



Isolation and restraint in mental health institutions

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**Contrôleur général des
lieux de privation de liberté**

Contrôleur
général
des LIEUX
DE PRIVATION
de Liberté

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About the author

The Contrôleur général des lieux de privation de liberté (CGLPL) is an independent administrative body created by the Act of 30 October 2007 following the ratification by France of the Optional Protocol of the United Nations' Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. In practice, the CGLPL began its work on 13 June 2008. Adeline Hazan was nominated on 17 July 2014 for a six-year, non-renewable term.

The Contrôleur général's aim is to ensure protection of all fundamental rights for persons deprived of their liberty, whether they are in prison, police custody, a mental health institution, an immigration detention centre, the cell of a courthouse, a juvenile detention centre, or in any other place where people are imprisoned upon the decision of a judge or other administrative authority.

In this way, the CGLPL ensures that the rights to life, to physical and psychological integrity and to not be subject to inhuman or degrading treatment are respected. It also falls to the CGLPL to ensure that there is a right balance between respecting a person's fundamental rights and considering public order and safety, in particular in terms of the right to a private and family life, to work and training, to access to healthcare and to freedom of expression, conscience and thought.

Likewise, the working conditions of staff and visiting staff are examined as they can have direct consequences on the treatment of people deprived of their liberty.

The CGLPL can visit, at any time, any facility in French territory where people are imprisoned to check the living conditions of the persons deprived of their liberty and to investigate the state, organisation and operation of the institution. The inspectors have free access to all of the premises and can discuss confidentially with the persons deprived of their liberty as well as the staff and any visiting staff.

As part of its mission, the CGLPL makes recommendations to public authorities. In addition to the reports published following each visit to an institution, the Contrôleur général can decide to publish in the Official Gazette recommendations specific to one or several institutions as well as general opinions on a cross-cutting issue. All of these documents are available on the CGLPL's website (www.cglpl.fr).

Finally, the CGLPL can receive referrals from any natural person (and legal entities which deal with human rights); the inspectors at the referral centre deal with the letters directly sent by persons deprived of their liberty or by their loved ones by verifying the situations recounted and by leading investigations, on site if necessary, to attempt to respond to the problems raised and also to identify potential shortcomings and, if necessary, suggest recommendations to prevent any new violations of fundamental rights.

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Introduction

Under the terms of the Act of 30 October 2007, the Contrôleur général des lieux de privation de liberté is tasked with ensuring that any person deprived of their liberty is treated with humanity and their dignity is respected.

Psychiatric hospitals are not by definition places where people are deprived of their liberty, but patients can be admitted to them without their consent, and therefore their freedom to come and go is restricted.

The issue of the rights of patients hospitalised without their consent, as well as the issue of psychiatric treatment of all people deprived of their liberty, are virtually absent from public debate, even though they pose genuine questions with regard to fundamental rights.

The French legislator regulated the measures for enforced hospitalisation by initiating, in particular, systematic monitoring of the judge supervising releases and detention. Therefore, guarantees for patients exist today, but the limits of these must be noted. Indeed, some people, in addition to being hospitalised without their consent, can be subjected to physical constraints (placed in seclusion rooms or in restraints), procedures which are not included in any legal checks.

These methods of physical constraint were thought to have been questioned during the second half of the 20th century by psychiatric schools and widely replaced by developments in pharmacopeia.

The CGLPL's visits to mental health institutions¹ have uncovered that isolation and restraint is used to such an extent that they seem to have become essential for professionals.

These physical constraints are, at the very least, a maximum violation of freedom of movement. The way in which they are used is often humiliating, undeserved and sometimes dangerous. Thus, paradoxically, the hospital, a haven of care, allows and perpetrates, within its facilities, practices which, under certain circumstances, constitute inhuman and degrading treatments.

The almost total absence of public debate on the development of these treatments is perplexing. Admittedly, as there is no evaluation tool, it is difficult to assess how widespread their use is. In a more harmful way, it is difficult, even for professionals, to question the methods which they have been taught and which they use in all good faith with the belief that it is a treatment, the proof being – if needed – that it is only used on prescription.

The assurance that isolation and restraint are only used in crises and as a last resort, the – justified – conviction that professionals are only concerned about the well-being of their patient and the ignorance of psychiatry, reduced to the image of the "madman tied up", do not cause citizens to be alarmed about their harmful effects – they may not even know about these measures unless they are directly affected.

The families, somewhere between overwhelmed and desperate, are relieved to transfer the care of their loved one to a mental health institution and upset that they have to resort to one. They rarely ask much about the treatments used.

1. Since it was created, the CGLPL has visited over a third of institutions authorised to receive patients without their consent including all UHSAs (specially-equipped hospitalisation units) and UMDs (units for difficult patients).

They are even less likely to dare to ask if they have resorted to the institution in response to their relative's "shameful" agitated or violent behaviour.

It is not up to the Contrôleur général des lieux de privation de liberté to assess the therapeutic relevance of resorting to coercive measures such as isolation and restraint. But the law has given it the mission of ensuring that the fundamental rights of people hospitalised and treated without their consent are respected and it notes that these practices clearly infringe upon them, more or less seriously and to a greater or lesser extent depending on the circumstances. This infringement is even less tolerable given that the people subjected to these measures are in a fragile and dependant state which does not allow them to defend themselves from them.

As such, it must be stated as a principle that these practices must only be used as a last resort, as a safety measure, if no other method will protect the patient and other people from danger. It goes without saying that as an emergency measure, all alternatives must be sought and that, the fact it is an emergency, implies that the duration of these placements is limited to only to what is strictly necessary. Furthermore, failing proven therapeutic value, resorting to restraint or isolation in any other situation must be forbidden.

The visits carried out for the last eight years in psychiatric institutions have allowed the CGLPL to identify some factors which are likely to lead to the development of these practices or, quite the opposite, to them being limited. In particular, these include regulatory measures, staff training and awareness, organisation of treatment, the layout of the facilities and the introduction of collective and ethical discussion.

This is the purpose of this report and the recommendations the CGLPL gives to mental health professionals.

Chapter 1

Practices which seriously infringe on fundamental rights and have unproven therapeutic effectiveness

Section 1

Isolation and restraint, such as used in psychiatry, call for particularly close attention from the CGLPL

The use of internal isolation inside a facility in which people are deprived of their liberty is not only found in psychiatric institutions. For example, separation is recommended for the purpose of fighting against the transmission of infectious diseases – which is carried out by limiting a person's movements to one room – practised in particular in administrative detention centres. Putting prisoners, at their request or at the request of the prison administration, in isolation is another example. The present report limits its area of study to psychiatric care facilities and will not deal with these separations.

The practice of physical restraint is no longer the preserve of psychiatry, it is also found in a number of medical services and medical-social facilities. It is often used, in particular in emergency services and gerontology; the reasons usually cited for this include the risk of falling (from the stretcher or bed) and confused states with wanderings and agitation, whether caused by alcohol poisoning or other intoxication.

Likewise, hospital emergency services regularly have to care for patients with psychiatric conditions who can arrive in a critical state with agitations, perhaps self-harming or being violent towards others; these clinical situations can lead the teams to restrain these patients or to isolate them.

These facilities and services do not fall under the CGLPL's jurisdiction as it only focuses on institutions where people are deprived of their liberty as a result of an administrative or legal judgement.

Likewise, the present discussion will only take into consideration mechanical restraint used in psychiatry, which involves using physical equipment – ties, bindings and straight-jackets, in order to stop or limit movement. It will exclude chemical restraint involving the administration of sedative medicines, often by injection, in crisis situations, in order to limit physical or motor activity. However, with regard to these sedative drugs, the CGLPL adopts the recommendation of the European Committee for the Prevention of Torture (CPT)¹ according to which, when "chemical restraint" methods are used, they must be combined with the same traceability requirements as other restraint methods.

Finally, it should be specified that by isolation, we mean all situations where the patient is placed, following a physician's or nurse's decision, in a closed space which he/she cannot get out of, whether it is the patient's own hospital room or a room intended for this use. The latter vary in layout and name according to the facilities (see. Chapter 2, Section 1): seclusion room, intensive care chamber, secure room, calming down room, restraint room.

1. CPT: European Committee for the Prevention of Torture and Inhuman and Degrading Treatments. The CPT, established by the European Convention for the Prevention of Torture and Inhuman and Degrading Treatments, which came into force in 1989, is a non-legal, preventative entity which visits places of detention in the Member States of the Council of Europe. Each visit is the subject of a detailed report for the State concerned.

The CGLPL has often looked, in vain, for the justification of the term "intensive care" chamber: there is no technological equipment in these facilities and the interventions that take place are no more specialised than usual except increased monitoring, which is not always the case.

Isolation indicates the fact that the patient cannot freely leave this facility, no matter the quality of the comfort or treatment.

Section 2

These measures appear to be the result of the evolution in the treatment of people suffering from mental disorders

Perceptions in popular culture are hard to shake: in the collective imagery, the "insane" has their code, which is difficult to change. He is in any case a troublemaker – we will see that the assessment even has a clinical development – and potentially (or as such?) is violently and dangerously disruptive. The most good natured people worry about the danger those afflicted with mental disorders pose to themselves, others are scared and above all worried about the danger they pose to others.

With the acknowledgement of the disorder came freedom from the chains, as Couthon described in his account of a visit to the Bicêtre hospital in 1792: "Pinel led him straight away to the area where the agitated people were held, where the view of the lodges did not leave a good impression. He wanted to question all of the patients. He only received insults and rude remarks from most of them. It was not worth spending more time investigating. Turning towards Pinel: "Oh citizen, are you mad yourself to want to unchain such animals?"¹ But, for all that, the physical restraint of mental patients was not completely abandoned and in specialised detention centres spread across France, as a result of the Act of 1838, resorting to restraint was far from being ruled out, in particular for those who did not obediently submit to the "moral" treatment of their illness.

1. Scipion Pinel, *Traité complet du régime sanitaire des aliénés*, Paris, 1836, p. 56.

During the 19th century, the use of mechanical restraint became widespread, in France as much as in the rest of Europe and the United States. The most ingenious procedures flourished: leather ties, handcuffs to attach patients to the bed, restraint chairs, straitjackets and protection beds¹. Only England partly resisted with the non-restraint movement championed by Conolly, a psychiatrist who invented the padded seclusion room, an alternative to mechanical restraint.

After the trauma of the Second World War and its effect on mental institutions (they were struck by an abnormally high death rate estimated at over 40,000 dead patients – mainly as a result of hunger and infections), the era of institutional psychiatry and the birth of the sector policy – one of the objectives of which was to ensure, as often as possible, the treatment of patients outside of psychiatric hospitals and as close to where they normally lived – created a revolution in practices. "The *désaliéniste* (anti-psychiatrist) is someone who, having abandoned the profession, introduces himself in the public square by saying: What can I do for you?" declares the psychiatrist, Lucien Bonnafé. The profession rallied and reinvented psychiatry. The treatment of patients outside of psychiatric hospitals considerably decreased the number of patients hospitalised full-time (from 170,000 beds in 1970 to 50,000 beds in 1999). In correlation, thus patients requiring more complicated care were hospitalised with reduced human resources.

A new shift took hold in the 1990s with institutional psychiatry being progressively abandoned and, from 1993, the specific training programme for psychiatric nurses was shut down, these nurses "who bet on their patients being able to rely, with them, on their sane part in order to fight against the sick part" (P. Delion).

1. A cover sewn to the bed closely enclosing the patient, stopping him/her from being able to move.

Psychopathology, in particular psychoanalysis, focused on the carer-patient relationship, was replaced with clinical diagnosis using symptoms, in the wake of the DSM¹ which came from English-speaking countries, making it difficult for the teams to analyse, understand and help mental people to recover.

At the beginning of the century, the shift increased with the political discourse of "total security" which stigmatised the mentally ill for the danger they pose rather than for their suffering. The media spread the message that society must protect itself and a part of the profession took hold of this and responded by returning to the use of isolation – and if necessary under restraint – of these patients. These methods would experience an upward trend.

Thus, since Pinel liberated the mentally ill from their chains, restraint and isolation have never truly disappeared.

Section 3

Even though their therapeutic effectiveness has not been proven

The science and medical practice report "thérapeutique psychiatrique" (therapeutic psychiatry) written with the collaboration of 153 specialists from all of the university psychiatry departments² dedicates 20 pages to the practice of electroconvulsive therapy (ECT or electro shock) but does not mention putting patients in seclusion rooms and only half a page deals with restraints. It states that physical restraint is a medical act, involving a medical prescription in its own right; it specifies that optimally, a member of staff should remain with the patient and adds that if a nurse cannot be constantly present, the patient must be monitored every five to ten minutes.

1. DSM: diagnostic and statistical manual of mental disorders – reference work published by the American Psychiatric Association, describing and classifying mental disorders.

2. *Thérapeutique psychiatrique* – Jean-Louis Senon, Daniel Sechter, Denis Richard – Hermann – 1995.

Debates amongst the psychiatric community between those who support isolation and restraint and those who do not, are numerous and date back many years. For those in favour of these practices, they have an undeniable therapeutic power; for those against, they are a punitive measure or to make the teams feel more at ease.

There are no therapeutic practices or treatments which are free from side effects, yet one of the main guidelines taught to medical students is "*primum non nocere*", in other words "above all else, do no harm". Hippocrates defined the aim of medicine in his treatise "Epidemics" as follows:

"As to diseases, make a habit of two things: to help, or at least, to do no harm". A practice's effectiveness, or, failing that, its safety, should therefore be proven before using it for therapeutic ends.

The regularly denounced risks and side effects of these practices include in particular: sudden death, asphyxia, accidental death, thrombosis and cardiac complications. A number of studies have been carried out but none of them enable us to formally state that the effects identified in people being restrained or in isolation are directly related to these practices.

Astonishingly, there are few studies dealing with the therapeutic effectiveness of the use of restraint and isolation. Defenders of these practices give them virtues based on the restriction of the environment, physical separation from others, reduction in sensory stimulation or the regression of the patient, thanks to the mothering relationship they have with carers during treatment. Even though some studies believe, without being able to confirm it, that the use of seclusion rooms helps to reduce the number of violent episodes, others conclude that reinforcing staff and training teams are more effective ways to respond to these episodes. No scientific study carried out to date confirms the therapeutic effectiveness of restraint or isolation.

The use of mechanical restraint can be therapeutic but not necessarily for the patient. Gray and Diers (1992) highlight the impact of the stress of nursing staff on the patients, thus contributing to increase the use of restraint. For Outlaw and Cowery (1992), mechanical restraint has an anti-anxiety effect for the team. They think that its use is not necessarily helpful for the patient.

The marketing authorisation procedure for drugs is long and difficult and often the drug is taken off the market due to the risks it can have for those who take it. Electro shock therapy, still contested by some people, is the subject of a large number of studies proving a certain effectiveness in very specific indications and its use can be challenged by the patient who is offered this treatment, or failing that, by the person who has been appointed "trusted"¹. Resorting to restraint or isolation in psychiatry is not subject to any authorisation nor, most often, the requirement to inform the patient's loved ones about why it would be required by the clinical state of the patient and that, in principle, it would only concern patients hospitalised without their consent.

All in all, these are practices which seriously infringe on fundamental rights and the implementation of which pose problems as it is and, in addition, in the way it is practised.

1. Article L.1111-4 of the Public Health Code provides that no medical act or treatment can be practised without the free and informed consent of the person and he/she can change his/her mind at any time. When the person is unable to give their consent, no intervention or investigation can be carried out, except in an emergency or if it is impossible, without his/her trusted person provided for in Article L.1111-6, or the family, or failing that, one of his/her loved ones, being consulted.



Chapter 2

Low and conflicting involvement within the hospital community

Since 2009 and its first findings concerning psychiatric services, the Contrôleur général des lieux de privation de liberté has been recommending that resorting to isolation and restraint be documented in a specially drawn up register and that quantitative and qualitative monitoring be carried out on these measures. This recommendation has finally been taken into account by the French Parliament in the Act of 26 January 2016 and the CGLPL will be especially vigilant regarding the way this recommendation is implemented in hospital institutions; but, at this time, staff still do not have any up-to-date inventory of these restraint measures.

