

The Evolution of Laws Regulating Psychiatric Commitment in France

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This column reviews the evolution of French laws governing psychiatric commitment, culminating in the July 2011 Act, which was opposed by most professional organizations. The 2011 Act has maintained the two traditional French approaches to involuntary treatment: at the request of a third person and upon a decision by a prefect representing the government. However, the 2011 Act introduced major innovations into French practices: systematic review by a judge, a 72-hour observation period, and the possibility of compulsory community treatment. (*Psychiatric Services* 64:609–612, 2013; doi: 10.1176/appi.ps.201300174)

Introduction by the column editor:

Laws governing involuntary admission and treatment have taken different paths in countries around the

world. In the United States, 19th century criteria for civil commitment based on patients' need for treatment and physician-controlled procedures gave way in the 1970s to dangerousness criteria, extensive procedural protections, and judicial review. Although most countries have moved in the direction of greater procedural formality and oversight, many nations have struck a balance different from the U.S. balance between the interests of people with severe mental illness in receiving treatment and their liberty and autonomy interests. This description of commitment law in France offers an illustrative example.

In contrast to the nearly exclusive focus on dangerousness to self or others in most American jurisdictions, the new French statute continues to permit involuntary hospitalization of patients who need immediate care but are unable or unwilling to give consent. Commitment in France provides facilities with the power to treat over patients' objections, whereas many U.S. jurisdictions separate the two issues, often requiring that committed patients be found incompetent before their refusals can be overridden. The status of involuntary inpatients in French facilities can be converted to involuntary outpatient status at psychiatrists' discretion, whereas U.S. states that have outpatient commitment laws invariably require additional court proceedings. However, in keeping with international trends, France now requires judicial review after two weeks of hospitalization, still a somewhat longer interval than the three to five days common in U.S. laws.

Comparisons of this sort should help us recognize that the complex balancing of interests required in drafting commitment laws does not have a single "right" outcome. Other democratic systems may make different choices about the value placed on provision of treatment versus protection of rights. Knowing that France has chosen a somewhat different course (as has England, where criteria oriented toward need for treatment remain a basis for commitment) should stimulate us to consider the appropriateness of the balance we have struck.

The first French law governing compulsory hospital admission of persons with mental illness was passed in 1838 (the Law of 1838), a dramatic democratic breakthrough at that time. Until the late 18th century, "the insane" were confined indiscriminately in penal facilities with various troublemakers or political enemies of the regime. A *lettre de cachet*—or royal sealed order—precluded legal recourse. In the early days of the French Revolution, a law entrusted local civil authorities with preventing "the insane" from roaming at large, but the means of carrying out this mission were not specified (1). Confinement of persons believed to be insane was not addressed in civil legislation despite the stipulation in the 1789 Declaration of the Rights of Man and the Citizen that "no person shall be imprisoned except in the cases prescribed by law."

In the early 19th century, psychiatry emerged in France, and insanity became a medical issue. The physician Cabanis taught that madness was

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a progressive rather than a fixed condition, requiring quick and flexible procedures at admission and discharge. In this context, Esquirol and Ferrus, disciples of Pinel, lobbied representatives in the National Assembly for the passage of the Law of 1838 (2). The new law was clearly designed for the protection of people with mental illness rather than for public security. It mandated every French district to set up a lunatic asylum; provided a framework for the assistance, care, and protection of people with mental illness; and eliminated the possibility of arbitrary detention.

The question of judicial involvement was sharply debated because of commitment's inherent restriction on freedom of movement. In the end, it was rejected on the grounds that the judicial process would be slow and entail public disclosure of the patient's condition, whereas the civil authorities could decide quickly and preserve confidentiality. Commitment was seen as a medical measure and thus a process that should occur without publicity or stigma. If the civil authorities or the physician made a mistake, patients or their relatives could appeal to the courts, which could sanction those responsible for the decision and invalidate unjustified admissions.

Two modes of admission into a mental hospital were created. *Placement volontaire* (voluntary commitment) was based on both a request from a third party (usually the family) and a medical certificate detailing the need for involuntary hospitalization. Specific criteria for commitment were not specified in the law. Discharge was decided by the hospital psychiatrist or the third party. *Placement d'office* (compulsory commitment), in the case of threat to others or public safety, consisted of an order by the prefect (the representative of the state); the main difference from the former *lettre de cachet* was a medical review of the appropriateness of hospitalization. Discharge was effected by a prefect's decree on the basis of a medical certificate. In both cases, periodic medical certificates were required to continue the commitment, and at every step the judicial authority was provided with complete information.

