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## From Compulsory Psychiatric Hospitalisation to Compulsory Treatment: First Results Following the Institution of the Law of July 5<sup>th</sup> 2011

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Based on data provided by the Medical Information Database for Psychiatry (Rim-P, *Recueil d'informations médicalisées en psychiatrie*), this study on compulsory psychiatric treatment following the enactment of the Law of July 5<sup>th</sup> 2011 follows a first overview for the year 2010 conducted prior to its enactment (Coldefy, Nestrigue, 2013a). The law, modified in September 2013, aims at providing for alternatives to full-time compulsory psychiatric hospitalisation by introducing a new legal procedure applicable in cases of imminent danger, acute involuntary admission, (SPI, *soins en cas de péril imminent*), and the intervention of a liberty and custody judge (*juge des libertés et de la détention* (JLD)) instituted within the legal framework.

This study presents the first results in the year following the enactment of the law and its deployment in France, and explores its impact on patient care. It is essentially focused on two sections of the law: the introduction of individual care plans and SPI. The aim of the study is to describe changes in involuntary psychiatric care following the implementation of the law, and to measure psychiatric activity by answering several questions: how can changes in the use of involuntary psychiatric care be characterised? To what extent do health establishments use the new legal procedures? What are the contents of an individual care plan? Which patients benefit from it? Has this reform improved access to continuity of care for patients with psychiatric disorders that can temporarily alter their awareness of the disorder or the need for psychiatric treatment?

The law of July 5<sup>th</sup> 2011 regulating involuntary psychiatric treatment follows previous reforms instituted by the laws of 1838 and 1990 (insert p. 6). Compulsory treatment is specific to psychiatric care as consent to care is an essential prerequisite for any other form of therapeutic treatment (article L.1111-4 of the Public Health code). It is legally applicable in cases of severe mental disorder rendering a person temporarily unable to consent or unaware of the need for treatment, and where the absence of care would

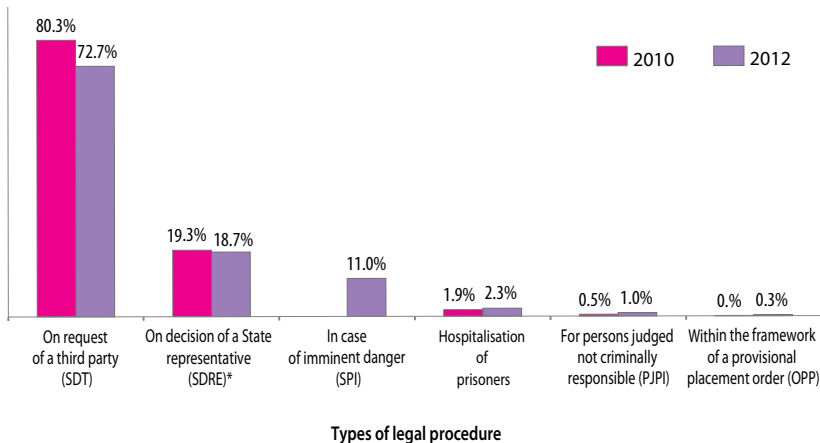
endanger the person's health, safety and that of others (Riecher-Rössler and Rössler, 1993). Compulsory psychiatric care is common practice throughout the world (Salize *et al.*, 2002, Zinkler and Priebe, 2002). The law of July 5<sup>th</sup> 2011 on the rights and protection of persons undergoing psychiatric care, revised in 2013, aimed at reforming this practice in France by introducing three major changes. Full hospitalisation is no longer the only form of involuntary care as it can now also take the form of out-patient or part-time care within the

framework of an individual care plan<sup>\*</sup>. The law also provides for a new legal procedure for emergency treatment in cases of imminent danger, acute involuntary admission (SPI, *soins en cas de péril imminent*), which no longer requires third party signatories, thereby accelerating admission procedures. Finally, the intervention of a liberty and custody judge ('*juge des libertés et de la détention*' (JLD)) both reinforces the rights

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

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## Proportion of patients by legal procedure for compulsory psychiatric treatment in 2010 and 2012



\* Previously compulsory hospitalisation order ("hospitalisation d'office" (HO)).

Source: Rim-P.

Realisation: Irdes.

Data available for download.

## CONTEXT

This study, financed by the General Directorate for Health (*Direction générale de la santé*, DGS), follows a first overview of involuntary psychiatric hospitalisation conducted by IRDES in 2010 (Coldefy, Nestrigue, 2013a). It falls within the framework of more general issues developed by IRDES on the variability of practices, the analysis of the organisation of care and the evaluation of public health policies applied in the domains of psychiatry and mental health

disorders that can temporarily alter their awareness of the disorder or the need for psychiatric care? Does compulsory treatment in the case of imminent danger provide extended access to care by simplifying procedures?

### The use of compulsory psychiatric care did not increase in 2012

In 2012, over 77,000 patients (against 74,000<sup>1</sup> in 2010) were subject to compulsory psychiatric treatment at least once during the course of the year; a 4.5% increase in relation to 2010. This increase, however, is consistent with the increased volume of the active patient list in mental health care facilities: patients having received compulsory care consistently representing almost 5% of the active patient list in 2012.