No scientific body strictly speaking recommends implementing restraint measures. Nonetheless, the CGLPL observes that, amongst the psychiatric institutions it visits, those which never resort to one or another of these measures are an exception. It also observes very diverse practices according to the institutions and within each one, depending on the departments, perhaps even from one unit to another, even when there is a validated common protocol within the institution. Finally, it notes that the use of seclusion rooms and restraint are not only found in admission departments which receive patients at a crisis point in terms of the evolution of their illness; far from it, there are reportedly more frequently used in long-stay departments which treat stabilised patients over long periods.

One would think that the differences in treatment methods used from one unit to another would be explained by the types of patient treated by each department according to its medical specialism. In reality, according to staff in these institutions, these differences would only weakly correlate to differences in patients' clinical situations or diagnosis. They would be attributed more to "department culture", showing the diverse approaches and points of view of doctors or teams: the varying amount of attention they pay to the fundamental rights of the patients and the search for the therapeutic alliance, their ideas and fears facing real or imagined violence from certain people, their abilities to develop alternatives and to offer a restraining function for the patients (see Chapter 4, Section 1).

Section 1

Practices applied in different ways but existing in almost all institutions

The vast majority of care units visited by the CGLPL have one, or even two, seclusion rooms, and restraint equipment. Some specific units, such as UMAPs (units for agitated or disruptive patients) or USIPs (units for psychiatric intensive care), are mostly or even exclusively made up of these rooms.

Even some psychiatry sectors in prison environments have them even though treatment using restraint is forbidden in prisons.

I – Diverse but often problematic indications

Some isolations result from decisions which are not guided by the clinical state of the patient, as such the reference document from the French National Health Accreditation and Evaluation Agency (ANAES, now the National Authority for Health (HAS)) only offers moderate assistance when it comes to indications and it is the same for other recommendations, as we will see below (see Chapter 3, Section 2).

Furthermore, these indications are often followed rather too flexibly.

A – An ANAES reference document which does not stop abuse

In 1998, the ANAES developed a reference document for the use of seclusion rooms which had five accepted indications for resorting to them:

1. to prevent a patient's imminent self-harm or violence towards others when other methods of control are ineffective or inappropriate;
2. to prevent a risk of therapeutic rupture when the state of health requires treatment;
3. isolation incorporated into the therapeutic programme;
4. isolation to decrease stimulation;
5. use at the patient's request.

The first two indications are most often stated by health professionals to justify the use of isolation. But there are few teams who report the methods implemented before resorting to them, as the first indication advises.

The inspectors have also often heard that isolation was used at the patient's request (fifth indication) without being able to verify this, with some exceptions. They have therefore had the feeling that the patient embraced the carers' discourse sometimes in resignation and sometimes to make the measure more bearable.

"Isolation incorporated into the therapeutic programme" (third indication) seems to only concern the treatment of people suffering from severe anorexia but the significance of the constraints imposed on patients in this framework would seem to justify that these treatments should only be used in specialised departments or, failing that, that the practitioners gain expert opinions from outside the department and a ruling from the ethics committee.

Furthermore, clinical research should evaluate the appropriateness of these therapeutic methods.

It is therefore anticipated that isolation or restraint are used to deal with a crisis situation when no other method can resolve it. By definition the crisis is time limited so isolation and restraint should, in all events, be used for a short time - the time strictly necessary to resolve the crisis or to implement another method to help bring it to a close.

But the CGLPL very frequently notices seclusion rooms being used as a result of indications which are not found in this reference document. Thus, some psychiatrists raise "the obligation to place a patient in therapeutic isolation before a shock therapy session in order to ensure that he/she has an empty stomach or just after a session when he/she is in a state of mental confusion". These practices are neither appropriate nor adapted (isolation can only heighten the extreme anxiety-provoking aspect of a state of confusion).

Worse still, sometimes isolation is used for disciplinary purposes or as a sanction. Some departments go so far as establishing a scale of days of isolation according to how the patient breaks the rules; this scale is fixed by the internal regulations or by the care framework. The CGLPL notes that, in this way, the law defines at least a minimum framework

for respecting the rights of patients since Article L.3211-3 of the Public Health Code pertaining to treatment without consent states that: "when a patient with a mental disorder is subject to psychiatric treatment in application of the provisions set out in Chapters II and III hereof or is transported for the purpose of this treatment, the restrictions to exercising his/her individual liberties must be **adapted, necessary and proportional** to his/her mental state and the execution of the treatment required. In all circumstances, the dignity of the person must be respected and his/her reinsertion sought after. (...)"

B – The application of protocols unconnected with the patient's clinical state

The CGLPL denounced, in an opinion dated 15 February 2011 pertaining to certain aspects of compulsory hospitalisation¹, the situation of people detained in hospitals in application of Article D.398 of the Criminal Procedure Code² and has regularly denounced it since. Indeed, these people are often subject to a negative preconception which makes people consider them to be dangerous and try to avoid them. Placing them in seclusion rooms is almost systematic, and is independent of their state of health. Isolation is sometimes limited to an observation period, but in most situations it lasts the entire hospitalisation period. This safety measure is not at all healing and is sometimes associated with restraint and deprives the person of access to the department's therapeutic activities. More generally, the way of life of people detained in hospitals is more restrictive than in prison (for example, they are forbidden to access the outdoor area or watch television and to receive or make phone calls to people authorised by the legal authorities who they would be able to call if they were in prison or who would come to visit them). This rigorous confinement regime, which makes the status of the detained patient prevail over the clinical requirement, regularly results in the patient asking to be returned to confinement before his/her state justifies it.

1. The Contrôleur général des lieux de privation de liberté's opinion dated 15 February 2011 was published in the Official Gazette dated 20 March 2011. It can also be consulted on the CGLPL's website (www.cgplp.fr). Point 7 of this opinion deals more specifically with the practice of putting people detained in hospitals in seclusion rooms.

2. Article D.398 of the Criminal Procedure Code: "Prisoners with mental disorders covered by Article L.3214-3 of the Public Health Code cannot be held in a prison. In light of a detailed medical certificate conforming to the applicable legislation, it is up to the Prefectoral authority to undertake, as soon as possible, their compulsory hospitalisation within a qualified health facility under Article L.3214-1 of the Public Health Code. (...)".

However, Article 46 of the Prison Act recalls, if there is the need, that the quality and continuity of treatment are guaranteed for people detained under the same conditions as those the rest of the population benefit from.

In this context, some institutions have resorted to law enforcement to present people detained at their hearing with the judge supervising releases and detention (JLD). They are, if necessary, handcuffed within the institution although they are not considered to be a particular risk by the prison administration. Other institutions call on security staff each time a seclusion room is opened.

This systematic use of isolation for detained people is the doing of the health professionals responsible for the penitentiary mission; they sometimes comply with the requirements of the hospital management, the prison administration or the prefect.

However, some staff feel very powerless facing decisions that they have to apply without any chance to be heard and very uncomfortable with these approaches which are exclusively for security and which harm the quality of care. They denounce a logic of the "disempowerment of health institutions" and an "umbrella policy" towards risks which are not pathological and do not come under their medical vigilance.

REPORT FROM A CGLPL VISIT CARRIED OUT IN 2015¹

At the request of the head of the institution, the detained patients were, (...), in addition to two male nurses, escorted by police from the precinct (...), from the time they left the seclusion room until they returned to it at the end of their appearance. According to testimonials collected, the police escort is generally made up of three police officers but can sometimes be as many as five, the patients are often handcuffed during the journeys and can sometimes remain so during the hearing and the police officers attend the hearing.

1. This document includes extracts from visit reports to concretely illustrate the situations observed by the CGLPL. The names of the institutions are not mentioned when the report publication procedure is still ongoing.

Similarly, as the CGLPL noted in its opinion dated 15 February 2011, there are some institutions where this system is not required, enabling quality treatment without any increase in the number of escapees. Some internal regulations in hospital institutions provide for a systematic stay in isolation for some patients when they are admitted. Such is the case in some institutions for patients hospitalised following the decision of a State representative or perhaps at the request of a third party; elsewhere, patients who are not known to the department undergo this systematic stay. These procedures indicate the confusion between the need to give constant attention to a new patient and the need to place him/her in isolation. Indeed, if the patient is then "monitored" (generally every hour), he/she is not observed in terms of how he/she interacts with others.

**REPORT DRAWN UP BY THE COUNCIL OF EUROPE'S
COMMITTEE FOR THE PREVENTION OF TORTURE
FOLLOWING ITS VISIT TO PSYCHIATRIC CARE
FACILITIES IN FRANCE IN 2010**

It is not up to either the prison authorities or the prefectural authorities to request isolation and/or restraint measures or to decide to impose these measures regarding patients detained and suffering from psychiatric disorders without the opinion of a doctor supporting this decision. Otherwise, imposing such measures risks subjecting vulnerable patients to inhuman and degrading treatments.

This policy of systematic isolation, potentially coupled with restraint, is noted in all UMDs (units for difficult patients) at admission, sometimes for a few hours but often for 48 hours and up to a fortnight in some cases. Even though we can concede that it is necessary to have particular methods to observe a patient when they arrive, it is difficult to understand the systematic recourse to locking a patient in a seclusion room irrespective of his/her state of health.

In some psychiatric hospital units, patients returning from a stay in a UMD are systematically placed in a seclusion room. Stigmatised and feared by the nursing staff looking after them before they leave, they see themselves deprived of everything and subject to a much more restrictive regime than that they encountered at the UMD. This regime, generally not dictated by their clinical condition, proves to be undignified and counter-productive - locking patients up risks making agitation and opposition reappear; behaviour which was often the reason for their transfer to the UMD.

Also, there are some instances, when a patient is transferred between two units in the same centre, even if he/she moved freely in his/her original unit, that he/she is placed in strict isolation in the new unit for an observation period of 24 hours.

In some institutions, the patients waiting to be admitted to a UMD or to a UHSA are subject to long term isolation until they leave, which can be several months later, potentially under restraints. Once again, these confinements are not always related to their clinical state.

In this context, the CGLPL recommends that an evaluation take place rapidly of the operating methods of UHSAs and UMDs in order to assess in particular the consequences of admission times and conditions on the treatment of patients waiting to be admitted to them. Indeed, these treatments are rarely compatible with a therapeutic attitude.

The CGLPL also calls for great vigilance in order to ensure that the UMDs and UHSAs always offer operational conditions which ensure people are cared for in a respectful way and which are favourable for the promotion of their autonomy. Indeed, it noted some safety abuses in treatment practices against which it is important to develop clinical and ethical work involving the patients or their representatives.

In other institutions, when psychiatrists are not there at the end of the day or at the weekend, uncertainty or tensions escalate leading nursing staff to decide to use isolation measures. They then rely on an "if needed" prescription made beforehand. Thus, paradoxically, even when the clinical state of the patient requires a psychiatric consultation, being placed in isolation defers, sometimes for an extended amount of time, this medical consultation. The situation can then be prolonged for longer than necessary, for want of a psychiatrist to remove the measure.

The CGLPL has also noticed recourse to locking patients up, generally in their own rooms, for the purpose of keeping them safe from other patients in the department. This generally involves minors in general psychiatric wards, people with mental handicaps or those who are particularly vulnerable: in this way we have seen young women being locked up to save them from insistent solicitations or inappropriate behaviour from male patients. In some cases, these people are permanently imprisoned in their room except for a few trips to the toilet, during mealtimes or for a therapeutic activity. This unacceptable situation requires the departments to be organised in a way which ensures that safety is guaranteed for all patients without resorting to locking up those who are most vulnerable.

Another situation which is often encountered is patients with a chronic deficit pathology or autistic patients, sometimes placed in seclusion rooms for weeks, months or even years¹.

1. The CGLPL encountered two occurrences of measures created for a patient for the purpose of lifelong isolation.

They can also be subject to different restraint methods (to the bed, in suits or other clothing). Most often, the, well-meaning, nursing staff does not have any alternative treatment methods and receives very little support from the medical establishment. Quite often in these types of departments, the physicians only pass through occasionally without establishing real treatment plans adapted to the clinical particularities of these patients. They do not look for help from resources developed in other facilities either, in particular in medical-social facilities. These particularly fragile patients rarely have the opportunities to appeal.

Sometimes, these measures tend to be prescribed to compensate for a structural problem, with a department which remains open but the nurses cannot monitor incomings and outgoings, due to the small number of staff and few nursing staff in contact with patients in communal areas.

**REPORT FROM A CGLPL VISIT
TO A SPECIALISED HOSPITAL IN LA CHARITÉ-SUR-
LOIRE (2009)**

A number of patients told the inspectors that refusing to take a drug systematically led to the threat of being placed in isolation with restraint and injection; according to them this threat is regularly carried out.

Finally, some patients are kept in seclusion rooms, if need be with open doors, sometimes with restraint equipment remaining on the bed, due to a lack of available space in the care unit to look after them with more dignity.

These systematic practices are not compatible with an approach which respects rights and the need for proportionality in terms of measures for restricting freedom and for individualising care.

In a number of previously mentioned cases, resorting to isolation and restraint constitute inhuman and degrading treatment.

II – According to disparate procedures

As with the reasons for using isolation, the procedures are organised and managed in diverse ways, depending on the institutions and even, within them, depending on the centres, departments and units.

The location of the isolation can be restricted to seclusion rooms designed and reserved for this purpose. They have various names: "seclusion room", "intensive care room", "restraint room", "comfort room" or "quiet room". The name is sometimes reassuring, at least for the nursing staff, the common reality is always confinement. Generally in these rooms, patients must wear pyjamas provided by the institution, which are not always their size and are not their own. This practice is a precaution, presumed to prevent any risk of violation of the person's integrity. In the majority of cases, confinement in a seclusion room, or in an ordinary room, only happens to people hospitalised without their consent. Confining patients who chose to be treated is not conceivable given their admission status, they should be able to leave the treatment institution if they wish to¹. However, there are exceptions and these do not always relate to emergency situations that are quickly resolved by the end of the restraint period or, if it is decided to continue with it, by changing the status of the hospitalisation.

1. Article L.3211-2 of the Public Health Code: "People subject to psychiatric care for mental disorders who consent to said treatment are considered to be in voluntary psychiatric care. They have the same rights linked to the exercise of individual liberties as those who are recognised as patients treated for another reason. This form of treatment is favoured when the state of the patient allows it.

The way in which the room is set up is not standardised: toilets can be installed close by and freely accessible or not. The choice of their layout and what they consist of is surprisingly motivated: sometimes it involves preventing "all danger" and thus there will be a metal basin, perhaps the toilet-sink unit installed in disciplinary areas of prisons, which can be seen from the hatch in the door or by a surveillance camera; or, the opposite, the patient's comfort and well-being are sought after and the bathroom, decorated in calming colours, is separate from the room, under constant surveillance and offers comfortable furniture, including a mirror.

The surface area can vary from very cramped – 2.3m wide by 2.7m long so 6.20m², observed in one specialised hospital – to over 25m². Thus, in one institution, a seclusion room with a surface area of over 20m² had a height of 6m; the large area enabled a sizeable team to intervene but one may wonder about the soothing effect of a large volume surrounding the patient attached to his/her bed.

The natural light in these rooms varies greatly from one site to another; the CGLPL saw seclusion rooms without windows or with such narrow windows that they evoke arrow slit windows. Even though in most cases the windows can be left a little open, in many situations none of the windows can be opened, preventing natural ventilation. Without a doubt, a dark room with no external ventilation plays a part in increasing the mental distress of the person who is locked in it.

The furniture differs just as much: even though most of the time there is only a bed, sometimes there are armchairs, a foam table or shelf to put something on. The bed can be made up of a metal frame allowing for the restraint to be attached; in such cases, the bed is either fixed to the floor in the middle of the room or the head is fixed against a partition. It can also be made up of blocks of foam covered with plastic canvas – which can also hold the restraint straps – and simply fixed to the ground. The stance is not always based on a clear medical approach.

The chamber is accessible through one or two doors, with or without a protective airlock. But this layout is far from being implemented everywhere, in particular in older institutions.

Some chambers lead to a patio which allows the patient to go outside and to smoke.

**REPORT FROM A CGLPL VISIT TO GEORGES
DAUMEZON HOSPITAL
IN BOUGUENAIS (2013)**

The intensive care chamber (CSI) is equipped with a call button which sends a signal to the nurses' office. As the signal can only be turned off from the airlock of the chamber, the nursing staff must go to the chamber if the call button is pressed. As accessing the toilets is impossible, in order to stop the occupant from using them too often, a sanitary bucket is placed in the chamber.

