom of persons) linked with the extent of the use of involuntary care and coercion in psychiatric facilities in France, regularly raised by the General Controller of Places of Deprivation of Liberty (CGLPL), the persons concerned and their relatives (CGLPL 2019, 2021, 2022; CRPA, 2017; Unafam, 2022), still need to be addressed. They also resurfaced recently and were at the forefront of public debate on legislative changes that aim to better control the use of seclusion and mechanical restraint, which were discussed at length by healthcare professionals, due to the administrative burden that they entail. Yet, innovative initiatives exist in France to limit the use of involuntary care and coercion in psychiatric facilities. They include the development of person-centred care, facilitating their involvement and participation; the establishment of relaxation areas (made available to those who wish to have a place where they can be on their own and appease their anxiety and aggressivity within psychiatric facilities) [HAS, 2016]; the strengthening of the training of health professionals in crisis management; and the development of psychiatric advance directives (document drafted by the person when his/her discernment is not impaired and in which the person specifies in advance how he/she, her relatives, and healthcare professionals should act in the event of a crisis). Their implementation could be facilitated after the recent publication of evidence that supports their beneficial impact on the decrease in the use of involuntary care, particularly when they are combined with peer support programmes (Tinland et al., 2022). The study of hospitals characterised by a low use of coercion in psychiatry, which remain relatively unknown and little researched, could also make it possible to identify the levers of psychiatric care that allow for a greater respect of individual liberties. ♦

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