The distribution of the different legal procedures remains fairly similar to that observed in 2010 (Graph 1). Prisoners (article D. 398 of the Criminal Procedure Code), persons judged criminally irresponsible (L. 706-135 of the Criminal Procedure Code) and juvenile patients on provisional placement order (OPP, *ordonnance de placement provisoire*) represent a very low percentage of patients treated without their consent in 2012 as in 2010. Their relative proportion nevertheless increased in 2012: the three legal procedures represented 2.5% of patients treated without their consent in 2010 and 3.6% in 2012 (2,700 patients).

<sup>1</sup> The 3,000 patients on trial release for the whole of 2010 were integrated here under a legal procedure for compulsory treatment.

of involuntarily hospitalised individuals and respects a constitutional requirement (Insert). In this study, we will specifically focus on two of these aspects: the alternative to full hospitalisation provided by compulsory out-patient care within the framework of an individual care plan, and the introduction of the new SPI treatment modality applicable in cases of imminent danger. The impact of interventions by liberty and custody judges cannot be examined on the basis of the medical-administrative data used here.

Following the overview of compulsory psychiatric hospitalisation conducted in

2010 (Coldefy, Nestrigue, 2013a), this study, based on results obtained in 2012 following the enactment of the law of July 5<sup>th</sup> 2011, proposes a first analysis of its implementation. The aim is to describe resulting changes in practice and to measure psychiatric activity by answering the following questions: how can changes in the use of compulsory care be characterised? To what extent do health establishments use the new admission procedures proposed by the law? What are the contents of an individual care plan? Which patients benefit from it? Has this reform improved access to care and the continuity of care for patients with psychiatric

## DEFINITIONS

**Individual Care Plan:** The care plan is both a written document and a therapeutic practice which is detailed in the document. All treatment modalities outside hospitalisation must be noted (part-time hospitalisation, out-patient care, home care, medications). It specifies the frequency of consultations and visits and can also determine the duration of treatment. The elaboration of the care plan and any modifications are preceded by an interview during which the psychiatrist records the patient's opinion.

**Acute Involuntary Admission (SPI, *soins en cas de péril imminent*):** If there is no means of obtaining a request for admission from a third party and that there is imminent danger (for the person's health or that of others), the hospital director can authorise admission on the advice of a psychiatrist (internal or external to the hospital). The director is under the obligation to inform the family or a third party and have a first

medical certificate drawn up by one of the establishment's psychiatrists (other than the one who decided admission) within 24 hours following admission confirming whether treatment should be continued or not (+ somatic examination by a doctor). A second medical certificate must be drawn up within 72 hours.

**Third Party:** In 2003, the Council of State (Conseil d'Etat) defined a third party as a person who could justify a relationship with the patient prior to the request for admission empowering them to act in the person's interest and independent of the admitting establishment treating the sick person<sup>1</sup>.

**Sequential Hospitalisation:** Within the framework of the individual care plan, the doctor can decide to include "if necessary, home hospitalisation, part-time hospitalisation or short-term but full hospitalisation in a hospital" (L3211-2-1 of the Public Health Code).

The most important change has occurred regarding admissions at the request of a third party (SDT, *soins à la demande d'un tiers*), amended by the new compulsory treatment procedure (SPI) used in cases of imminent danger. Psychiatric care at the request of a third party\* is used when the individual presents obvious mental disorder and is not in a position to consent despite the necessity for treatment, in which case two detailed and concordant medical certificates are required. The SDT procedure is still applied in the majority of cases with 73% of patients treated without their consent (60,000 patients), representing a slight decrease since 2010 (57,000 patients; 80% of the population). This relative drop results from the introduction of the SPI procedure\* which concerned 11% of the patient population (8,500) admitted at least once during the course of the year without their consent.

### Acute Involuntary Admission in the case of imminent danger, an increasing form of treatment without consent that covers diverse practices

The new SPI procedure responds to care providers' demands to overcome difficulties obtaining third party signatures allowing the hospitalisation of patients

unable to give informed consent themselves. The SPI provides for a more simplified procedure in that the only justificatory requirement is a medical certificate stating the motive of "imminent danger". It enables the care teams to orient the patient and authorises the director of the health establishment to admit the patient in the absence of a third party. According to experienced practitioners, compulsory treatment in cases of imminent danger (SPI), possible since 2012, is used in a variety of contexts: as an emergency measure for the health and safety of the patient or others, as an organisational facility, in the real absence of a third party (for an unknown, isolated or desocialised patient), or refusal on the part of the family to agree to hospitalisation, etc. It appears to be used frequently by emergency services in which care teams have no prior knowledge of the patient, have no indication of who to contact, lack the resources to undertake a search and need to act quickly to reorient the patient to adapted care services.