It was explained to the inspectors that, when the institutions' doctors criticised the lack of direct access between the CSI and the bathroom, the project was too far advanced and it was no longer possible to fix it. This deficiency is greatly criticised by the latter for many reasons: in addition to the violation of the patient's dignity, the sanitary bucket can be a danger in itself – a patient has been known to drink from the bucket in the night – and for the nursing staff – a patient has been known to throw the bucket and its contents in the face of the nursing staff.

The lack of a national standard was regretted – and even the lack of discussion – concerning the layout of an intensive care chamber, which could have prevented such a deficiency in a new build.

In principle, a clock should enable the occupant to get their bearings in terms of what time it is but we have seen seclusion rooms where, in order to find out the time, the patient had to look through a window at a digital clock (difficult to understand when one is "disorientated") fixed on the wall of the outdoor area which the window looks out onto and about 15m away from the window; the patient can see the time provided that they are not restrained and that they have good eyesight... or their glasses, which is rarely the case for restrained patients.

The management of the isolation period is just as variable without the reasons relating to the clinical state of the patient always being put forward. In some units there is a protocol which is applied without any other form of discussion, in others, access to tobacco or reading and release periods, in particular in the outdoor area, are adapted and revised during the isolation period or depending on the patients. The duration can also be presided over by a protocol, according to the status of the patient – as already mentioned (see Chapter 2, Section 1) those entering UMDs are almost always placed in a seclusion room on arrival for a minimum of 24 hours – or the status of the prescribing physician. A nurse reported that when the on-duty doctor prescribed the intensive care chamber, the duration of the prescription was always 24 hours although the state of the patient may not have always required it.

Isolation can be continuous, or "sequential": the patient is regularly placed in isolation for a predetermined time. Release is either progressive or direct.

Furthermore, the CGLPL has frequently noted isolation taking place in the patient's room – being confined can be scheduled and regular: in one specialised hospital unit, a patient hospitalised with their consent for the past five years was subject to a daily isolation protocol in their room both in the morning and afternoon, from 10:30am to 12:00pm and from 2:00pm to 3:30pm, the prescription specifying "isolation plus potentially restraint".

Conversely, seclusion rooms are used for accommodation due to a lack of available rooms. In such cases, the door remains open but, if a camera is installed, remote surveillance remains possible.

The forms of restraint are no more uniform: in one institution – where it is exceptionally resorted to, it is limited to two diametrically opposed limbs as "the person must be able to move". Elsewhere, the opposite, restraint is total: four limbs attached as well as the chest and the pelvis, any other method being thought of as dangerous: risk of strangulation etc. And patients can be restrained in their room, on a chair, in a seclusion room, on their bed or in a Sécuritérap® safety sheet.

Some institutions do not have a seclusion room and resort exclusively to restraint.

With regard to isolation and restraint as a treatment, an idea supported by part of the medical community, the diversity of these practices is perplexing with regard to the coherence of the indication and its implementation.

Essentially, depending on facilities and approaches to responding to the need for isolation, isolation spaces are made available to patients for their convenience or, on the contrary, chambers for isolation are made available to staff to isolate patients.

III – And with a frequency which is impossible to quantify

The health authorities do not have any reliable tools to quantify recourse to isolation and restraint.

The data provided by the ATIH (Technical Agency for Information on Hospitalisation) can offer an indication but its reliability is far from guaranteed. According to the ATIH, in 2014, nearly 25,000 patients spent at least one day in therapeutic isolation; the duration of the therapeutic isolation treatment is steady: around 15 days per patient. This type of treatment represents at least 2% of the full-time days in psychiatry (so 378,000 days).

However, this data probably does not reflect reality, on the one hand, because the information is not correctly entered, and on the other, because the ATIH's information system does not provide for registering isolations carried out in places other than chambers designed for this strict purpose.

With regard to restraint, "statistics in this field are scarce and there is no monitoring carried out at national level" (Joseph Halos, Head of the Association des directeurs d'établissements participant au service public de santé mentale (Association of Managers of Institutions playing a part in the public Mental Health Service). Nonetheless, a study carried out by the Secretary General of the IDEPP (Inter-Trade Union for the Defence of Public Psychiatry), Christiane Santos, highlighted that "the practice of restraint was used everywhere" and that half of staff questioned stated that it had increased in recent years.

Thus, although all observers of this issue claim that there is great inequality between the number of times restraint is resorted to between one institution and another, it is difficult to measure the differences. The CGLPL visits resulted in some markers emerging which, while they have a weak arithmetic character, offer a basis for discussion and analysis.

The relationship between the number of hospital beds and the number of seclusion rooms is an initial indicator, the relevance of which must be adapted depending on their rate of use. There may be a lot of seclusion rooms which are hardly used or there may be fewer rooms which are used more often. The fact remains that some institutions have very few seclusion rooms, perhaps – exceptionally – none, and others have an abundance: in this way, two institutions of a comparable size (one with 512 beds, the other with 412) were visited; the first had three seclusion rooms in the strictest sense of the term and 24 calm rooms while the second had 46 seclusion rooms.

The rate of use is rarely recorded with precision. Often, only the security staff, who must be informed each day about the presence of patients in the seclusion rooms, are able to give quantified information.

An institution of 600 beds "only" had 27 seclusion rooms but their rate of occupation reached 86%; the nursing staff in one of the units of this hospital which had suddenly been deprived of a seclusion room following an incident, had explained "we learnt to do without, we anticipate crisis situations and act differently".

With regard to changing practices, the health professionals encountered claimed that resorting to restraint or isolation increases without being able to quantify it due to the lack of traceability within the institution and at regional or national level. Interviews carried out with nursing staff showed that the practice has become stripped of its human dimension. The older nurses explained that once, "relational restraint" was king.

These differences between one institution and another in terms of resorting to isolation are even more difficult to measure given that the institutions has different understandings of what this measurement implied. Thus one psychiatrist specifies, when talking about his/her institution, that "isolation procedures are traced (in the patient's file) but the use of "intensive care chambers" [the name used in his/her hospital] is not; likewise, sequential isolation is not assessed".

In units where patients are confined within an ordinary room, they are not considered to be "in isolation" and are not declared as such to the security department. However, some of these patients only leave their rooms for several hours or minutes per day. Even though, as the inspectors noted, patients are confined to their rooms to be "protected" from other patients, the measure of confinement applied to them de facto, is not always the result of a prescription and does not appear in their file. If evaluations were carried out on the basis of medical files, these isolations would not be recorded.

IV – An especially worrying situation for the practice of restraint

Even though teams usually have protocols for using seclusion rooms, those who have them for the use of restraint are much rarer. When there is such a protocol, it is based on the HAS guide which deals with limiting the risks of physical restraint for older people (see Chapter 3, Section 1) and does not deal with chemical restraint.

A – "Insidious" usage

The CGLPL noted that the practice of restraint also varies greatly from one treatment unit to another (including within the same establishment) and sometimes gives rise to statements which are as peremptory as they are contradictory. For example, even though a psychiatrist at one site indicates that "this happens exclusively in a seclusion room", another elsewhere indicates "restraint is most often used in the patient's bed in an ordinary room (provided it is an individual room) without it being necessary to put the patient in isolation; the room of the door is then locked to avoid other patients walking in".

Likewise, when in one institution "restraint is only used when patients display aggressive behaviour towards themselves", in another "it is envisaged that people detained are systematically attached to their bed for the first few hours of their stay."

Finally in some exceptional institutions the choice has been made to never isolate the patients and to favour restraint if necessary.

The duration of the use of restraint also varies greatly; in one institution it is limited to one or two hours, whilst in another people can be restrained in this way for several days, sometimes several months, with, in most cases, methods used to prevent any movement for up to 23 hours a day, without a nurse present and without any call system.

The person is therefore extremely uncomfortable and cannot even satisfy his/her basic needs.

**EXTRACTS FROM VARIOUS
CGLPL VISIT REPORTS**

– [...] a protocol for resorting to physical restraint had been drawn up but [...] there was still "internal debate" regarding the opportunity to publicise it; indeed, there is a fear that this practice might become more common, it is currently used as an exception and is contrary to the "spirit of the institution".

– Restraint is a practice which arrived late, around the 2000s, within the hospital.

The equipment used for restraint is made up of straps locked with a key. All members of the nursing staff have a key enabling them to unlock the system and so free the patient. The straps only impede the wrists and ankles. There are no full straitjackets within the institution.

– Nursing staff highlighted the particular nature of such a measure: "Restraint is very difficult for not only the patient to go through but also for the nurse."

– Each nurse agreed that the procedure remained violent and that an adapted drug therapy should be made available to the patient, "there cannot be one without the other". All restraint measures occur systematically in a seclusion room; the patient is therefore dressed in pyjamas.

The insufficient consideration given to the rights of people is detrimental to them, in particular in departments dealing with elderly people where an abusive recourse to physical restraint to the bed or the chair develops, sometimes in an insidious fashion.

Already, the consideration given to existing HAS recommendations should enable organisational methods and alternative treatments to be found, helping to significantly reduce this recourse.

Likewise, in care units treating some autistic patients or those with deficit pathologies, the teams sometimes reach treatment impasses with people who can display aggressive behaviour towards themselves or others; this leads to restraint measures being resorted to significantly for people who are often hospitalised voluntarily. The fact that restraint has become common-place is scarcely questioned by nursing staff teams and the doctors who are often hardly present in these units. These clinical situations justify work in connection with other health or medical-social teams to find alternatives to these approaches and to design treatment or life plans which are more respectful of the people involved.

Despite the violent nature of restraint and the fact that it so violates freedom of movement, the teams do not generally carry out a file review following the use of such measures.

B – Approximative medical monitoring

Medical monitoring is often insufficient. With regard to the risks of the pathogenic effects linked to the lying-down position, it is absolutely vital that a somatic examination is regularly carried out to look for contraindications and side effects. Yet, it has been repeatedly noted that the somatic physician was not informed about the implementation of a restraint measure making it unlikely that this vital and attentive monitoring of the person concerned was carried out.

Thus, the CGLPL became aware of an internal memo in an institution which specified that "restraint must be an exception and reduced to emergency situations, it must be validated in three days by a physician".

**REPORT FROM A CGLPL VISIT
CARRIED OUT IN A MENTAL HEALTH INSTITUTION**

Patients are prescribed isolation periods with or without restraint, systematically, at precise timeslots during the day, to which procedures are often added "if needed"; in addition, patients are systematically restrained in their beds during the whole or part of the night. The inspectors were told that the physician was not informed about these isolation and restraint procedures in the hour following the decision – contrary to what the procedure stipulates – but by the daily report which was emailed to him/her at the end of the day. Furthermore, prescriptions were carried out with a period of validity of one month – so more than the 24 hours stipulated in the procedure – and were renewable during review meetings without the physician necessarily seeing the patient concerned.

Finally, the CGLPL denounces any use of handcuffs in care centres and in particular their use, even as an exception, by prison staff for the purpose of controlling a patient during a crisis situation, particularly within a hospital facility, which constitutes mistreatment.

**REPORT FROM A CGLPL VISIT
TO THE TOULOUSE UHSA (2013)**

Since the UHSA opened, it has been indicated that handcuffs had been used during interventions in the accommodation and care areas; this is not the norm and only relates to the control of a detained patient in "crisis" or a patient who is highly agitated, which must be carried out in a seclusion room at the request of a physician.

C – Particularly secure transport conditions

Restraint is also quite commonly used when transferring persons hospitalised without their consent in order to "secure the conditions of transportation by the hospital teams". The use of restraint methods adapted to the stretcher can enable the patient to be held for the duration of their transportation by ambulance. The patient will therefore be strapped (with a safety belt) and the nurse will evaluate the need to use restraint methods fixing the wrists and ankles. In most cases the physician will validate this use *a posteriori*.

Restraints are also used when transferring a patient from a hospital to a UMD for example and this will be irrespective of the treatment the patient is receiving and their clinical state.

**REPORT FROM A CGLPL VISIT TO THE EYGURANDE
UNIT FOR DIFFICULT PATIENTS (2013) REGARDING
THE TRANSFER OF A PATIENT FROM HIS ORIGINAL
HOSPITAL**

This patient had left his original hospital at 5:20am after having had breakfast. He had travelled in a semi-reclined position, with restraints, in an ambulance, accompanied by two nurses and two drivers [...]. He had been allowed two stops to smoke a cigarette and to go to the toilet. The journey lasted seven and a half hours.

The use of restraint methods is, sometimes, systematic with regard to detained persons. Sometimes, the physician, who is not always there to examine the person, decides, after a phone exchange with the nursing staff providing the transport from the prison to the hospital, to use premedication so that the patient is "sedated"; the patient is held by an abdominal safety belt and his/her four limbs are attached to the stretcher (maximum level of restraint) in order to stop him/her from trying to escape.

Section 2

The violation of fundamental rights, the common theme of these disparities

Beyond even the fact that physical constraint is a restriction of freedom of movement, the conditions in which these measures are implemented are often themselves violations of the fundamental rights of the patients. The CGLPL noted that the perception of these violations by the people who carry them out is not equal, often impaired by the fact that these situations have become common-place, despite them placing the patients in an especially undignified situation.

I – Right to medical treatment and care

One of the rights that the hospital should have to guarantee is hospitalised people's right to medical treatment and care. Yet, people in crisis situations do not always receive adequate monitoring or a medical examination when they are placed in isolation or restrained. However, this examination should be carried out immediately in order to eliminate any contraindications to the measure.

In practice, the protocols are far from properly respected. It appears, through analysing different files, that:

- the prescription is almost always anticipated with a "prescription if needed" which, in addition, is not always confirmed as soon as possible by a new prescription following a medical examination of the patient concerned;

CGLPL VISIT CARRIED OUT IN 2015: TWO ISOLATION SITUATIONS NOTED

– prescription "if needed" dated 7 July; placed in CIT¹ on 9 July at 1pm; information according to which the patient was seen by a psychiatrist the next day at 6pm so 29 hours after being placed in the CIT. There are only two medical consultations during the first five days in the CIT according to the medical file.

1. CIT: therapeutic seclusion room.

– put in a CIT with restraint for 53 hours which included a Sunday, no evidence of a physician or monitoring by nursing staff between 7am and 1pm that Sunday.

– psychiatric medical monitoring is not carried out in particular on Sundays and bank holidays, or when the measure is extended. Furthermore, the measure is not, in most cases, traced when therapeutic isolation is carried out sequentially. Thus, during a visit to an institution, a psychiatrist declared, even though the protocol required at least two visits per day, "we are vigilant with a new patient and see them every day but when the isolation period lasts for a while we are not as involved and we count on the nursing staff to let us know if there is a problem";

– even though isolation and restraint can have extremely serious consequences for the health of the patient, especially when the contraindications are not carefully eliminated, the somatic physician is not informed about this measure. The CGLPL recently became aware of a patient with a fractured ankle being placed in isolation with restraint. It took 24 hours for the diagnosis to be made;

– monitoring patients in seclusion rooms, which by regulation is the nursing staff's responsibility¹, does not appear systematic in some time slots, during the day or night, and the various parameters provided for in the protocol are not always recorded in the sheet designed for this use, however, it is not possible to state that this is due to this measure being lifted, a flaw in monitoring or the traceability of the acts carried out;

1. Article R.4311-6 of the Public Health Code specifies that in the field of mental health, [...] the nurse carries out the following treatments and actions: [...] 3° Monitoring patients in seclusion rooms [...].

– most often, surveillance is carried out once an hour, which is grossly inadequate for a patient who is not doing well and calls the name 'intensive care chamber', which is sometimes used, into question (see Chapter 1, Section 1);

– in some treatment units housing patients suffering from deficit and chronic pathologies, the people are not examined by a physician for several weeks even though they are isolated or restrained for days, perhaps weeks or even months. Whether the measure has a therapeutic effect or not, the absence of medical monitoring and consideration of the patient's progress testify to the ignorance of the right to attentive and balanced treatment;

– the implementation of these measures, given the absence of searching for alternative strategies and the lack of consideration given to the way in which the patients perceive their care, prevent any therapeutic alliance which is vital to the quality of care and its effectiveness;

– most of the time, resorting to these measures means that the patients are deprived of all therapeutic activity, in particular structured consultations with the nurses enabling "the dialogue to be renewed and the patients to put how they're feeling into words..."