The Law of 1838 remained unchanged for more than 150 years, despite recurrent criticism. Surprisingly, some authors argued that it was designed to protect society from patients rather than the opposite. Also, judicial involvement, being optional and occurring only after the fact, was considered ineffective for preventing abuses. For some, the law was obsolete by sole reason of its age. A new law was promulgated in June 1990 (3) that aimed to reinforce patients' individual rights and take into account more recent approaches to psychiatric care. In fact, this revision rendered the law more complex, although with little substantive change.

The 1990 law gave official status to voluntary admission, which was not mentioned in the Law of 1838. The *placement volontaire* was renamed *hospitalisation à la demande d'un tiers* (admission at the request of a third party), with two certificates required instead of one (except for emergencies). Indications were specified with more precision—patients unable to consent and whose condition requires immediate care and continuous monitoring. *Placement d'office* became *hospitalisation d'office* (compulsory admission). As in the past, the judiciary was informed at every step, and patients and their families could file an appeal at any time. However, the persistent lack of judicial intervention before admission was debated once more, and new arguments were based mainly on resolutions promulgated by the European Community. But in the end, France remained one of the few countries in Europe opposing “judicialization” of commitment procedures.

Overall, the 1990 law was a pragmatic construction, intended to accommodate clinical needs, family participation, individual rights, and the requirements of public order. In the last years of its existence, it resulted in about 75,000 commitments annually of a total of 600,000 hospital admissions (4). However, it was considered from its inception to constitute a transitional step toward an inevitable expansion of the judiciary's role. Other limitations included the lack of an option for compulsory community treatment (CCT). French

public opinion was aroused by a few tragic events involving violence committed by psychiatric patients. All of this resulted in the controversial July 2011 Act (5), which aimed at reconciling the rights of persons with mental illness and demands for increased public safety.

The July 2011 Act

The July 2011 Act was preceded by reports recommending two innovative procedures: a 72-hour observation period before any type of involuntary placement and some form of CCT (6,7). As in the 1990 law, consent to care whenever possible remains the rule in the new statute. Patients can be hospitalized without their consent only in cases of absolute necessity (8). The two older forms of involuntary commitment remain: at the request of family or friends, when patients fail to consent and require immediate care (*soins psychiatriques sur demande d'un tiers*); and by public authorities (*soins psychiatriques sur décision du représentant de l'état* [SPDRE]), the administrative form in case of dangerous behavior.

Major changes, meant to reinforce the rights of patients, were included in the act. Involuntary treatment, such as with medication, can now be carried out without a third party's agreement in the case of immediate danger (*péril imminent*) when it is not possible after an active search to obtain a third-party request. In this case, specific certification from a physician independent of the admitting facility is required. Second, although patients can be discharged at any point at which their condition has improved, the initial observation period must include a thorough physical examination in the first 24 hours. Additional psychiatric certification is required on days 1 and 3 and again on days 8 and 12 (the certification on day 12 must be signed by two psychiatrists); monthly certification is then required. During the admission procedure and the initial 72-hour observation period, the patient's need for hospitalization is reviewed by at least three physicians.

Another change included in the 2011 Act is that involuntary care can be carried out either in a hospital or in

the form of CCT (*programme de soins* [program of care]) in a specialized center or in the community. If the patient can be discharged, CCT may be carried out under any type of involuntary procedure as early as the third day after admission. This measure requires a medical certificate from the psychiatrist in charge of the patient's care, as well as a detailed description of the proposed modalities of care. If CCT is instituted after fewer than 15 days of hospitalization, judicial review is not required.

A fourth change is that a judge (Judge of Liberties and Detention) reviews commitments between 12 and 15 days after admission. The judge must hear directly from the patient, unless precluded by the patient's condition as documented by a psychiatrist's certificate. After the hearing, the judge decides whether involuntary hospitalization is appropriate, unless further examination by medical experts is required, in which case the decision is postponed until day 29 after admission. The next judicial review takes place six months after admission and then every six months thereafter. Hearings can take place in court, in the hospital, or by videoconference.