In demographic terms, the exploitation of available data shows that, with 55% of men and an average age of 44, the characteristics of patients admitted under SPI are comparable to those admitted at the request of a third party (SDT). The same applies to clinical characteristics with 39% of patients admitted under SPI suffering from schizophrenia or psy-

chotic disorders (44% for patients admitted on request of a third party)<sup>2</sup>. On the other hand, patients admitted under SPI differ from patients admitted at the request of a third party in that treatment periods are shorter: an average 26 days full hospitalisation per year against 40 days for patients admitted at the request of a third party<sup>3</sup> (and 46 days on average, all legal procedures combined). Treatment periods are also less intense: 8 acts on average in the year for SPI against 12 for SDT. This shorter treatment period is consistent with the transitory nature of SPI admissions as patients then shift to voluntary care or compulsory care at the request of a third party. Nevertheless, 3,500 patients (46% of SPI patients) remain in hospital for periods equal to or above 15 days. For half the patients admitted under the SPI procedure, it represents a first entry into care, but few of these patients subsequently enter into another mode of compulsory care (13%, the majority at the request of a third party, proportion equivalent to that observed before admission under the SPI

<sup>2</sup> For the demographic characteristics of the involuntary patient population, see Coldefy and Nestrigue, 2013a, changes in terms of age, gender and clinical diagnosis are very slight.

<sup>3</sup> The average annual duration of hospitalisation per psychiatric patient by legal procedure only takes full involuntary hospitalisation sequences into account for the given legal procedure, here the SPI procedure (excluding sequences under the SDT procedure for certain patients).

## SOURCE AND METHODS

All the results presented here are based on the exploitation of data provided by Medical Information Database for Psychiatry (Rim-P, *Recueil d'informations médicalisées en psychiatrie*) for the years 2010 and 2012. The Rim-P, managed and disseminated by the Technical Agency for Information on Hospital Care (ATIH, *Agence technique de l'information sur l'hospitalisation*), set up in 2007 in all public and private sector hospitals authorised to provide psychiatric care, makes it possible to describe the characteristics of patients monitored as well as all forms of care provided (full-time, part-time or out-patient) within health establishments. Even if the quality of data has improved, complete at 96% in terms of responding establishments in 2012, the Rim-P, a medical-administrative database, does not provide data on all the reforms enacted in the law of 2011, notably the intervention of a liberty and custody judge and the notion of individual care plan\*. Finally, treatment on request of a third party is not distinguished from emergency admission on demand of a third party.

The ANO number, an anonymised national identifier given to each patient receiving full-time or part-time hospital care, is used here to follow a patient's care path from one health establishment to another and for the total duration of care. For patients that were not hospitalised during the course of the year being studied or without a valid ANO number, we used the permanent patient identifier (IPP) specific to each establishment used. Despite adjustments, an over-estimation of the number of patients not hospitalised in 2012

is possible as some patients were treated in several establishments during the course of the year.

Following exchanges with the experts in the field, several corrections were carried out on the initial sample base. As out-patient care administered to prisoners without their consent (art. D398) is prohibited by law they were recorded as voluntary care. An individual care plan is defined in this study as being all forms of care administered between two out-patient acts or part-time care. Whenever an episode of voluntary care occurs between these two boundaries, it was recorded as involuntary care. Full-time hospitalisation without the patient's consent occurring between these two events is possible in cases of relapse, termination of the care plan contract or sequential hospitalisation\* included in the care plan.

Due to incomplete data, the French Overseas Departments and *Les Deux-Sèvres* and *Nièvre* departments were not included in the study.

The analyses presented here were conducted by the IRDES team with support from a working group composed of psychiatrists, doctors from the Medical Information Service (Dim, *Département information médicale*), user representatives and their families, representatives from the Directorate for Research, Studies and Statistics (DREES, *Direction de la recherche, des études et des statistiques*) and the ATIH, and social science researchers.

procedure), and the majority then follow a voluntary care regimen.

These results question the use of admissions under the SPI procedure with regard to its initial aims, especially as the first exploitation of 2013 data indicate an increase in the use of this procedure with 15,000 patients treated at least once during the course of the year, almost twice higher than in 2012. As this is a derogatory procedure with regard to common law, it should only be used in exceptional circumstances, notably in the case of desocialised individuals for whom a third party cannot be found. Frequent use of this procedure could indicate a misuse of procedure and raises the following questions: does the possibility of using the SPI procedure deter care teams from searching for a third party? Does it allow the third party requesting admission to withdraw from the compulsory care procedure by devolving responsibility to the health professionals? Does this simplified legal

procedure represent a new form of accessibility to care for individuals who would not have had access otherwise? The lack of data on the motives for admission under the SPI procedure, the individual's social characteristics and that of the admissions team make it impossible to answer these questions. Only qualitative observations and a comprehensive approach would provide the answers by accounting for the diversity of professional practices in psychiatric services and the meaning they have for the actors concerned.

### The use of SPI is unevenly spread between regions

The use of SPI has seen an uneven development between regions. Certain regions count over 30% of patients admitted under the SPI procedure whereas seven regions had none in 2012 (map 1). Furthermore, 182 health establishments out of 270 authorised to admit involuntary psychiatric patients had admitted at

least one patient under the SPI procedure during the course of the year.