REPORT FROM A CGLPL VISIT CARRIED OUT IN 2016

In one unit, ten patients were locked in their rooms including two patients in seclusion rooms and eight patients in locked rooms. Some of them were there for 23 or 24 hours each day depending on the case with restraint for all or some of this time, for months, without consideration for adults' daily physiological needs for physical activities.

Nursing staff visited each room every hour but this is not sufficient to talk about any sort of therapeutic approach and there was naturally a significant gap between the perception of the nursing staff, who spent a significant amount of their time making rounds of the rooms given the number of confined patients, and the perception of the patients who saw a nurse quickly pop in for a few minutes every hour to check he/she was doing well or to give him/her something from the cupboard or to accompany him/her to the toilet for example.

II – Right to safety

Often the location of the seclusion room(s) is very close to the nursing staff's office which is naturally to facilitate their intervention and regular monitoring of the person placed there. Sometimes, however, the architecture of the department means that the room is completely isolated at one end of the unit, which naturally has an effect on the nurses' workload as well as on the reality of monitoring the patient.

The placement of a patient in isolation, like placing a patient in restraints, is not without adverse side effects and either way does not protect the patient from other health problems.

Yet, sometimes the rooms concerned either have no call buttons, or have call buttons which do not work, or the patients cannot reach the button from their bed if they are restrained so are unable to use them. Even though a number of seclusion rooms have a call system, it is very unlikely that it is accessible for a patient who is restrained even though, in one institution, the CGLPL saw a call button integrated into the bed to guarantee this access permanently.

Thus confined patients have no method to call the nursing staff other than banging on the door or shouting, sometimes in vain – "we do not necessarily hear them", as one nurse summed up.

Some restrained patients have no choice but to wait for the nurse to pass by, sometimes only every two hours, or even less frequently at night, to get a drink or to ask for the toilet, or, more seriously, to report feeling unwell or an urgent issue.

In one institution it was even noted that the patients could be confined to their rooms upstairs even though the nursing staff remained on the ground floor for most of the time; thus, although monitoring rounds were regularly carried out, the patients were completely isolated.

REPORT FROM A CGLPL VISIT CARRIED OUT IN 2016

A man was in an individual room with a locked cupboard which he did not have the key to; the patient lay in his bed with a watch on his wrist, confined to his room for several months, he was allowed to leave between 6:30pm and 7:30pm for dinner in the dining room; he was restrained in bed between 9am and 10am, between 1pm and 3pm and between 8pm and 7am, i.e. 14 hours out of 24. This patient said "I would really like to leave the department once in a while; my sister took me out for a day about a year ago and I would really like us to do it again", this led to the health managers agreeing as they seem to see it as a possibility; "they [the nursing staff] come in the morning at 8:30am, at midday for lunch, at 3pm to release me, at 4pm for a snack and in the evening I leave for dinner" but he accepts, following a comment from one of the nurses, to "recognise" that the nurses go into the room at least six times and not just four times a day. "Is it the 12th or the 13th?" he asked, leading to a response from the nurse indicating that it is the 14th. A nurse mentions the patient's great anxiety in front of him, the latter states "No, I'm not anxious"; "the doctor came into my room a year ago".

The CGLPL specifically requests that any person who is put in isolation or restrained must always have access to a call system which must be responded to straight away.

Furthermore, even though, as a general rule, the protocol requires systematic information in real time for the institution's fire-security services, it has been noted that it is not always transmitted. Here again, there could be serious damage if there is a fire in a unit, for example.

In order to reduce temporal disorientation, the people need to be able to consult a clock, if possible with hands, yet the lack of clocks has often been noted in the seclusion rooms visited.

III – Right to privacy

The CGLPL has noted the development of seclusion room surveillance using cameras; the images can be received in the nursing staff's office. In some cases, depending on their workload, rather than going to see the isolated patient, the nurses will settle for checking his/her state remotely on the video screens. Furthermore, the camera's field of vision often covers the whole room: the bed but also the toilets, removing all of the patient's privacy as he/she can be "watched" during his/her most intimate acts. The CGLPL finds this video-surveillance regrettable even though there have been rare situations in which the cameras are deactivated when the patient showers or is being treated.

The same goes for the hatches in the doors of these chambers which offer not only a view of the chamber but also the bathroom to the staff, to other patients or even to visitors who pass by the doors.

In addition, the CGLPL has noted that the images sent to the nursing staff's office, which often has windows, can sometimes be seen from the communal areas; thus, patients, visitors or any other person (technicians for example), can see what is happening in the seclusion room.

Finally, the CGLPL was able to see rooms equipped with microphones and thermal imaging cameras in addition to video-surveillance enabling the patient's actions to be observed and listened to from the nursing station, even at night. These surveillance methods violate the patients' dignity; in addition, they should not replace a regular and frequent presence for the patients placed in seclusion rooms.

In some units, the rooms are adjacent to the nurses' office without enough attention being given to sound-proofing the premises. Thus the person placed in the seclusion room can always be heard by the nurses, including when he/she has a visitor (in the rare cases where this placement does not forbid all visits). Vice versa, the person can hear everything which is said in the nurses' office, and know, if the nursing staff are not careful, information concerning other patients being treated in the department.

The CGLPL pointed out that, in some institutions, to help ensure the isolation and restraint of patients, as well as for isolated patients' mealtimes and when they go to wash, the nursing staff sometimes call in security officers. This practice goes against the ethical rules of the staff concerned and jeopardises the patients' privacy.

IV – Right to receive visitors

In the majority of cases, being placed in physical restraints is coupled with a prescription forbidding visitors; the patients are therefore deprived of contact with their loved ones for the period during which they are subjected to these measures. This ban thus concerns the trusted person when he/she has been designated, which does not enable him/her to play their role with regard to the patient concerned.

Sometimes it is indicated to the CGLPL that "the patients placed in isolation can have the right to visits if their mental state is stable"; this is perplexing as why would such a restricting measure, depriving the patient of their liberty, be continued for patients whose state is stable?

In addition, there are times when patients receive visitors in rooms which are not only under video-surveillance but also sound surveillance, which adds a violation of the confidentiality of conversations.

There are very few institutions where the architecture of the isolation space has been thought through to enable people to receive their loved ones, when they are allowed to, in a space which is not necessarily the seclusion room, for example, making a living room available where they can also eat, sit or move about.

V – Right to the respect of dignity

Even though some institutions have seclusion rooms with bathrooms, there are many where the patients have to use a commode chair or a sanitary bucket, potentially under the gaze of nursing staff or video-surveillance. In some institutions, this situation can continue despite refurbishment and renovation work being carried out on the premises.

The CGLPL has also been able to note some seclusion rooms giving off a strong smell of urine, either their upkeep is unsatisfactory or sometimes, even kept in a perfect state of cleanliness, a persistent and unpleasant odour persists in these rooms. The fact that some patients are held attached to their beds without a call system can put them in a situation where they sometimes have no other option than to soil themselves; this situation which is imposed upon them is most often a very humiliating experience.

The conditions in which the patients eat their meals are not very respectful of their dignity, most often in the presence of one, perhaps even two, nurses standing in the room.

If the patient does not have a table or a chair, and a side table is not brought in during meal times, he/she eats on the bed. Some patients eat sitting on the floor, using their bed as a table.

Sometimes all they are given as cutlery is a spoon which is unsuitable for some dishes such as salad, and meat must therefore be served cut up or perhaps puréed.

During the course of its visits to psychiatric institutions, the CGLPL noted on a number of occasions that hospitalised patients had to wear pyjamas for all or some of the time and this was always imposed for patients in isolation.

The requirement for psychiatric patients to wear pyjamas perhaps originated in the medicalisation which marked any admission to a psychiatric department in order to eliminate a somatic cause as the origin of the pathology. The current methods employed to search for a somatic aetiology do not generally justify wearing pyjamas. However, the pyjamas continue to be worn in many units. Incapable of disputing this practice, the health professionals offer other explanations, as variable as the teams, including: the need to medicalise, a way to locate a patient attempting to leave without authorisation and the need to make the patient understand that he/she is ill and in hospital. Given the diversity of these responses, the CGLPL questions the real motivation behind this practice; it seems more to be an old habit which has been kept alive and for which health professionals try to find a justification, when they are not using it to sanction the "unruly" patients, as the CGLPL has sometimes noticed. In addition to the fact that this behaviour is undignified elsewhere than in a bed, it evidently leads to an unequal relationship: pyjamas vs. the white coat.

The reasons for isolation and restraint, as well as the way in which they are implemented, can finally be abusively infantilising. Indeed, it is understandable that a sick person in a period of decline, during a crisis situation or immediately following one, accepts to put themselves completely in the hands of the nursing staff and feel a certain healing in standing back and letting someone else take charge.

But, the patient is often, de facto, placed in an infantilising situation, when the indication is not appropriate, for example in chronic pathologies or when the measure is employed as a sanction.

CGLPL VISIT TO THE PSYCHIATRIC SERVICES OF THE SAINT-MAURICE HOSPITALS (2011)

The inspectors met a young patient with very severe autism whose particular situation must be mentioned. 21 years old and hospitalised since the age of 15, this patient had been placed in almost complete isolation in his room for almost one year. Any time anyone went into his room it involved four members of the nursing staff sometimes with restraints. The staff's exhaustion was only equalled by the lack of solution regarding the future for this young man. In such extreme cases, the situation of the patient must be taken into account, not only by the staff of the unit where he is held but also by the whole hospital community, in order to find an adequate solution which respects human dignity. The timetable drawn up for him is displayed in his room and mentions for each day, breakfast at 8:30am, shower at 10:30am to 11:00am (once a week he is also weighed), a medical at 11:00am, lunch at 12:30pm, a snack at 4:30pm and dinner at 7:15pm. [Very] recently, two outings per week have been added to the timetable: one, on Tuesday between 5pm and 5:30pm in a passageway which is closed to other patients for this purpose; the other, on Wednesday between 5pm and 5:30pm in the park, accompanied by four members of the nursing staff.

Every time people go into the patient's cell, for meals, to take him for a shower or to take him for his two release periods per week, there are systematically four members of the nursing staff including a minimum of two men. This suggests that male staff from other units are enlisted.

This situation is very burdensome on the staff and involves unpredictable timings for the patient. The staff says they are "worn out, without a solution; we are asking that someone else take over. We no longer have enough time for the other patients, we are disappointed in ourselves."

VI – Consideration of the physiological needs for physical mobility

A significant number of people affected by these restraint measures are subject to situations where they cannot satisfy their physiological need to move and to cultivate basic physical activity. It is therefore very frequently noted that the ANAES recommendation (see Chapter 3, Section 2) that a patient's stay in a seclusion room be broken up by short release periods during the day, is not respected.

Some institutions have thought about the architectural layout to enable the people concerned to have larger spaces to walk about within the isolation area.

REPORT FROM A CGLPL VISIT CARRIED OUT IN 2016

A woman in her fifties, in a seclusion room for the last six months; the prescription for isolation is renewed every seven days as is the prescription associated with restraint to the bed between 9am and 11am, 1pm and 3pm and 8pm and 7am i.e. 15 hours out of 24. The chamber does not have a call button. The isolation is strict, nothing is brought into the room and there is no television, radio or books or any other form of occupation in the room. Meals are eaten in the seclusion room but, for the past few weeks, the patient has been released from the room to watch television for one hour per day.

The only therapeutic activity is the participation in a group about self-image for one hour per week.

Very few isolation areas have an exterior patio enabling the patients to smoke in addition to increasing the available space. However, it is unfortunate that these spaces are always cramped and with few plants. In some units without such spaces the patients are regularly accompanied to the outdoor area which the other patients have access to. At times, this is only possible after repeated requests from the patient to the staff, especially when the patient wishes to smoke.

This lack of consideration for the need for space, for going outside and for the possibility to develop a minimum amount of physical activity, in addition to the discomfort it fosters, also increases the side effects of muscle wasting or weight gain, especially when the measures are prolonged for several months.

**REPORT FROM A CGLPL VISIT
CARRIED OUT IN 2014**

At unit X, a patient had been restrained for five days, during the CGLPL's visit. At unit Y, the patients can be placed in a restraint chair in the middle of the living room by the nurses.

At the USIP, it is systematic to use a CSI for an observation period of 48 hours for patients coming from psychiatry departments and for 96 hours for those coming from prison establishments. If the psychiatrist decided to put a patient in a CSI, the mandatory minimum length of stay was 24 hours.

VII – The right to smoke or the methods for managing tobacco

The methods for managing tobacco often appear to hardly respect the rights of people. Although the legal ban on smoking within hospital institutions is applicable, smoking is a very pervasive reality in the majority of psychiatry departments – people with mental disorders smoke much more than the general population. However, in a context where the health aspects of dependence on tobacco are hardly taken into account, it is astonishing that smoking is banned for those who, during a crisis moment in their psychiatric pathology, are subjected to isolation and restraint measures.

The situation is counter-intuitive; even though periods when mental disorders stabilise are without a doubt the best times to consider stopping smoking (something which is exceptionally suggested by the nursing staff to people who are out-patients or at the end of their hospital stay), it is the patients in most difficulty, those who are in crisis, who are most often forced to completely stop smoking. Minimal support, at best a nicotine substitute, is prescribed to them without any other form of support; potentially it is suggested that they reduce their consumption to a few cigarettes (two, three, four or six depending on the unit) which are smoked in the presence of one or two members of the nursing staff.

These cigarettes, when it is possible to smoke them, can be smoked either at fixed times, as is most often the case; at the patient's request, subject to the nursing staff being available, or sometimes each time the nursing staff come into the room as they are able to open the window (when there is one and it can be opened). The incoherence resulting from the violation of an internal regulation makes a professional approach to this question impossible.

It is sometimes possible, in a paradoxical way yet again, to have a medical prescription stating the number of cigarettes allowed and the times as if they were a type of medicine.

Thus, tobacco represents a significant challenge to the carer-patient relationship, in particular as a power issue. This challenge materialises around the rigidity imposed on these patients, an arbitrary logic, especially since boredom and inactivity, which foster smoking, are particularly hard to bear during these imposed withdrawal periods.

EXTRACTS FROM VARIOUS CGLPL VISIT REPORTS

- Cigarettes are given one by one to patients confined to seclusion rooms who smoke while remaining restrained to the bed, with one hand detached, or at the window or are taken to the smoking room depending on their state: "we do not add fuel to the fire for a cigarette".
- If the patient is in isolation then they can no longer smoke.
- Smoking is banned within the unit. It is however allowed in the fenced courtyard. Nicotine replacements can be offered to patients who ask for them. For patients in seclusion rooms, [...] they are accompanied outside to smoke or are provided with a nicotine replacement (patch) if their state of high agitation requires it.

VIII– The opportunity for activities

As a general rule, patients who are isolated are not involved in activities, whether they are therapeutic or occupational, at least during the strict isolation period. This rule is sometimes very rigid: thus in one unit "the physician stated that no reading material, music or personal objects can be taken into the seclusion room".

**REPORT FROM A CGLPL VISIT
TO THE JURY HOSPITAL (2012)**

- The room is occupied by a patient who is restrained at five points. The room has a television bought

by the family and a hi-fi system integrated into a piece of furniture made by one of the patient's relatives. According to information collected, "as soon as the restraints are taken off, a nurse must stay with him at all times, due to the risk of self-harm and ingesting foreign bodies".

Sometimes seclusion rooms are equipped with a sound system controlled from the nursing station.

In exceptional circumstances, the chamber is equipped with a television potentially protected by plexiglas. There was even one case where the television was supplied by the family as reported in the text box above.

Boredom and a lack of anything to do are sometimes very difficult to bear for the patients concerned.

The decision to alleviate the measure, which often involves a phase of sequential isolation, is naturally seen as very positive by the patient concerned and most often allows him/her to eat with the other patients, to be able to watch a television programme during certain time slots and to take part in some occupational activities on offer in the hospital unit or perhaps in organised therapeutic activities.

IX – Intervention from the ethics committee

Institutions' ethics committees are sometimes referred these isolation and restraint subjects, but to date, few have proposed firm positions for the institution, such as, for example, abolishing resorting to restraint within the institution.

Some have taken up the question of access conditions to tobacco for isolated patients or an aspect related to their freedom to move about.

Even though some are still discussing these issues, surprisingly, many of them have not been referred to at all or are still not dealing with the conditions in which the patients are restrained within their very institution.