Fifth, the 2011 ACT promulgates specific procedures and cautions for patients admitted because of dangerousness (SPDRE) after having been declared mentally irresponsible in a court or after being admitted to a special forensic unit. Specific procedures are also stipulated when the psychiatrist and the prefect do not agree on decisions about discharge or changes in modalities of compulsory care.

A local committee comprising physicians, a magistrate, and representatives of patient and family groups provides support to patients and informs them of their rights. The Regional Health Authorities have established a list of authorized hospitals for the treatment of persons with mental illness. These authorities define modalities of care and transport to a hospital for psychiatric emergencies and identify the resources that exist for patient follow-up.

Discussion

The 2011 Act has been in effect for approximately two years, and it is too

early to appreciate its full impact and usefulness. Its gestation offered a fair prospect, but its birth was precipitous. Both professionals and patients' relatives had long advocated reforms. For instance, patients' relatives had pleaded for some sort of flexible involuntary outpatient treatment. However, legislative discussions launched in the immediate aftermath of a highly publicized homicide committed by a patient who had escaped from a psychiatric hospital were perceived as emphasizing security at the expense of civil liberties. From the start, the proposals gave rise to profound disagreement between the government and most professional organizations, with the latter expressing concern that the bill overemphasizes public safety issues at the expense of increased stigmatization of people with mental illness. It appears from the French National Assembly (9) and Senate (10) transcripts that the law was debated along partisan lines rather than on its technical merits.

On the whole, there is a perception among mental health professionals that the new act introduces unnecessary complexity and paperwork, notably with the multiplication of medical certificates during the initial 72-hour phase of compulsory treatment. In contrast, the 1838 and 1990 laws are remembered with nostalgia as flexible, efficient, and easy-to-use instruments that offered a harmonious balance between administrative and judiciary authority, medical decisions, and the role of the family.

Mandatory judicial review was imposed fairly late in the development of the 2011 Act by the French constitutional court in order to conform with the French constitution and European regulations. As stipulated in the 2011 Act, a judge is required to evaluate the degree of proportionality between restriction of the patient's liberty and need for psychiatric care. In other words, is hospital commitment necessary for treatment? Could treatment be administered without restricting the patient's freedom of movement? The judge can only validate or invalidate the current method of care; in the latter case, the patient is discharged. The judge cannot change a patient's inpatient status to CCT. In

practice, compulsory commitment entails that treatment with medication can be imposed against the patient's will, which is not the case in all countries. In everyday practice, the location of hearings (hospital versus court) is a contentious issue, mostly because nursing staff are diverted from their primary mission in order to escort patients to court. In addition, bringing patients to court may induce misunderstandings; patients may be left wondering whether they have done something unlawful or whether a conflict between them and their physicians has to be settled by a judge.

Involuntary admission without a third party's request is obviously very useful in some circumstances. In this case specifically, systematic judicial review is appropriate because it introduces third-party oversight—a very useful counterweight. But there is a risk of excluding families from the therapeutic process, especially if they are ambivalent or simply not easy to contact.

The 2011 Act introduced CCT. Although CCT orders began to appear during the 1980s in the United States, Australia, New Zealand, and Israel, they are a fairly recent trend in Europe (11,12), with the exception of Norway (in 1961). In Europe, CCT was introduced recently in Belgium, Luxembourg, Sweden (13), and the United Kingdom (in 2007). In Spain (14), certain cities are experimenting with CCT. Under the French 2011 Act, CCT can be initiated only after compulsory inpatient care (≥ 72 hours), whereas the 1999 mental health act in Norway allows CCT without a prior hospital stay. Patients who do not comply with the outpatient treatment program can be recalled to the hospital, although the enforcement mechanisms are not yet defined. The previous French law—the 1990 law—had a precursor of CCT in the form of a conditional discharge (*sortie d'essai*), similar to conditional leave from the hospital provided in the 1983 Mental Health Act (section 17) in the United Kingdom. Before the introduction of CCT in France, hospital treatment could be forced on the patient only during critical periods, to handle an acute episode. CCT now offers the

possibility of extending coercive treatment for an indefinite period to prevent a potential relapse, even when its likelihood is difficult to evaluate (15). Whether this power will negatively affect psychiatrist-patient relationships by reducing the incentive for treatment providers to pursue a therapeutic alliance remains to be seen.

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