### A diversification of compulsory psychiatric care modalities driven by the individual care plans

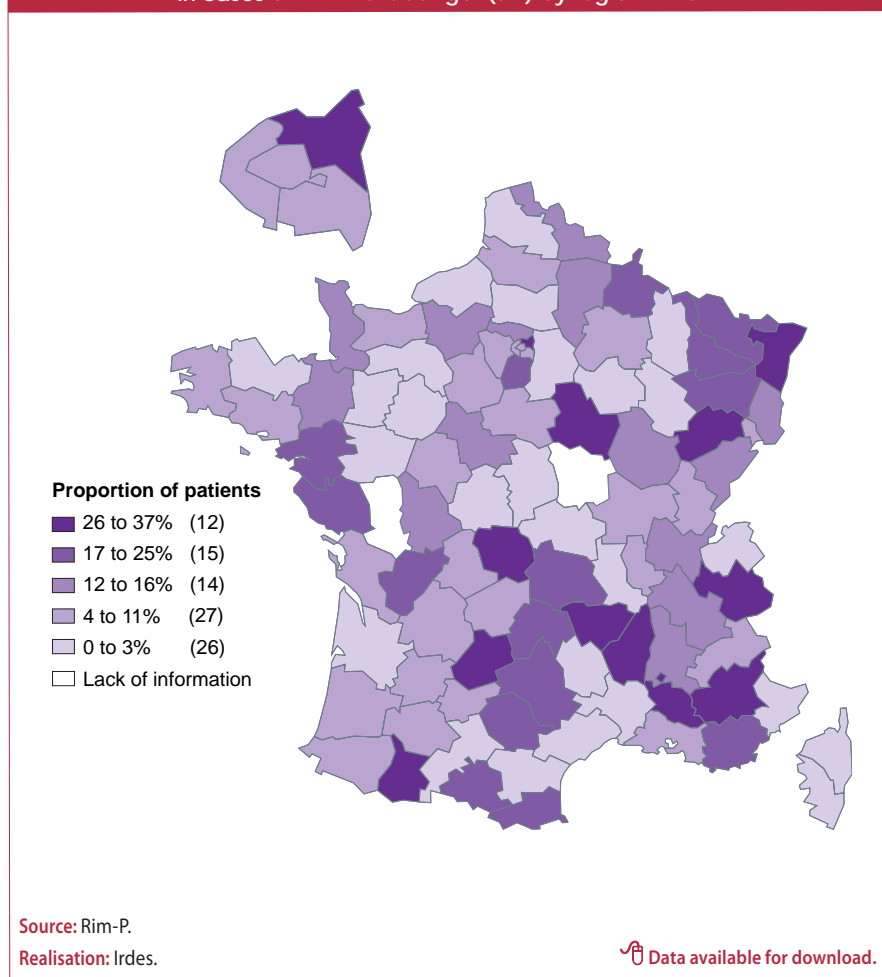
Alternative compulsory care modalities to full-time hospitalisation are now accessible since the law of July 5<sup>th</sup> 2011: out-patient care (notably consultations in medical-psychological centres and home visits), part-time care (day or night hospitalisations and/or workshops and part-time therapeutic activity centres). The psychiatrist determines the care framework and records it as part of a compulsory individual care plan. Compulsory out-patient care has been implemented in a number of Anglo-Saxon or European countries, and prior to 2000 in certain American States, Belgium, Luxembourg, Portugal and Sweden (Salize *et al.*, 2002, Kisely *et al.*, 2012, Niveau, 2012). Its aim is to improve the continuity of patient monitoring and to propose an alternative to hospitalisation. In this way, it extends the deinstitutionalisation or dehospitalisation of psychiatric care, initiated in the 1960s in Europe, to individuals requiring care without their consent (Couturier, 2014). A year after the enactment of the law, 26,600 patients were treated within the framework of an individual care plan. This care modality was identified in the Rim-P (Medical Information database for Psychiatry, *Recueil d'informations médicalisées en psychiatrie*) database through records of at least two out-patient procedures or a sequence of involuntary part-time hospitalisation during the year 2012; that is to say 34% of patients having received involuntary care in 2012.

### A care modality that legally regulates trial releases

The introduction of individual care plans as an alternative involuntary treatment modality appears to be a major aspect of the law of 2011. However, professionals agree that it is more an adaptation and generalisation of former practices through the introduction of a legal framework regulating "trial releases", the former version of the care plan. In 2010, trial releas-

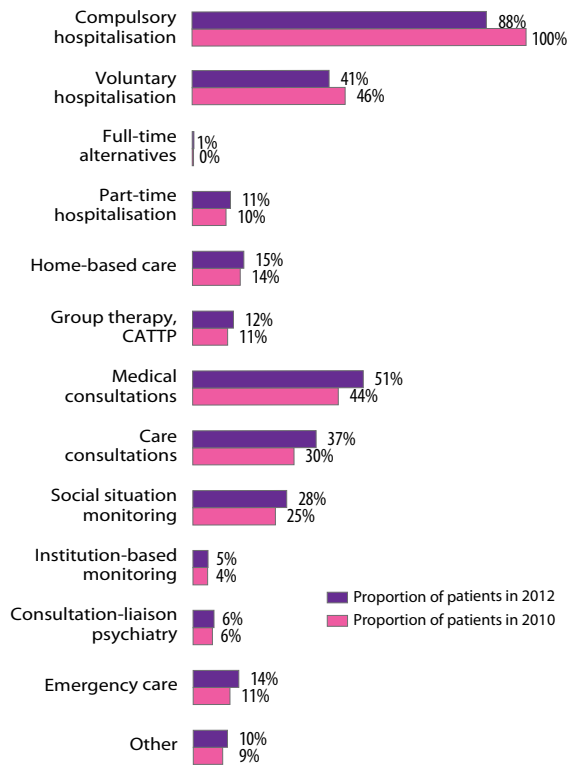
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Proportion of patients subject to compulsory treatment in cases of imminent danger (SPI) by region in 2012