Section 3

Patients' experiences

The feelings expressed by patients who have put in seclusion rooms or restrained are clearly not the same depending on the duration, quality of support from the nursing staff – frequent visits and consultations – material conditions and the circumstances of their confinement. The interpretation they have of the decision which was made with respect to them permeates their perception but the feeling of incomprehension or even punishment prevails. The patients who are restrained often explain that they feel hatred towards the people who restrained them, "it is moral rape" – one of them confided. This feeling of being treated like an animal – coming back to the qualifier "it is inhuman" – feeds a desire for revenge. The perception of the power struggle with the nursing staff, who are looking for compliance with the treatment, is aggravated when the patient is physically restrained. According to statements collected from those who have experienced restraints, the powerlessness – genuine given that the patients cannot simply relieve a tickle on their cheeks, or blow their noses, for example – contributes to a feeling of sorrow. The humiliation is abject, and objective, when, unable to call for someone, since restraint stops the patient from being able to use a call button, or have access to toilets, the patients end up soiling themselves.

In this solitude, anger and anguish increase as does the feeling of incomprehension, followed by resentment.

In his medical thesis¹, Raphaël Carré related patients' experiences. Amongst them, a woman: "It should still be a sanction. You must be sanctioned for what you've done. Afterwards, it's certain that generally nothing can be done about it – it's the sickness that requires it or it's the drugs that require it. And you don't get told off systematically for things that aren't your fault.

1. Thesis for the State diploma of doctor of medicine "Contention physique : revue de la littérature et étude qualitative du vécu des patients".

When you're a bit maniac in general and especially when you're strapped up, you're forever treated like a dog as if it was your fault. It's true that we're a nuisance; it's true that we can be dangerous and it's true that we're insulting. They really should realise that we're sick above all – they no longer treat us as patients, they truly treat us like deranged people. Confinement, it's the same thing, it's an unbelievable sanction. They shout at you. They shout at you all the time, like you're a prisoner. It's degrading, completely degrading. An injustice. It's not at all in proportion with what you've done. No one has the right to treat us like that. They could do it in way which allows the person their dignity and does not degrade them. It is already pretty hard-going to be strapped down and on top of that they verbally put you down. That's the feeling, of having no possible recourse, at all levels, both physical and psychological. They bind you.

The patients say they get the impression that the nursing staff "enjoy" strapping them up. Resentment often sets in; in these conditions, it is difficult to imagine that the therapeutic alliance is not broken or can take hold.

A testimony published in a professional journal sums up what the patients encountered were able to voice¹:

"It was long, too long, hell! I was put there because I'd drunk alcohol during an outing. I wasn't bad, just a bit cheerful. They made me take a breath alcohol test. Once the alert was out, ten people chased me... I was hit; I yelled and asked to lodge a complaint... When we got to the seclusion room, I was stripped... Stark naked. I still dream about it now... or rather have nightmares about it. We're here at the hospital to be treated, not to be punished. We're human, there must be other solutions. Since then I've asked myself questions and it's like a sudden chill comes over me. All this brutality... and then why did they strip me? I felt profoundly humiliated.

1. *Revue Santé mentale* n° 139, June 2009.

What's more, they restrained me, hands and feet tied! Bared in front of everyone, that's no way to behave... This idea of "having to think", it's not like you can do anything else – no writing, chats or listening to music... It was like being an animal, very physically painful, even when I talk about it now. A torture, especially because of the very tight restraints – I'm still suffering after-effects of them... I can confirm that my relationship with the nursing staff got worse... If I told this experience to anyone who hasn't ever been through it, they wouldn't believe me... there should therefore be an internal regulation to tell us about the rules applied in the seclusion rooms. I'm sure of one thing, when there is great suffering, isolation is not enough. Ideally we would be able to talk, at the right time, to teams trained to listen to people who are suffering. It's clear that isolation make us better! Worse, it's not therapeutic."

The experience of physical restraint justifies the threats that patients say they feel – in particular from the use of the seclusion room – if they do not appear sufficiently "docile" to the nursing staff. One of them explained to the inspectors, "I'm really careful in that respect otherwise it's to isolation!". Some confirm they take medication in order to avoid being restrained.

This feedback does not highlight the difference between the patient's perception, in principle undergoing a crisis when he/she is restrained, and the real behaviour of the nursing staff. But it is important to take into consideration the way in which the patient perceives the humiliation, beyond the objective reality of the situation. In this regard, professionals insist on the importance of going back over, in consultation with the patient, the circumstances of the use of ultimate restraints and how she/he felt about it.

The patients encountered are not necessarily in denial about the need for isolation when they are agitated, especially as reassurance, but they claim that the result could be obtained by a constant presence or some people evoke friendship and understanding as the answer.

The CGLPL regularly receives letters from patients relating their feeling of being devalued when they are physically restrained.

These testimonies, as well as those collected during consultations, highlight the traumatising effect being restrained has for patients, as well as the negative memory which they keep of it (coupled with the potential memory of violence they were subjected to previously); these effects can only undermine treatment and are an obstacle to developing a therapeutic alliance and perhaps to accessing treatment during a subsequent crisis episode.



Chapter 3

Professionals' lack of interest – an obstacle to the recommended development in practices

The need to protect mentally ill patients placed in isolation or restrained is identified in the western countries where resorting to restraint is accepted; in the majority of them, these practices are regulated by law.

This was not the case in France until 2016. However, the hospital community has not seen the interest of examining ethical and procedural issues which the national legal measures have neither precisely nor strictly regulated.

Section 1

The legal and regulatory framework is evolving in France and in some comparable countries

I – There are few countries which have brought the supervision of restraint practices to the highest regulatory level

The situation in Iceland is distinctive as restraint and isolation are excluded from psychiatric practices; this position must be assessed in light of the fact that it has the highest rate of nursing staff in Europe: one nurse per patient.

A – Belgium

There are no legal texts specific to isolation and restraint practices in psychiatric environments. The preservation of fundamental rights within the context of mental health treatment therefore stems from the combination of more general texts including:

- the Belgian Constitution which specifies that i) the freedom of the individual is guaranteed, ii) everyone has the right to the respect of his/her private and family life, iii) everyone has the right to lead a life in keeping with human dignity;

- the Penal Code which punishes "...anyone who does not go to help or get help for a person in serious danger, whether he/she has noticed this person's situation him/herself, or whether this situation has been described by people requesting his/her help. In order to be an offence, the person who does not help must have been able to intervene without serious danger to him/herself or to others..."

- the Act of 26 June 1990 related to the protection of people with mental health disorders does not include provisions regarding the treatment of patients;

- the Act of 22 August 2002 related to the rights of the patient which concerns all treatments including psychiatric treatments, specifies that the patient's consent must be obtained before he/she is restrained.

Measures preventing physical harm, including restraint and the isolation procedure, are part of the nursing procedures authorised by law. In Wallonia and Brussels, the regional directives do not require a medical prescription before restraint is used unlike the Flemish directive. In Brussels, it is mandatory to keep a record and to draw up a code of good practice (Weckx circular dated 24 October 1990). In Wallonia, the restrictive measure shall be recorded in a register (Wallonia public service circular dated 26 October 2009). This circular specifies that isolation is an exceptional measure in circumstances where the health or safety of the patient, or someone else's safety, is in danger.

Finally in the Flemish community, measures depriving the patient of his/her liberty can only be taken with agreement from the attending physician.

B – Germany

In Germany, any psychiatric treatment carried out without the patient's consent is regulated by the Act on guardianship (*Betreuungsrecht*) applicable in all the federal states. Debates had been ongoing for around a decade in Germany and headed towards a desire to deal with hospital admissions without the patient's consent and treatments without the patient's consent in two separate Acts. In 2011, the Federal Constitutional Court delivered two decisions on the treatment without consent of patients who have been arrested, which have had a major impact on psychiatric practices. According to these decisions, the Acts regulating treatment without consent were unconstitutional. The Court required that drug therapies which are not consented to only be administered to people who are completely unable to give their consent, as a last resort, after a Court decision based on the opinion of an independent expert. The other courts expanded this idea, initially intended for patients who have been arrested, to all patients and all treatments which are not consented to. Consequently, treatments could no longer be carried out without consent unless in an extreme emergency. In 2013 new Acts responded to the requirements of the Federal Constitutional Court. It was only very recently that a new Act took into account technical coercive measures such as isolation and restraint.

C – The Netherlands

The 1994 Act relative to psychiatric admissions without consent, *Bijzondere Opnemingen Psychiatrische Ziekenhuizen* (BOPZ), authorises certain types of treatment without consent under very strict conditions. In emergencies, isolation and mechanical restraint can only be used for a maximum of seven days.

These treatments must be reported to the health inspectorate. In cases where the measures would need to be continued for more than seven days, they must be incorporated within a treatment plan which must be approved by a psychiatrist who is not involved in the treatment. The patient can pursue legal proceedings against the physician who prescribed the treatment and also against the expert.

D – United Kingdom

Hospitalisation without consent is determined by the Mental Health Act of 1983. A regularly updated guide, the Code of Practice, gives anyone, whether they are a health professional, administrative officer or patient, the opportunity to get a clear understanding of the principles of the Mental Health Act.

The Mental Health Act does not deal with isolation and restraint measures, instead the recommendations guiding these practices are found in Chapter 26 of the Code of Practice which deals with the safe, therapeutic responses to disturbed behaviour. The chapter begins with the need to have a plan to reduce practices which restrict liberty. The other recommendations are quite similar to those developed in the good practice guides. It is noted that the need to have a record of the use of isolation and mechanical restraint has not been addressed.

E – Quebec

Article 118.1 of the Act respecting health services and social services (LSSSS), focuses especially on the question of the exceptional use of restraint, isolation and chemical substances as control measures:

"Force, isolation, mechanical means or chemicals may not be used to place a person under control in an installation maintained by an institution except to prevent the person from inflicting harm upon himself or others. The use of such means must be minimal and resorted to only exceptionally, and must take the person's physical and mental state into account.

Any measure referred to in the first paragraph applied in respect of a person must be noted in detail in the person's record. In particular, a description of the means used, the time during which they were used and a description of the behaviour which gave rise to the application or continued application of the measure must be recorded.

Every institution must adopt a procedure for the application of such measures that is consistent with ministerial guidelines, make the procedure known to the users of the institution and evaluate the application of such measures annually."

In 2002, the Minister of Health published recommendations in order to better supervise these practices. These recommendations take the form of six principles:

- chemical substances, restraint and isolation shall only be used as control measures in terms of security measures in a context of imminent risk.

- chemical substances, restraint and isolation must only be considered as control measures as a last resort.

- when using chemical substances, restraint or isolation as control measures, the least restrictive measure for the patient must be used.

- applying control measures should be carried out with respect, dignity and safety, by ensuring the comfort of the patient, and should be subject to attentive supervision.

- the use of chemical substances, restraint and isolation as control measures must, in every institution, be demarcated by procedures and checked to ensure that protocols are respected.

- the use of chemical substances, restraint and isolation as control measures must be subject to an evaluation and monitoring by each institution's board of directors.

The recourse measures are described in an organisation for defending mental health rights' brochure:

"Do you want to embark on a rights defence procedure after having been subjected to a control measure? You can:

1. Ask for your disagreement regarding the control measure to be recorded in your file.
2. Contact the regional group for the promotion and protection of mental health rights which can:
 - Inform you about your rights.
 - Support you in exercising your rights.
 - Help you to lodge an appeal.
3. For a first level complaint, you can make a complaint either in writing or verbally to the Service Quality and Complaints Commissioner for the institution in question. For a second level complaint, if you are not satisfied with the Service Quality and Complaints Commissioner's responses or conclusions, you can contact the Québec Ombudsman".

II – The evolution in measures adopted by France is not entirely satisfactory with regard to the respect of human rights

Even though the use of seclusion rooms or restraint is the most radical means of depriving someone of their liberty, these acts and their consequences have not been encompassed by any legislative or regulatory framework for a long time.

A – The "Esquirol" Act

Since 1838¹, the government has shown much concern for the treatment conditions of the mentally ill, expressing the desire to protect the latter's care and society. The Act provides for the material treatment conditions: "each *département* is required to have a public institution specifically intended to receive and care for mentally ill patients" (Article 1) "placed under the surveillance of the public authority" (Article 3).

1. Act no. 7443 dealing with the mentally ill dated 30 June 1838.

People sectioned in these institutions can submit a complaint to one of the authorities responsible for inspecting the institutions: the prefect (...), the presiding judge, the public prosecutor, the justice of the peace and the mayor of the municipality must visit private institutions at least every quarter and public institutions at least every six months.

Finally, the Act of 1838 emphasises the specificity of the patient and the quality of care which must be given to him/her: "In all municipalities with hospices or hospitals, the mentally ill may only be placed in these hospices or hospitals. In areas where there are no hospices or hospitals, the mayors will have to provide housing for these patients, either in a hostelry or a facility rented for this use. The mentally ill can, under no circumstances, be dealt with alongside the convicted, nor can they be imprisoned" (Article 24).

First and foremost, the Act is concerned with preventing arbitrary placements: it requires that the following be checked: the person's identity, the reality of the illness and the need for treatment as well as, if the patient is being committed by a third party, the identity of the third party. All of this information needs to be noted in a record. The legal authority is notified of the placement. The need for hospitalisation must be certified by a medical certificate and the person must be "released as soon as the institution's physicians declare (...) that the illness has been cured". The person should even be released as soon as their release is requested by a relative in situations involving voluntary placement (this has since become psychiatric treatment at the request of a third party).

The Act was not always convincing as shown by the opinion of Albert Londres¹: "The Act of 1838, by declaring the psychiatrist infallible and all-powerful, enables arbitrary internments and makes it easier for those trying to get someone interned arbitrarily.

1. *Chez les fous*, Albert Londres, 1925, éditions Arléa.

[...] Under the Act of 1838, two thirds of mental health patients are not actually mentally ill. As they are inoffensive, they become prisoners with unlimited sentences.

The concern to maintain public order only comes into the second section which deals with placements of individuals, whose mental state would jeopardise public order or people's safety, ordered by the public authority. Even though the public authority has the possibility to put any person presenting this state of health in a mental institution, these placements must be justified and their extension medically justified at regular intervals.

In all cases, placement in a mental institution is a deprivation of liberty which justifies placing the person under the supervision of the legal authority, as provided for by law: the legal authority can be called upon at any time, by "anyone interned or held" or by one of their relatives or the people who asked for the placement, to request release (Article 29).

The protection of the goods of the person interned is also provided for: "At the request of the parents, spouse or administrative committee or incited as a matter of course by the public prosecutor, the civil court of the place of residence will be able to, in accordance with Article 497 of the Civil Code, nominate, in the council chamber, a temporary administrator for the goods of any person not prohibited interned in a mental institution. This nomination will only take place after the family council has deliberated and based on the public prosecutor's conclusions. It will not be subject to an appeal."

Even though it also intends to ensure that people are protected against abusive internments and presupposes that mental patients "handed" to institutions will be treated there, the Act of 1838 does not deal at all with the treatment methods they will be subjected to, or the content and quality of care provided or the respect of their rights by the institution. Once inside the institution, practitioners and nursing staff are masters in the "kingdom" of psychiatric institutions.

B – The change of 1990

Act no.90-527 of 27 June 1990, relative to the rights and protection of people hospitalised due to mental disorders and their conditions of hospitalisation, did not amend the balance between the protection of the mentally ill and protection of public order. It gives anyone suffering from mental disorders the opportunity to be voluntarily hospitalised, specifying that these people “have the same rights linked to the exercise of individual freedom as those who are recognised as patients hospitalised for another reason”. At the same time, it provides that:

”when a person suffering from mental disorders is hospitalised without his/her consent (...) restrictions to the exercise of his/her individual freedoms must be limited to those required by his/her state of health and the implementation of his/her treatment. In all circumstances, the dignity of the person hospitalised must be respected and his/her reinsertion sought after. He/she must be informed when being admitted, and afterwards, at his/her request, about his/her legal situation and rights. This Act emphasises safeguarding against abusive internments by increasing and differentiating between the medical opinions at the basis of and validating the confinement. In parallel, it requires that the release from hospital of patients recognised as criminally irresponsible be subject to two consistent medical opinions which attest that the patient is not dangerous. Finally, it accepts that the social reinsertion, rehabilitation and cure of people who are hospitalised without their consent, involve adjusting their treatment conditions by means of trial releases, potentially within infrastructures and departments not involving full time hospitalisation. With regard to the nature of care, the Act indicates that "any therapeutic protocol practised in psychiatry can only be implemented with the strict respect of the ethical rules applicable.

But it does not provide for any way of checking that this is actually the case. In particular, it makes no comment about the issue of the use of seclusion rooms or restraints.

The Council of Europe's recommendations, and in particular recommendation no.2004/10 dated 22 September 2004, called for a revision of French legislation.

RECOMMENDATION NO.2004/10 OF THE COUNCIL OF EUROPE

The Council of Europe's recommendation no.2004/10 defines the rights of people suffering from mental disorders. It is made up of 38 articles, most notably the following:

Article 6 – Information: persons treated or placed in relation to mental disorder should be individually informed of their rights as patients and have access to a competent person or body, independent of the mental health service, that can, if necessary, assist them to understand and exercise such rights;

Article 8 – Least restriction: persons with mental disorder should have the right to be cared for in the least restrictive environment available and with the least restrictive or intrusive treatment available, taking into account their health needs and the need to protect the safety of others;

Article 12 – General principles of treatment for mental disorder: care provided by adequately qualified staff and based on an appropriate individually prescribed treatment plan prepared in consultation with the person concerned and his or her opinion should be taken into account, the plan should be regularly reviewed; this treatment may only be provided to a person with mental disorder with his or her consent; if he or she does not have the capacity to consent, with the authorisation of a representative, authority, person or body provided for by law; when because of an emergency situation the appropriate consent or authorisation cannot be obtained, any treatment for mental disorder that is medically necessary to avoid serious harm to the health of the individual concerned or to protect the safety of others may be carried out immediately;

Article 17 –Criteria for involuntary placement: the person has a mental disorder, the person's condition represents a significant risk of serious harm to his or her health or to other persons, the placement includes a therapeutic purpose, no less restrictive means of providing appropriate care is available;

Article 19 – Involuntary treatment: this should address specific clinical signs and symptoms, should be proportionate to the person's state of health, should form part of a written treatment plan and should aim to enable the use of treatment acceptable to the person as soon as possible; **Article 20** – the decision to subject a person to involuntary placement should only be taken by a court or another competent body, based on an examination by a qualified physician;

Article 25 – Reviews and appeals: persons subject to involuntary placement can exercise the right to appeal against a decision, to have the lawfulness of the measure reviewed by a court at reasonable intervals and to be heard in person or through a personal advocate or representative, with the option of having a lawyer, the court should deliver its decision promptly with the possibility to appeal.

C – The reform of 5 July 2011

Given the events which led to its adoption, it might have been expected that the Act of 5 July 2011 would deal with the question of isolation and restraint. Indeed, it approves the possibility of hospitalising a person without their consent but recognises that the procedure is a blatant violation of the patient's personal liberty. As such it establishes the systematic control of the legal authority, the guarantor of the Constitution of Personal Liberty, regarding the decision to hospitalise someone without their consent. Even though the decisions to place someone in hospital made automatically or at the request of a third party could, previously, be presented to the judge, they were only done so on the patient's or a relative's initiative. Placement was *a priori* justified, in principle and duration, and even if this duration was not determined. Now, the decision to hospitalise a patient without their consent is systematically presented to a judge supervising releases for due scrutiny of the principle and duration as well as the legality.

But this change in perspective is not the reflection of a vast conceptual movement within the medical profession or a change in the way society views mental health patients. On the contrary, this Act was included in the parliamentary agenda following an injunction by the Constitutional Council (which had been referred to by a private individual regarding a priority constitutionality matter). This therefore was on the initiative of an individual, admittedly supported by the Groupe information asile association, and against the backdrop of European recommendations and in a context of change in the case law in this regard.

And even though the Act of 2011, amended in 2013, focuses in great detail on the conditions for giving treatment without consent, as part of in-patient or out-patient care, it does not give a position regarding the nature of these treatments and does not prohibit any of them. Until the intercession of the Act of 26 January 2016, the use of seclusion rooms and restraints came under, in accordance with the general understanding in France, treatment logs and, as a consequence, only fell under ethical and deontological controls with the control or assessment of the effectiveness of these measures falling under another field.

Even though the implementation of isolation and restraint is not regulated, it is however guided, or should be, by the respect of patients' rights. Amongst these is the right to dignity, expressly guaranteed by Article L.1110-2 of the Public Health Code¹, with no exceptions, whatever the legal status of the patient's admission.

With regard to people who are voluntarily hospitalised, Article L.3211-2 of the Public Health Code emphasises that: "People subject to psychiatric care for mental disorders who consent to said treatment are considered to be in voluntary psychiatric care.

1. Article L.1110-2 of the Public Health Code: "The ill individual has the right to have his/her dignity respected."

He/she has the same rights linked to exercising personal liberties as those recognised as ill being treated for any other reason.” Amongst these rights is the freedom to move around inside the institution; freedom which should not be called into question by being placed in isolation or restraints. These practices should therefore be excluded for people who are being treated with their consent, however, this is not always the case today.

D – The conventional context and the recent change in French law

Guidelines and recommendations have been given by national and international bodies, but they are not binding.

The United Nations (UN) adopted in a plenary meeting on 17 December 1991, resolution 46/119 “The protection of persons with mental illness and the improvement of mental health care”. Amongst the principles adopted in this meeting, principle 11 relates to consent to treatment; Article 11 states that: “physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. [...] A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff [...].”

The Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, considered, in 2013, it vital to completely ban all coercive and imposed measures, in particular resorting to restraint methods and isolation for people suffering from a psychological or intellectual handicap, in all facilities where people are deprived of their liberty, including psychiatric institutions and social care centres.

The World Health Organisation recommends “refraining from resorting to isolation and restraint”.

The Committee of Ministers of the Council of Europe decreed the principle of least restriction¹: “persons with mental disorder should have the right to be cared for in the least restrictive environment available and with the least restrictive or intrusive treatment available, taking into account their health needs and the need to protect the safety of others.” However, the position of the CPT (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment) is very reserved:

“The CPT has come across various methods of controlling agitated and/or violent patients, which may be used separately or in combination: shadowing (when a staff member is constantly at the side of a patient and intervenes in his/her activities when necessary), manual control, mechanical restraints such as straps, straitjackets or enclosed beds, chemical restraint (medicating a patient against his/her will for the purpose of controlling behaviour) and seclusion (involuntary placement of a patient alone in a locked room). As a general rule, the method chosen in respect of a particular patient should be the most proportionate (among those available) to the situation encountered; for example, automatic resort to mechanical or chemical restraint is not called for in cases when a brief period of manual control combined with the use of psychological means of calming the person down would suffice. (...) As regards seclusion, this particular measure is not necessarily a proper alternative to the use of mechanical, chemical or other means of restraint.

1. Article 8 of the Recommendation No.Rec(2004)10 of the Committee of Ministers to the Member States relative to the protection of the human rights and dignity of persons with mental disorder (adopted by the Committee of Ministers on 22 September 2004).

Placing a patient in seclusion may produce a calming effect in the short term, but is also known to cause disorientation and anxiety, at least for certain patients. In other words, placement in a seclusion room without appropriate, accompanying safeguards may have an adverse result. The tendency observed in several psychiatric hospitals to routinely forgo resort to other means of restraint in favour of seclusion is of concern to the CPT."

On the other hand, administrative case law considers that "the physical restraint of patients which involves them being kept confined to their beds with their limbs attached by straps is only used, owing to the violation of the patient's dignity, as a last resort, after the nursing staff has first used speech, adequate doses of pharmacopoeia and placed the patient in a seclusion room"¹.

Until the Act of 26 January 2016 was promulgated, the French government, despite several reports on the subject, including one by Denys Robiliard, MP, submitted to the National Assembly in December 2013, had not regulated recourse to isolation and restraint; however, these measures seriously infringe on fundamental rights, first and foremost the right to the freedom to come and go. No legal framework limited these measures; thus the hospitalisation of a patient without his/her consent took the violation of people's freedom of movement to its physical maximum: once the right to restriction was established on the basis of a medical certificate, it was without legal limit. Until very recently, this lack of framework allowed for any interpretations, any practices and any submission by the nursing teams the moment a medical prescription was being applied, or for any initiatives the moment they were to be validated by a physician who would prescribe them *a posteriori*.

1. Administrative Court of Appeal (CAA) of Paris, request no.13PA02584, 6 March 2014.

Only the ANAES reference document, in no way binding, listed 23 criteria regarding the practices of using seclusion rooms (see Chapter 3, Section 2).

Article 72 of the Act dated 26 January 2016 finally gives a legal framework to isolation and restraint practices; thus the new Article L.3222-5-1 of the Public Health Code stipulates: "Isolation and restraint are practices to be used as a last resort. They can only be resorted to in order to prevent immediate or imminent danger to the patient or someone else on the decision of a psychiatrist for a limited amount of time. Their use must be subject to strict surveillance entrusted to health professionals designated by the institution for this purpose. A record must be kept in each authorised psychiatric health institution appointed by the Director General of the Regional Health Service (ARS) to ensure psychiatric treatment without consent in application of I of Article L.3222-1. For each isolation or constraint measure, this record mentions the name of the psychiatrist who decided to take this measure, the date and time, its duration and the name of the health professionals who monitored the patient during this time. The record, which can be digital, must be presented, when requested, to the *Départementale* Commission for Psychiatric Care, the *Contrôleur général des lieux de privation de liberté* or its delegates and to members of Parliament. The institution establishes a report each year giving a full account of the practices for admitting patients to seclusion rooms and for restraint, the defined policy for limiting recourse to these practices and evaluation of their use. This report is forwarded to the Users' Commission (CDU) for an opinion under Article L.1112-3 and to the Supervisory Board under Article L.6143-1".

By defining the circumstances in which isolation or restraint can be resorted to and by obliging institutions to register the measures taken in a record, these provisions are likely to initiate a discussion amongst the nursing teams about the fact that these practices have become common-place and, as a result, to limit their use (see Chapter 4, Section 2).

By qualifying isolation and restraint measures as a "decision" rather than a "prescription"¹, these provisions change their medical and legal status considerably: they no longer benefit from the assumed "caring" nature which is associated with a medical prescription. Hitherto, administrative case law has only had the opportunity to rule on the issue of the compensation due to a patient given the conditions of being confined in a seclusion room. Now, it is reasonable to think that any decision to use isolation or restraint will be grounds for an appeal before an administrative judge.

Section 2

The ANAES recommendations are a common reference document but are in no way binding.

The French National Health Accreditation and Evaluation Agency (ANAES²) published, in 1998, as part of its policy to encourage the evaluation of professional practices, a guide for carrying out a clinical audit applied to the use of seclusion rooms in psychiatry³. By definition, therefore, the criteria that the ANAES highlighted, which were only indications, have no prescriptive impact.

The quality criteria proposed were developed from the experience of professionals rounded off by an analysis of the literature and experts' recommendations. The guide's introductory remarks explain that the approach was not so much linked to the "actual principle of therapeutic action through isolation" as to the risks associated with this practice with, "in the fore, the risk of violating individual freedoms, the risk of fire and the risks linked to self-harm or harm to others".

1. This choice was made after a number of debates within the scientific community and within Parliament.

2. The ANAES was replaced by the National Authority for Health (HAS) in 2005.

3. This guide, "*Évaluation des pratiques professionnelles dans les établissements de santé – L'audit clinique appliqué à l'utilisation des chambres d'isolement en psychiatrie – juin 1998*", is available to download from the HAS website at the following address: www.has-sante.fr/portail/upload/docs/application/pdf/CHISOL.pdf

From the outset, this guide points out that, "despite the progress made in psychiatric care, isolation for a therapeutic purpose is both frequently practised and subject to continued uncertainty with regard to the relevance and the appropriateness of procedures carried out in this field". It is also noted within the guide that the definition of the quality of this practice could not incorporate "effectiveness and efficiency due to the lack of studies on the evaluation of the result and its cost. As a result, and because there are still questions surrounding the legitimacy of this practice, a policy of on-going reduction in the use of isolation must be carried out in order to reduce inappropriate isolations as much as possible."

Work to create this guide was carried out in a context where it was already becoming clear that it was a non-recognised practice which was not taught in doctors' or nurses' training courses, and a practice implemented in very different ways in terms of frequency and duration of isolation depending on the institution.

The ANAES's work was carried out following the publication of a Ministerial circular¹ dated 19 July 1993.

**MINISTERIAL CIRCULAR
DATED 19 JULY 1993 RELATING TO THE RECEPTION
AND CONDITIONS OF
PATIENT STAYS FOR THOSE HOSPITALISED FOR
MENTAL DISORDER**

The circular from the Minister of Health dated 19 July 1993 recalls the principles laid out by the legislator: thus "the right to freely come and go inside the institution cannot be disputed for people who have given their consent to receive psychiatric treatment.

1. Ministerial circular no.48 DGS/SP3/ dated 19 July 1993 regarding a reminder of the principles related to the reception and conditions of patient stays for those hospitalised for mental disorder.

These people cannot, under any circumstances, be put in departments which are locked, or *a fortiori* in locked rooms". "However, in an emergency, it is possible to isolate a patient for reasons related to his/her safety for several hours until, either the emergency situation is resolved, or the patient's hospitalisation status is changed to enforced hospitalisation". It also recalled that for patients whose hospitalisation is enforced: "the restrictions which can be made with regard to the exercise of their individual liberties must be limited to those required by their state of health and the implementation of their treatment" and that in "all circumstances, the dignity of the person hospitalised must be respected and his/her reinsertion sought after". "Even though placing a patient within a locked unit can be essential in some circumstances, these circumstances must be precisely assessed and the duration of the confinement limited to what is medically justified. Thus keeping a patient in a locked unit must respond to an indication made by a physician and not simply be convenient for the department; it must be able to be questioned at any time as the patient's state of health changes..."

It continues by also calling for "treatment team staff and management staff to be extremely vigilant with regard to respecting safety regulations and the monitoring required by such patients".

Article L.3211-3 of the Public Health Code incorporates these provisions: "when a person suffering from mental disorder is subject to psychiatric treatment [without his/her consent] or is transported for the purpose of this treatment, restrictions to the exercise of his/her individual freedom must be adapted, necessary and in proportion to his/her mental state and the implementation of the required treatment.

In all circumstances, the dignity of the person must be respected and his/her reinsertion sought after".

By laying out its assessment criteria, the ANAES should enable teams to evaluate the quality of their professional practices with regard to isolation, to quantify the divergences between the reality and the reference document and thus to look for potential improvements.

This reference document contains 23 criteria which state good practice points to check in this quality approach and which relate to the prescription, monitoring and treatment scheduling (with respect to indications and contraindications), the search for risk factors likely to endanger people's safety, questioning the conformity with the hospitalisation status, informing the patient and the consultation intended to record his/her experience of the seclusion room (see the text box below).

In particular, it is specified that a medical prescription must be drawn up in the hour following the start of the isolation period at the latest and that this prescription, as well as each potential renewal, is valid for a maximum of 24 hours; the requirement for a medical examination in the two hours following the start of the isolation period and two medical examinations per day is noted.

**ANAES REFERENCE DOCUMENT DRAWN UP IN 1998
FOR THE PURPOSE OF THE CLINICAL
AUDIT OF THE USE OF
SECLUSION ROOMS IN PSYCHIATRY**

1. The data concerning the identity and the dates and times of the start and end of the patient's isolation in a seclusion room are recorded.
2. If the patient comes from another treatment unit, as part of what is known as a seclusion room "loan", the patient's file and all the necessary information are provided, in due course.