G2

**Psychiatric treatment modalities during the course of the year among patients having had at least one compulsory care episode in 2010 and 2012**



**Reading:** In 2010, 100% of patients subject to compulsory psychiatric treatment were hospitalised full-time and 44% had medical consultations. In 2012, the proportions were respectively 88 and 51%.

**Source:** Rim-P.

**Realisation:** Irdes.

[Data available for download.](#)

treatment for patients requiring compulsory care will create an impetus to develop a more general diversification of treatment modalities, whether voluntary or not. In 2012, the number of full hospitalisations, whether voluntary or involuntary, decreased among patients needing compulsory treatment at some point in time (Graph 2). Over the same period, a greater number of involuntary patients had access to treatment modalities other than full hospitalisation (in the form of voluntary treatment or individual care plans). The highest increase concerned the proportion of patients having had access to consultations with a care provider (nurse, psychologist) and a doctor; a 6 and

of 2011 has improved and diversified the treatment modalities proposed to these patients.

The trend towards the diversification of psychiatric care is validated by the monitoring of patients after a spell of involuntary hospitalisation. In total, almost half the patients subsequently received out-patient care (voluntarily for 27% and involuntarily for 19%). The greater accessibility of alternative treatment modalities to full hospitalisation is also expressed by an intensification of care with an increase in the number of out-patient procedures. The average number of procedures per patient increased from 10 to 12 between the two years (with an increase from 3 to 5 consultations with a care provider per patient during the course of the year).

This greater access to alternative treatment modalities has also had an impact on the average annual duration of compulsory hospitalisations. In 2010, the average annual number of days involuntary hospitalisation per individual was 53 days, whereas in 2012 it had dropped to 46 days (Graph 3).

Whereas in 2010, 72% of patients hospitalised without their consent also followed voluntary treatments during the course of the year, it dropped to 66% for the year 2012. This decrease can be

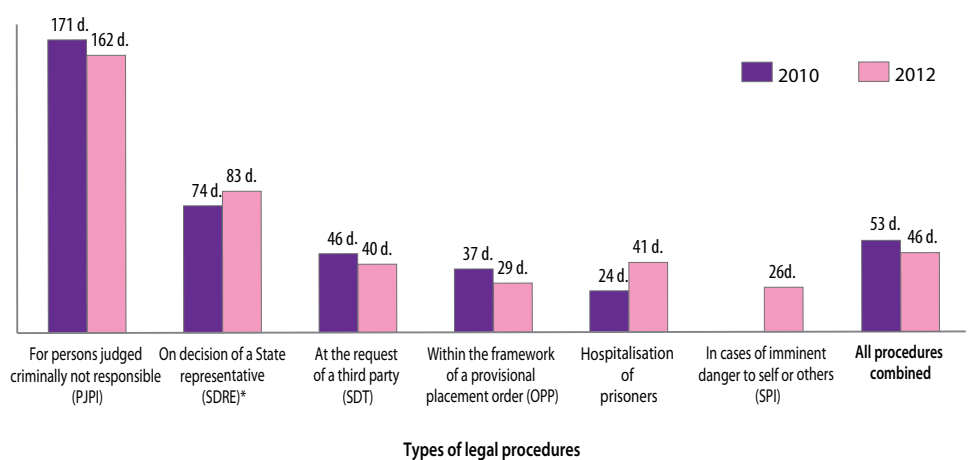
es concerned 25% of patients hospitalised without their consent for periods of several months or even several years. Trial releases constituted a means of adjusting care regimens whilst keeping the patient under constraint. The aim was to facilitate patients' reintegration by allowing them out of the hospital sometimes for indefinite periods. The care plan clarifies and extends this practice by officialising the treatment modalities to be respected (medical consultations, social situation monitoring, renewal of home-based treatment, etc.) during the patient's leave from hospital within the framework of a contractual agreement between the doctor and the patient.

Individual care plans, by opening up the possibilities of accessing more diverse forms of

7 point increase respectively between 2010 and 2012. In this respect, the law

G3

**Average annual duration of involuntary psychiatric hospitalisations by legal procedure\* 2010 and 2012**



\* Previously compulsory hospitalisation order (HO).

† Duration is calculated from involuntary hospitalisation sequences per patient for a given legal procedure, without the cumulation of the different legal procedures recorded for a same patient.

**Source:** Rim-P.

**Realisation:** Irdes.

[Data available for download.](#)

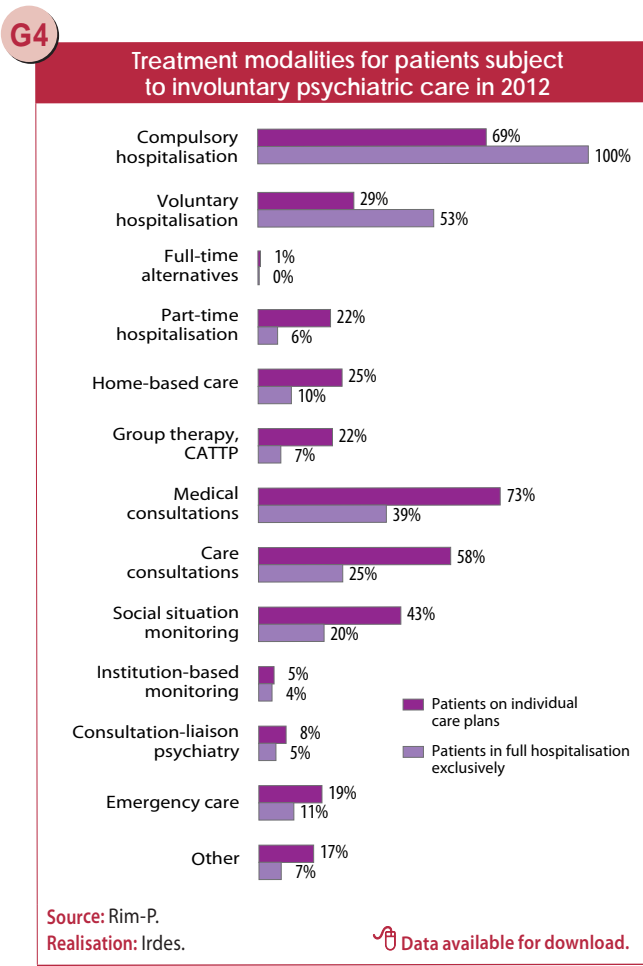
explained by the fact that the individual care plan allows out-patient treatment with the potential effect of maximising compliance on the part of the patient. One of the consequences discussed by professionals and social science researchers (Guibet-Lafaye, 2014) could be a prolongation of the total duration of compulsory treatment despite the decrease in the duration of hospital stays.

**Patients with individual care plans, known by the care teams, are subject to varied, intense and long-term treatment modalities...**

The individual care plans appear to be more frequently prescribed to patients requiring varied, intense and durable care (Kisely *et al.*, 2012). Patients suffering from schizophrenia and other psychotic disorders are over-represented in the care plan modality (respectively 38% and 26% of patients on care plans, against 23% and 22% of patients exclusively hospitalised without their consent). Inversely, care plans are less frequently used in cases of depressive disorders (11% of patients on care plans against

16% of patients exclusively hospitalised without their consent), the hospitalisation of these patients often being limited to an episode of hospitalisation (Coldefy, Nestrigue, 2013b).

Whatever the treatment modality, patients integrated in a care plan have benefited from greater access care. Thus, three quarters of patients on a care plan had at least one medical consultation (in a medical-psychological centre for the most part) during the course of the year against only 39% of patients hospitalised without their consent and without a care plan (Graph 4).



**E**

**Short history of involuntary psychiatric care**

The Law of June 30<sup>th</sup> 1838 regarding the insane defines "voluntary placements" and admissions "requested" by a member of the family as distinct from "admissions ordered by the public authority". The Evin Law of June 27<sup>th</sup> 1990 introduced the notion of "voluntary hospitalisation" on request by the patient, which constitutes the majority of hospitalisations, together with five modes of compulsory hospitalisation (the main procedures being at the request of a third party, and compulsory admission order). The Law of July 5<sup>th</sup> 2011 clarifies and extends the procedures: voluntary hospitalisation remains the "primary mode if the person's state of health allows it" and hospitalisation is extended to alternative forms of care (notably out-patient care).

**The need for a new law to regulate compulsory care.** The reform introduced by the Law of July 5<sup>th</sup> 2011 legalises certain practices and responds to certain criticisms. The role played by the patients and their representatives in these reforms should be noted (Kannas, 2013). The law opens up access to other modes of psychiatric treatment than full hospitalisation, such as community-based out-patient care and part-time care within the framework of the individual **care plan**<sup>a</sup>. The aim of compulsory out-patient care, legally authorised in numerous Anglo-Saxon and European countries, (Salize *et al.*, 2002, Kisely *et al.*, 2012, Niveau, 2012) is to improve the continuity of care and offer an alternative to hospitalisation and thus confirm the deinstitutionalisation of psychiatric care (Couturier, 2014). Existing practices, such as short-term releases, have thus been endorsed (article L29-11-1-1 of the Public Health Code) so as to favour the healing, rehabilitation or social reintegration of patients hospitalised without their consent prior to 2011.