- 3.** Seclusion rooms are used on medical prescription, immediately or incidentally. In the latter case, the prescription must be drawn up in the hour following the start of the isolation period.
- 4.** The initial isolation period and each potential renewal are prescribed for a maximum of 24 hours.
- 5.** The disorder presented by the patient corresponds to the indications for the use of a seclusion room and it is not for a non-therapeutic use.
- 6.** Somatic contraindications of using seclusion rooms are identified and noted.
- 7.** The potential risk factors (suicide, self-harm, confusion, metabolic risks, medicinal risks and those linked to thermoregulation) are identified and a special monitoring and prevention programme is implemented.
- 8.** The conformity of the use of the seclusion room to the hospitalisation status of the patient is examined during the prescription.
- 9.** The seclusion room and the patient are checked to ensure there are no dangerous objects. If there are, appropriate measures are taken.
- 10.** The patient's isolation and release with regard to the seclusion room are reported to the fire-safety services in real time.
- 11.** The seclusion room is used under adequate safety conditions for the patient and the nursing staff team.
- 12.** The patient receives the necessary explanations regarding the reasons, purpose and methods of the implementation of the isolation. The need to inform the patient's family/friends is examined.
- 13.** If physical restraint is resorted to, this is carried out using suitable equipment, in complete safety for the patient, taking into account his/her comfort.
- 14.** A medical examination is guaranteed within the two hours following the start of the isolation period.
- 15.** The patient benefits from at least two medical examinations per day.
- 16.** The planned monitoring schedule of the mental state is respected.

17. The planned monitoring schedule of the somatic state is respected.
18. The prescribed biological monitoring is carried out.
19. The patient's stay in the seclusion room is broken up by short breaks during the day.
20. A consultation focusing on the patient's experience in the seclusion room is carried out at the end of the procedure.
21. The hygiene of the patient is ensured during the entirety of this treatment phase.
22. The cleanliness of the room is checked at least twice a day.
23. The documents (monitoring sheet and accident report for example) are incorporated into the patient's file.

Criteria 5 and 6 specify the indications and contraindications of being confined in a seclusion room and are reiterated in the text box below.

**ANAES REFERENCE DOCUMENT
CRITERIA RELATED TO THE INDICATIONS OF
CONFINEMENT IN A SECLUSION ROOM
AND NON-SOMATIC CONTRAINDICATIONS**

Criteria 5: The disorder presented by the patient corresponds to the indications for the use of a seclusion room and it is not for a non-therapeutic use.

Indications

1. Prevention of the patient's imminent self-harm or violence towards others when other control methods are neither effective nor appropriate.
2. Prevention of a risk of therapeutic rupture when the state of health requires treatment.
3. Isolation incorporated into a therapeutic programme.
4. Isolation to reduce stimulation.
5. Use at the patient's request.

Contraindications

6. Use of a seclusion room as a punishment.
7. The clinical condition of the patient does not call for isolation.
8. Use only to reduce the nursing staff's anxiety or for their convenience.
9. Use only linked to staff shortages.

The CGLPL noted that a number of institutions referred to this guide to formalise, in subsequent years, a protocol specific to the use of seclusion rooms, with various different titles but in essence picking up aspects of the ANAES reference document.

There are fewer institutions which have actually carried out audits in order to assess whether their practice conforms to the protocol stipulated in the institution and if need be, to enter into a responsible approach to deal with it.

The HAS has not published any specific recommendations with regard to restraint in psychiatry. The only reference document, sometimes cited by the people encountered, results from work carried out by the ANAES to "limit the risks of physical restraint for older people" published in October 2000¹. The findings include the significance of risks and the relative ineffectiveness of restraint for people over 65 years old in order, in particular, to avoid falls and the benefit of developing, as an alternative, a medical, psychological and nursing evaluation of the patient and the difficulties encountered with implementing occupational activities and an adapted environment. Even though it is explicitly stated that this document does not broach "the use of restraint, associated or not with isolation, during the treatment of mental disorders which are not linked to age", the understanding of criteria, identified within it, in order to minimise the dangers of restraint and above all to reduce the prevalence of restraints and develop alternatives, would be absolutely necessary by teams working in psycho-geriatrics.

1. This document is available on the HAS website at the following address: www.has-sante.fr/portail/upload/docs/application/pdf/contention.pdf

Furthermore, the HAS, as part of its multi-year work programme relating to psychiatry and mental health, especially the theme "rights and safety in psychiatry", has planned to create, on the one hand, a guide "*Mieux prévenir et prendre en charge les moments de violence dans l'évolution clinique des patients adultes lors des hospitalisations en services de psychiatrie*" (Better prevention and management of violent incidents in the clinical development of adult patients hospitalised in psychiatric services) and on the other hand, memos on the "*Place de la contention et de la chambre d'isolement en psychiatrie*" (Place of restraint and seclusion rooms in psychiatry). These documents should be published in 2016.

The HAS has retained, within the certification procedure for health institutions, the requirement to systematically check, within the heading "patient's rights and role", criterion 10e "Respect of individual liberties and management of measures which restrict freedom". However, the analysis focuses more an evaluation of the processes implemented in the institution than the reality of practices, which leads some institutions to have an approach which is more formal than genuinely concerned with respecting individual liberties; the CGLPL has thus noted that some institutions were working on their certification process but were keeping almost all the patients, even voluntary patients, in closed units and were frequently resorting to isolation and restraint measures.

Finally, the contributions from two consensus conferences¹ dealing with a wide variety of themes, including the psychiatric field, must be mentioned. These conferences drew up a technical and ethical policy framework for professionals concerned including, therefore, psychiatric staff.

1. A consensus conference is a method enabling a summary of knowledge on a precise theme to be created, with the aim of drawing up recommendations. It highlights the points of agreement and disagreement and enables a consensus to emerge, in order to facilitate competent authorities' decision-making.

The first, organised in December 2002 by the Société Francophone de Médecine d'Urgence (French-speaking Emergency Medicine Society), dealt with "agitation in emergency situations" and was based on the ANAES's methodological regulations.

**CONSENSUS CONFERENCE
ON AGITATION IN EMERGENCY SITUATIONS,
SOCIÉTÉ FRANCOPHONE DE MÉDECINE D'URGENCE,
DECEMBER 2002**

The texts¹ produced by the consensus conference on "agitation in emergency situations", point out that in 62% of these situations psychiatric pathologies are involved; they insist on the need to maintain an interpersonal approach with the patient at all times. "Verbal contact should help to establish trust with the aim of making a therapeutic alliance" and on the need to have an adequate number of professionals present. Regarding restraint, the texts specify that "there is no proof that it is therapeutically effective in the literature whereas serious side effects are known" and that "resorting to it is only justified after other treatment methods have failed". "Physical restraint must be a temporary measure and used as an exception. Alone it does not constitute a therapeutic measure. It must therefore always be linked to drug-induced sedation". With regard to monitoring, it is specified that "a restrained patient is an at-risk patient and dependant on those close by. He/she should, in no circumstances, be isolated and/or locked up" and monitoring his/her vital signs must be carried out at least every half an hour. A protocol for restraining an agitated and violent patient is appended to this document; it adopts a definition and the aims of restraint as well as its contraindications and the methods for carrying it out in practice, as well as a restraint monitoring and traceability document.

1. This document is available on the "Urgences-online" website at the following address: www.urgences-serveur.fr/Agitation-en-urgence,459.html

It is remarkable that the majority of institutions do not have a protocol for the use of restraint. One institution drew up a protocol on the only point related to monitoring by nurses but in this particular case, the protocol was produced by the care management team and is endorsed by the different health managers but not endorsed by a physician when it specifies that medical monitoring must be carried out at least every 24 hours.

The subject of the second, held in November 2004, was "Freedom to come and go in health and medico-social institutions, and care and safety requirements¹".

**CONSENSUS CONFERENCE
ON THE FREEDOM TO COME AND GO,
SOCIÉTÉ FRANCOPHONE DE MÉDECINE
D'URGENCE, NOVEMBER 2004**

The jury at the "Freedom to come and go in health and medico-social institutions, and care and safety requirements" consensus conference in particular indicated that "the restriction of the freedom to come and go in health and medico-social institutions is rarely the result of indifference or a lack of humanity on the part of the nursing staff" and that "unjustified confinement and lack of resources and staff training are the main causes of abuse in institutions".

1. The documents related to this consensus conference are available on the HAS website at the following address:

www.has-sante.fr/portail/jcms/c_272394/fr/liberte-d-aller-et-venir-dans-les-etablissements-sanitaires-et-medico-sociaux-et-obligation-de-soins-et-de-securite

It affirms that "the freedom to come and go should not [...] be restricted in a systematic way according to a risk which is simply assumed [...], the balance between the risks really incurred by the freedom to come and go, in and outside an institution and the risks of aggravating the state of health and consequences of confinement, must be evaluated and discussed with the family and close circle and regularly re-evaluated.

It also points out that any confinement decision must be subject to a precise protocol, be justified, be documented in the patient's file and written in a record which the supervisory authorities can consult.

It recommends that human intervention be always favoured [...] over automatically locking the premises or resorting to confinement methods, or even restraints. For the jury, restraint is a violation of the inalienable freedom to come and go" and "systematic restraint must be forbidden". The jury also insists on teamwork and staff training and that these facilities should be open to families and volunteers.

Institutions have not tended to refer to the results of this consensus conference to work more particularly on the subject of the freedom to come and go within the institution or in different units.

Even though the results of these collective works are in no way binding, they nevertheless provide material which the institutions could use to establish rules of conduct for nursing staff teams. Some have done so.

However, the method can entail, in itself, two unfortunate consequences.

The respect of the protocol can become an end in itself to the detriment of the relevance and effectiveness of the treatment, with the aim to avoid becoming liable; it could lead some staff, despite themselves or unwittingly, to sometimes mistreat patients and not respect them and their dignity.

Furthermore, the CGLPL has also noticed that the desire to have a protocol, in particular with a view to obtaining a certification, led to harmful approaches distorting the aim of quality. Some institutions have largely modified the criteria of their protocol in relation to those of the ANAES, so that it is in line with the local, deplorable realities which hardly respect patients, and so is applicable in their units. In other words, when someone has a fever, some people choose to change the thermometer's calibration rather than addressing the problem of the organisation of care. Thus, in one such institution, a first isolation period was scheduled for a minimum of 24 hours whilst another had not retained the need for a visit twice a day or the contraindication specified in the reference document regarding the use of restraint/isolation as a sanction; others mention that prescriptions for long term isolation periods "cannot exceed 7 days".

Section 3

The lack of collective discussion between professionals has prevented standards from being developed, which has left broad scope for medical arbitrariness in a context of security

I – The effects of a security context

The fact that, under the influence of their disorders, mentally ill patients can sometimes commit acts which are harmful to others is not a recent observation. Article 64 of the 1810 Criminal Code concluded that these actions were attributable to the disorders: "There is neither a crime nor infraction, when the accused was in a state of insanity at the time or when he/she was obliged to do it by a force which he/she was unable to resist. However, the Act of 1838 drew a different conclusion, ruling that the mentally ill had to be locked up.

It took more than a century after the promulgation of this Act to admit that the mentally ill could live and be treated outside of hospital. The fact remains that the mentally ill do not benefit from the associations attached to other illness: suffering, fragility and need for care and compassion. Instead they evoke incomprehension, unpredictability, violence and finally, danger.

However, as Guy Lefrance, rapporteur of the Act of 5 July 2011¹ showed, "the reality is that people suffering from psychiatric disorders in the general population (excluding the homeless) are 12 times more likely to be victims of physical assault, 130 times more likely to be victims of theft and their life expectancy is 25 years lower than their fellow citizens. The "Samenta" survey (mental health and addiction in homeless people), carried out under Anne Laporte (Paris Samusocial Observatory) and Pierre Chauvin (Inserm) in 2009 in Paris and its inner suburbs, showed that schizophrenics living in the street are victims of violence more often than they are responsible for violence. The report "Violence et santé mentale" (Mental health and violence) (Anne Lovell, 2005), requested by the government following the murder of two nurses in Pau in 2004, showed that only 2.7% of acts of violence are committed by people suffering from psychiatric disorders. Finally, according to the Archives of general psychiatry, the most significant psychiatric journal in the world, the risk of people with psychiatric disorders committing acts of violent is low. These acts are generally carried out with associated factors (social and biographical factors: violent past, delinquency, physical abuse, substance abuse or unemployment, for example) found in the general population. And even though patients suffering from psychiatric pathologies often take substances (alcohol and drugs), they are above all "selfmedicating", taking substances as a way to reduce suffering or calm the voices, for example, and rarely for pleasure".

1. Report no. 3189 made on behalf of the Social Affairs Commission at first reading presented to the Presidency of the National Assembly on 2 March 2011.

The importance of public security which permeates the political debate has found, in the assumed dangerousness of the mentally ill, material to reassure the citizen regarding a fear which was more fuelled by the media's treatment of dramatic, but exceptional, events than by the statistical reality of this danger. Indeed, it was not until the HAS's public hearing in March 2011 that precise details regarding psychiatric dangerousness came to the fore in a "study of risk factors of violence towards others in people with schizophrenic disorders and mood disorders"¹. Without anyone having previously measured, nor even tried to measure, the reality of the danger which people suffering from mental disorders represent, the law was more concerned with locking them up and forcing them to be treated than with protecting them from the consequences of their distress for themselves.

Social fears were thus found in successive parliamentary reports which amalgamate, through presumption, dangerousness with mental disorders: in July 2005, in the introduction to the report, "*Santé, justice et dangerosité*" (Health, Justice and Dangerousness), Jean François Burgelin wrote that the Commission had to recognise that mental illness and dangerousness do not overlap: "Society, largely influenced by the media discourse, therefore wrongly associates the madness of especially serious criminal acts with the madness of their perpetrators, and society has an image of these perpetrators based on partial and questionable presuppositions"². The same applied for the Goujon Gauthier report to the Senate on "*Mesures de sûreté concernant les personnes dangereuses*" (Security measures regarding dangerous persons) in June 2006 and Jean-Pierre Garraud's report in November 2006 on "*Réponses à la dangerosité*" (Responses to dangerousness).

1. HAS, *Dangerosité psychiatrique : étude des facteurs de risque de violences hétéro-agressives chez les personnes ayant des troubles schizophréniques ou des troubles de l'humeur*, March 2011.

2. *Santé, justice et dangerosité : pour une meilleure prévention de la récidive*, Report from the Health-Justice Commission, April 2005.

This confusion reached its peak in the Act of 25 February 2008 regarding secure detention when, during Parliamentary debates, detention was envisaged for dangerous people "because they are particularly dangerous, characterised by a very high probability of recidivism because they suffer from a serious personality disorder", by stressing, for some MPs, that detention can be carried out in a psychiatric hospital as compulsory treatment, before Socio-Medico-Legal Centres were finally selected by the legislator¹.

Social fears are also found in bills confusing the health goal with internal security: the Act for preventing delinquency was drawn up during 2006; at the instigation of the Minister of the Interior, it envisages reforming the 1990 Health Act regulating treatment without consent into the Internal Security Act: control trial discharges from psychiatric hospitals, change the length of the diagnosis, give the prefect the ability to arrange a psychiatric expert opinion at any time, set up a national register of compulsory treatment and exclude the hospitalisation of someone with disorders jeopardising people's safety at the request of a third party from Article 20. Faced with pressure from professionals, these Articles were removed at the last minute from the final Act promulgated on 5 March 2007.

The speech given by Nicolas Sarkozy, then President of the Republic, during his visit to the Erasme d'Antony hospital (Hauts-de-Seine) on 2 December 2008, a few weeks after a Grenoble student was murdered by someone suffering from a mental disorder, fuelled this logic by declaring:

"I have been shocked by this business. Here is a person – a future murderer – who had already committed several very serious assaults both inside and outside of hospital!

1. The Contrôleur général des lieux de privation de liberté recommended that the measure for secure detention be removed in its opinion related to secure detention published in the Official Gazette dated 5 November 2015 and available on the CGLPL's website: www.cglpl.fr/2015/avis-relatif-a-la-retention-de-surete/

Here is a person who is eminently dangerous who however benefits from two trial discharges per week! And I hear it said that nothing indicated that this person was capable of taking action again, that nothing had been done to heighten his surveillance? (...) these various events must lead us all to question the deficiencies which they can reveal in the system organising and implementing treatment. Above all when these dramas cannot be considered inevitable. (...) My duty, our duty, is to also protect society and our fellow countrymen. The hope, sometimes faint, to return to a normal life, cannot take precedence in all circumstances over the protection of our fellow citizens. Potentially dangerous patients must be subject to special surveillance in order to stop any possible commitment to action".

Such statements cast doubt on the probability of returning to "normal life" – a vague concept if ever there was one – and implicitly spread the certainty of an identical nature of the dangerousness of mental illness. Largely spread by the media and coupled with the moral authority of the status of those who spread this message, the message reinforces an already deeply rooted representation.