In addition, since the mid 1990s, a series of public reports and case-law reports have noted the need to review in

depth the ethical and empirical terms governing compulsory care procedures. Two decisions made it imperative to reform the law: the European Court of Human Rights reported France's failure to respect one article of the Convention regarding the liberty of individuals and the Constitutional Council (*Conseil constitutionnel*) declared involuntary hospitalisation unconstitutional without control by a liberty and custody judge. The legislator thus provides for the systematic control of involuntary full-time hospitalisation by a **liberty and custody judge (JLD, juge des libertés et de la détention)** at the earliest on the fifteenth day of hospitalisation (reduced to 12 days by the reforms of October 2013), and at the latest during the sixth month of hospitalisation. The judge validates or invalidates the procedure and declares whether treatment should be maintained or terminated. Patients can at any moment exercise their rights and demand an audience with a JLD.

**Acute Involuntary Admission**, a new legal procedure providing for the shortcomings of the previous procedure (law of 1990). This procedure can be useful in the absence of a third party (notably for desocialised persons), or refusal from the patient's relatives to take the decision to have the patient admitted into psychiatric care, even if it appears necessary. The director of the psychiatric unit may in that case take the decision on the advice of the psychiatrist. This "simplified" procedure, in the first instance requiring only one medical certificate (and not two), and not requiring a third party's signature, accelerates the admission procedure. The law also provides that a third party must be found and solicited as quickly as possible so that the legal procedure can be altered to that of admission at the request of a third party (SDT) if necessary.

Finally, the law stipulates that patients should have access to more information so as to provide them with the means to exercise their rights.

	From 1990 to 2011 (loi Evin)	Since the reform of July 5 <sup>th</sup> 2011
	Compulsory hospitalisation (HSC)	Compulsory treatment (SSC)
Legal procedures <sup>a</sup>	<ul style="list-style-type: none"> <li>• Compulsory Hospitalisation Order (HO, <i>hospitalisation d'office</i>)</li> <li>• Compulsory Hospitalisation Order with emergency procedure (HO with emergency procedure)</li> <li>• Hospitalisation at the request of a third party (HDT, <i>hospitalisation à la demande d'un tiers</i>)</li> <li>• Emergency hospitalisation at the request of a third party (HDTU, <i>hospitalisation à la demande d'un tiers en urgence</i>)</li> </ul>	<ul style="list-style-type: none"> <li>• Compulsory treatment on decision of a representative of the State (SDRE, <i>soins sur décision d'un représentant de l'Etat</i>)</li> <li>• Treatment at the request of a representative of the State with emergency procedure (SDRE with emergency procedure)</li> <li>• Treatment at the request of a third party (SDT, <i>soins à la demande d'un tiers</i>)</li> <li>• Emergency treatment at the request of a third party (SDTU, <i>soins à la demande d'un tiers en urgence</i>)</li> <li>• Acute Involuntary Admission (SPI, <i>soins en cas de péril imminent</i>)</li> </ul>

<sup>a</sup> Psychiatric treatment within the framework of a Provisional Placement Order (OPP, *ordonnance de placement provisoire*), psychiatric treatment for persons judged not criminally responsible (PJI, *personnes jugées pénalement irresponsables*) and psychiatric treatment for prisoners (art. D398 of the Criminal Procedure code) remain unchanged. Due to the low numbers they represent, they were not treated in depth in this article.

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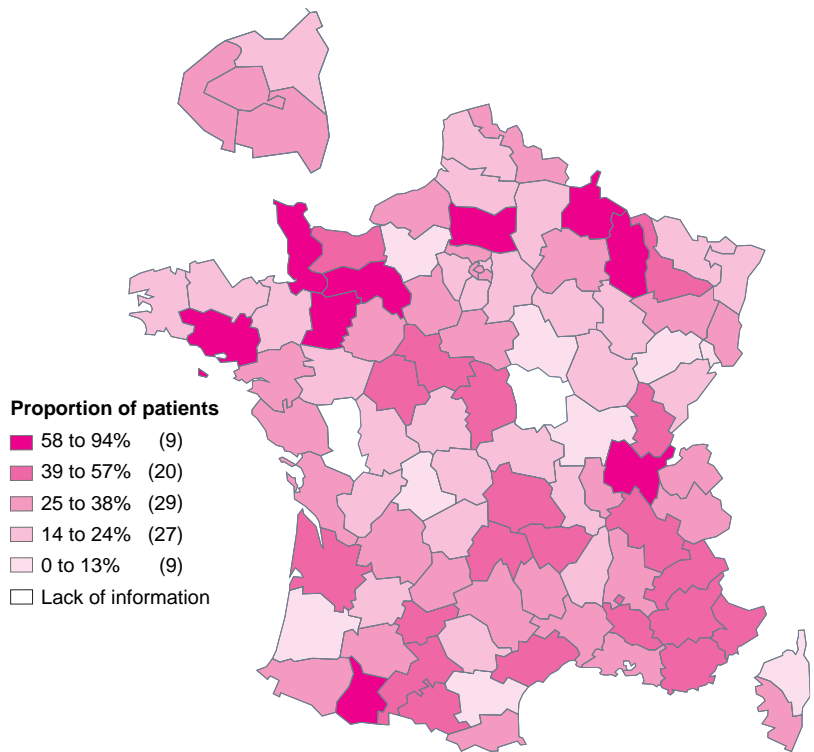
Involuntary part-time hospitalisation concerned 4,500 persons in 2012 (essentially in day hospitals) with an annual average of 36 stays (but a median of 15 days). 3,500 patients had part-time access to a workshop or part-time therapeutic activity centre (CATTP, *Centre d'activité thérapeutique à temps partiel*) under a compulsory treatment procedure, with an average of 12 participations per year. This greater access to different treatment modalities for patients on individual care plans is associated with a greater number of out-patient procedures and with a greater number of hospitalisations over longer periods than for patients hospitalised without their consent. Patients on care plans followed one and a half times more out-patient procedures (over 20 voluntary procedures per patient during the course of the year) than patients without a care plan who could have voluntarily received treatment before or after their period of involuntary hospitalisation (15 on average).

On average, patients on care plans are hospitalised for longer periods than other involuntary patients: 64 days on average for patients on care programmes, 42 days for other involuntary patients, and an average 53 days for the total active patient list (voluntary and involuntary hospitalisations combined). This is partially due to the fact that, contrary to the majority group of patients in full-time hospital care, often hospitalised once during the year, patients on care plans are hospitalised several times during the year. For some of them, these episodes form part of the care plan therapeutic strategy: repeated, programmed hospitalisations are known as sequential hospitalisations\* whilst for other patients it is often due to a relapse or non-compliance with a care plan requiring the patient's readmission to hospital.

**Variable use of individual care plans according to region**

From the first year the law was implemented, individual care plans were used by the majority of health establishments: 91% of establishments admitting patients without their consent and supplying data to the Rim-P database established at least one care plan in 2012, 70% of the activity being registered by public establish-

Proportion of patients monitored under an individual care plan among patients subject to involuntary treatment in 2012



Source: Rim-P.  
Réalisation: Irdes.

Data available for download.

ments specialised in psychiatric care. At national level, 34% of patients admitted without their consent were monitored by means of a care plan in 2012. However, in the same way as the SPI procedure, the use of care plans varies considerably from one region to the next. In the *Aude*, *Haute-Corse*, *Eure*, *Landes*, *Haute-Saône* and *Saône-et-Loire* regions, less than 10% of involuntary patients were integrated in a care plan. Inversely, in the *Ain*, *Manche*, *Mayenne*, *Meuse*, *Oise* and *Hautes-Pyrénées* regions, over 60% of patients had access to this type of plan (map 2). Furthermore, 25% of care plans were established by only five health establishments, each in different regions indicating a variable dissemination of practices among professionals and health establishments.

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To conclude, if the number of patients concerned by involuntary psychiatric care has increased in terms of absolute value between 2010 and 2012, it continues to represent a relative part of almost

5% of the active patient list receiving psychiatric care in a health establishment. In accordance with the law's expectations and the more general context of the deinstitutionalisation of psychiatric care, the treatment of persons requiring compulsory care at some point in time has tended to move away from hospitalisation towards more diversified out-patient care, notably in medical-psychological centres. In this respect, the reforms have extended deinstitutionalisation to populations whose informed consent to treatment can be temporarily altered by their mental disorder (Couturier, 2014). However, the duration of hospital stays for patients treated under an individual care plan are longer (64 days on average), whereas the average annual duration for compulsory hospitalisations decreased in relation to 2010 due to an increase in very short treatment periods: 30% of patients treated without their consent during the course of 2012 were subject to a single spell of hospitalisation (possibly within the framework of voluntary treatment), equal to or less than 7 days for half the patients.

2012 was the first year in which the reform was implemented, with an uneven distribution over the French territory and emerging trends put forward in this article. It is difficult such a short time after reform implementation, and given the limitations of the Rim-P database to grasp its complexity, to provide a detailed analysis of its impacts. If the individual care plans appear to favour access to diverse and adapted treatment modalities, one can question the extent to which they have been applied in the field as well as the extended use of compulsory out-patient care. In addition, the reforms implemented in 2013 following a Constitutional Council decision of April 20<sup>th</sup> 2012 to include a text in the Public Health Code indicating that "no form of constraint can be applied to a patient under a care plan" makes application of the law and setting up care plans difficult for the health professionals. Similarly, the increase in the use of the derogatory SPI procedure raises questions and deserves further monitoring in the years to come. How will the individual care plan and SPI procedure be used two and a half years after implementation? What effects will be observable on the number of patients concerned and the associated treatment regimens? How does one characterise the dissemination of alternative treatment modalities to hospitalisation among psychiatric care providers?

The increase in the duration of involuntary care, with care plans that represent long-term treatment modalities, should mechanically increase the number of involuntary patients over the next few years. This progression raises both ethical questions in terms of individual rights, the respect of individual liberty and the practical realities of implementation. In effect, the law lacks precision on certain aspects: the interest and the role of SPI and what can be expected in the

future, the extent and implementation of acceptable constraint in a care plan, the use of sequential or immediate hospitalisation for a patient under a care plan. An evaluation of the public policies is needed, based on qualitative approaches with

a focus on the diffusion processes and the diversity of practices, as well as on the effects of the new treatment modalities in terms of health status and quality of life for the individuals concerned and their families (Rosenfield, 1997). ♦

## FOR FURTHER INFORMATION

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