The endless repetition of a right to security and, in the background, the nefarious media coverage of dramatic events end up disrupting even the mental health professionals' perception. The patient's dangerousness is no longer the result of the pathology that needs treating but of the grounds for the treatment which determines the way the patient is regarded.

The fight against "dangerousness" becomes a purpose which infuses into the practices, and in particular legitimises resorting to isolation and restraint to limit the risks (or effects) of violence. Fostering this slide, the erosion of clinical knowledge which as a consequence means that the clinical state of patients is overlooked. Situations and patients are qualified as dangerous even when they are not without, however, looking to prevent transition to action in any other way than confinement.

At worst, the development of dangerous behaviour in patients is fostered by inappropriate attitudes.

The – real – risk is of making these procedures common-place and of seeing them implemented in contexts where the notion of dangerousness is more muddled. There is a threat that convenience will insidiously replace the concern to protect against difficulties which are not all dangerous, even though danger, when verified, can be avoided by "de-escalating" treatment approaches.

Dangerousness is never permanent nor definitive; it is fundamentally contextual, linked to the clinical symptoms of the illness. It requires an in-depth examination of the patient. Even though specific measures can be considered, at a time when there appears to be a risk of transitioning to a violent action, they should not represent the treatment method for people reputed to be dangerous.

The placement of a patient in a seclusion room or under restraint, which is an extreme violation of the freedom to move about, will only be considered legal when this placement is "necessary and proportionate"¹. Failing this, these measures, in addition to being inhuman and degrading treatment in terms of their methods, can be seen as arbitrary confinement. Even though the qualification "prescription" associated with these methods until the promulgation of the Act of 26 January 2016 enabled a veil to be drawn over their legal consequences, the move to the qualification "decision" should considerably change this approach.

1. Article L.3211-3 of the Public Health Code: "When a patient with a mental disorder is subject to psychiatric treatment in application of the provisions set out in Chapters II and III hereof or is transported for the purpose of this treatment, the restrictions to exercising his/her individual liberties must be adapted, necessary and proportional to his/her mental state and the execution of the treatment required. In all circumstances, the dignity of the person must be respected and his/her reinsertion sought after".

II – Between a medical prescription and pressure from nursing staff teams

According to institutional contacts spoken to by the CGLPL, the practice of resorting to isolation and restraint is increasing. As neither national nor regional data have been collected it is impossible to objectify this increase. However, testimonies from former nurses and physicians in the profession are consistent; some even remember a time when institutions did not have seclusion rooms which now seems to have become inconceivable.

Whilst it may be difficult to precisely determine the causes of this growing trend, some observations do nevertheless deserve attention.

Apart from isolations provided for by internal regulations or protocols (see Chapter 2, Section 1), generally, nursing staff use isolation in any situation which cannot be managed by speech or contact. Yet, they say that they have noticed an increase in patient violence. Whether this perception conforms to reality or not, the difficulty teams face in dealing with this violence is increasing, as if what used to be perceived as manageable is no longer viewed as such. Two relatively recent changes could explain this. Firstly, due to the discontinuation of specific training for psychiatric nurses, teams are progressively losing specialised nursing staff who had chosen from the outset to work with mentally ill patients and whose training meant that they were more familiar with the clinical specificities of the disorders presented by their patients. The gradual departure of these "reliable and experienced nurses" has, furthermore, deprived the teams of the ability to pass on the experience and know-how of nursing staff who are calmer facing violence and crises, more comfortable with relating to an agitated patient and practised in anticipating and defusing difficult situations. Secondly, the decrease in the number of staff, in addition to having led to burnout in some cases, has created a feeling of weakness in the face of violence, weakness which the patients feel is stressful.

Thus, the teams, who feel they do not have enough nurses, justify avoiding violence by using preventative isolation. Even though it is indisputable that the size of the team is a difficulty, the CGLPL saw institutions where in one unit, two caregivers – including at least one nurse – were fully responsible for the care of up to 17 patients; when one of the caregivers was in consultation, the other stayed alone with the patients present. The unit did not have a seclusion room. Admittedly, in cases of heightened agitation, the patients could be left in their rooms with the furniture removed but this never lasted for more than a few hours.

Sometimes the nursing staff complain that they have been abandoned by the doctors and that they are not properly supported by the latter. The CGLPL has too often noticed that the medical presence was low, sometimes only anecdotal in some units: physicians passing through one or two half-days per week, in the worst cases just for a summary meeting. Some patients explain that they only see the psychiatrist once per month and for some chronic patients even less frequently than that.

According to some physicians, many colleagues have given up getting involved in crisis situations; in practice the management of crises is left to the nursing staff team, implicitly facilitated by "if needed" prescriptions which will, indeed, be applied if it is impossible for a physician to quickly intervene.

The fact that there were more placements in isolation at the end of the day and during weekends was pointed out; the duration of these placements is, in addition, higher than what would be necessary to manage a crisis but the physician who is supposed to come out in the hours which follow to validate or terminate them is not always available. The junior doctor for the department who is then called to confirm the placement or decide to terminate it after 24 hours, rarely makes the decision to terminate it. It is difficult to imagine a junior doctor deciding to change a prescription made by a senior doctor.

Moreover, as one of them explained, "we do not ask questions; in psychiatry everything is abnormal so the threshold for strangeness is very high".

Some staff, in particular the "collectif des 39"¹, maintain that physicians "have thrown in the towel", advancing recourse to chemical treatment over all other approaches to the illness. Some department heads have "forbidden" psychoanalysis and institutional therapy which put the nursing staff in a supportive relationship rather than a restrictive relationship with the patient. The correlation between abandoning these therapeutic schools and resorting to isolation and restraint would be worth evaluating.

Thus, a vicious cycle is formed as teams, who are insufficiently trained and insufficiently supported, put pressure on physicians to resort to isolation practices which initially relieve the teams and give them an excuse to deal with agitation and violence differently, but the management of these practices ends up weighing heavily on the way in which the unit works. These methods also foster a feeling of guilt amongst the nursing staff, of being a persecutor, some say "I feel bad when I restrain the patients". When the "agitated" patient becomes what is known as a "disruptive" patient in medical – and even institutional – jargon², punishment taints the treatment. But, finally, the patient emerging "calmed" from isolation, since he/she remains there until he/she has calmed down, everyone is convinced that it is a necessary evil for a good cause, and does not have to think up other techniques to achieve the same result.

The patients are not in a position to contest the "treatment", its principle or its duration. Even though many of them feel guilty for their illness and their difficult behaviour for those surrounding them, they submit to the medical imperium: isolation and what goes along with it: pyjamas, lack of communication and tobacco and if needed restraints.

1. The "Collectif des 39" came into being following an appeal lead by 39 professionals from various fields, after Nicolas Sarkozy's speech at Antony on 2 December 2008.

2. If considered in light of the acronym UMAP: unit for agitated or disruptive patients.

They convince themselves, or are convinced, that this measure is used for their own good and are sorry to have caused the nursing staff so much trouble. Some patients state that being placed in a seclusion room and/or restrained is inevitable, that they could not have been calmed by any other methods.

The worst part of this vicious cycle could perhaps be reached when the patient's stance goes from compliance to guilt-relieving indulgence. The CGLPL has too often met teams who say that some patients, often those with chronic illnesses, ask to be restrained or isolated, when it is not an emergency situation: "if they ask for it, it is because they know themselves that they need it". These patients indeed felt that this practice had a beneficial effect on their actual or potential agitation, but know above all that they will then be subject to greater support from the nursing team. The second benefit is that, by asking for this treatment, they send a positive signal, seen by the nursing team as reinforcing the therapeutic alliance since this approach is validated by the patient subjected to it. These patients become protagonists who are at least reassuring, or perhaps even – and this is to be lamented – gratifying for the team who implement these methods. In doing so, they invert a countertransference with the team, from negative to positive.

The inspectors have thus met a patient who asked to be restrained in order to fall asleep. The team took the time each evening to attach him, with the purpose of helping him to sleep, and took off these restraints once he was asleep. Even though this team's good intentions were not questioned or doubted, the conditions of setting up this ritual should be questioned, in particular the reasons regarding why helping the patient to give up this habit was not prioritised, given that, at the very least, it stopped him from having any autonomy when it comes to falling asleep.

More concerning is the fact that the inspectors met patients who had been put in seclusion rooms for months and who ended up convinced that they could not – or did not even have the right to – use the common areas because they found the proximity to other patients disturbing. They did not consider that the isolation which they were held in for months, was actually reinforcing this weakness and that treatment would have been, rather, to acclimatise them to the space and to support them in regaining the ability to relate to others.

Between the physicians' withdrawal and the submission of patients, the increased recourse to restraining practices is without a doubt evidence of a lack of clinical, medical and nursing work. The summary meetings, relating to complex individual situations and enabling meaning to be given to situations and a clear treatment response to be drawn up, are without a doubt equally insufficient.

III – A lack of a shared vision of the freedom of patients

Psychiatric professionals are not sufficiently taking on board the contributions of the approaches initiated by the HAS and the consensus conferences. As a result of the lack of collective approach at a relevant level, respect for the rights of patients does not have the place it should in the discussion of the conditions for implementing physical constraints.

A – The right of patients to their freedom of movement is not the subject of discussion amongst the whole psychiatric profession

The variety observed by the CGLPL with regard to treatment methods does not appear, as such, as a sign of confusion. Quite the opposite, it can testify to a diversified and constant search for performance in terms of the effectiveness and quality of care.

In a field where the optimum is not one-sided and applicable in all cases, it can also demonstrate fine-tuning of practices to people and places.

However, this diversity is also generated by a lack of collective institutionalised discussion about the need, usefulness and therefore the legitimacy of limits given to the restrictions to patients' rights to move about.

In the organisation of institutions and their units, the choice of methods for treating patients considered to be the most difficult – "agitated" or "dangerous" – has repercussions on the living conditions, and even the treatment, of other patients.

In all institutions it was observed that, when patients, considered to be unable to freely move around outside the unit, are living beside people who do not require the same degree of surveillance, the unit is in practice locked: it is impossible to leave without the help of one of the nursing staff. Physically enabling some of the patients to leave in an autonomous way is a measure which is rarely planned for (handing out a key pass or code for example). The highest restriction therefore applies to everyone. Conversely, opening up a unit leads to more serious confinement of the first type of patients, in their own rooms or in a seclusion room.

The choice of what operating system is to be adopted in a unit is not always clear nor the result of carefully thought through and discussed arbitrations with regard to the effects this choice has on violating liberties and rights. It can be simply the continuation of habits which have never been questioned, or the personal decision of the head of the unit which is imposed on everyone. In addition, the accommodation within the same unit of patients with different regimes, regarding their freedom to move around, is often down to the management of the institution, which results from the strict, even cadastral, application of sectorisation. In some hospital institutions, each unit accommodates patients from one geographic sector or sub-sector. The choice of the accommodation unit is thus based on the place of residence rather than the nature of the pathologies or the consistency of the therapeutic projects to develop in order to take into account the reality of the patients' needs.

Each time a patient who is not allowed to leave is hospitalised, in other words in practice all the time, the unit is closed for everyone, closed off by the obsession to stop any risk of a patient running away.

The violation of the right to movement is not contested but tolerated as an unfortunate, regrettable but inevitable consequence. As the patient hospitalised is a subject of care before being a subject of rights, the respect of the right to move around is not a fundamental standard around which the way the institutions and units work has been thought about and organised. It is indisputable that the reconciliation between treatment conditions and respect for the rights of patients can be complex to manage, in particular when the facilities were not designed with this in mind. Even so, the CGLPL visited institutions which took the opposite approach, organising care and the operation of the units in a way which maximised the opportunities for movement, in particular for the most problematic patients, by adapting the way they were organised.

In addition, since the conviction that isolation and restraint is a treatment is dominant, it acts as a shield against any consideration for the rights of the patients and does away with the need to consider, from the perspective of these rights, alternatives to restraint as a treatment method. The prominence of the patient as a subject, who can exercise rights, rather than a subject of care, supported, among others, by institutional therapy fizzled out. This approach has disappeared from teachings.

These concerns are just as absent from architectural discussions. The few architectural recommendations raised relate to security – access airlocks to seclusion rooms and surveillance methods – and sometimes to the level of comfort. The effect of these architectural choices is reviewed in terms of the ease of care or monitoring, and only incidentally in terms of the violation of dignity. A number of nursing staff have deplored the fact that patients in seclusion rooms can be seen by other people – and see them – through the hatch in the door, explaining that this can "excite" or disturb those on either side of the door.

Even though being seen in pyjamas, restrained or in the process of nature's call is a violation of dignity and privacy, it is seen as a collateral worry. However, the chairman of the conference of chairmen of mental health medical institution commissions expressed doubts as to the relevance of surveillance, in person or by video, of the area where the patients wash.

B – This failure deprives all abuse prevention and monitoring approaches of a common basis

The reference document of good practices drawn up by the HAS is more often than not familiar to teams. However, in addition to the fact that the latter do not always follow it (see Chapter 2, Section 1), these recommendations only apply once a decision is made and do not deal with the issue of relevance or the issue of preventative or alternative measures, or the issue of the duration of physical restraints.

Without a standard or even a guide, it is impossible for professionals to position themselves, evaluate and think about their practices. The interviews carried out by the CGLPL during its visits confirm the observation (noted by professionals who have studied the issue of physical restraint) that teams do not have a reference point to measure the extent to which these practices are used. One team will say that the isolation period was long and, as a clarification, indicate that it lasted several hours, others will say several days, or even weeks, as a standard and common measure, which does not worry them. Restraint is familiar to some, entered into a protocol which, as such, is not subject to discussion. Others, as it has been reported, are barely accustomed to this measure and reply that they have resorted to it "a few times" when the last time was some years before.

This grey area allows, with all good intentions – or in perfect obedience – ever more frequent recourse to physical restraint to develop.

Families lack criteria to determine whether the treatment given to their relatives is excessive or inappropriate. Incidentally, they are not systematically informed about the conditions regarding the use of isolation or restraint on their relative; it is difficult for them to intervene and they are rarely encouraged to do so. The CGLPL was thus referred to by a family whose relative had been placed in a seclusion room for over a year and who had been unable to get the treatment changed.

Finally, while the use of the seclusion room and restraint are radical violations of the right to movement and intrinsically for restraint, a violation of the patient's dignity and privacy, the judge supervising releases is not called upon to intervene in such measures.

The administrative judge has stated several times that the physical restraint of patients is a violation of the patient's dignity and, as a result, should only be used a last resort after the nursing staff has first used the power of speech, sufficient doses of pharmacopoeia and seclusion rooms. As a result, he has made the use of it dependant on circumstances where the patient "proves to be aggressive" or "seeks to be violent to him/herself"¹ and opens up the possibility to invoke the erroneous character of the measure if it was used in another situation. With regard to the physical conditions and the duration of the placement in a seclusion room, he recalls "the general obligation incumbent upon care facilities, and in particular those which care for patients made vulnerable by mental disorders, to respect these patients' dignity and to ensure that the methods implementing measures to place patients in seclusion rooms do not submit them to an ordeal which exceeds the level of inherent suffering of any isolation measure not freely chosen"¹.

1. Administrative Court of Appeal (CAA) of Marseille, 25 January 2007, request no. 05MA01245.

In these conditions, the medical and nursing community must be quickly encouraged to carry out a collective discussion on the benefit of these practices with regard to the violation of the rights of the patients they entail and to define the limits of them or risk the judge standing in and sanctioning what he/she considers to be excessive.

Section 4

Professional lack of interest in evaluating restraint practices is surprising given their impact in terms of human resource management

A lack of institutional evaluation of the consequences of treatment choices is surprising when the effect of restraint practices on the units' operation and, more largely, that of institutions is, it seems, far from being neutral.

I – Health authorities which are insufficiently involved in this subject

The "Psychiatry and Mental Health 2011-2015" Plan drawn up by the Ministry of Health and the Ministry of Solidarity, is currently being evaluated and fixed the objective of "giving all French people a clear understanding of the issues of an ambitious mental health policy and offering a common framework to all the stakeholders committed to combating psychiatric disorders and to developing responses, enabling life with and despite these disorders to be envisaged".

1. Administrative Court of Appeal (CAA) of Marseille, 21 May 2015, request no. 13MA03115.

The prevention of ruptures in the life pathways of people concerned, whatever their living environment, including those in very precarious situations or in prison, was identified as a major challenge from the perspective of prevention.

This plan only indirectly deals with isolation and restraint measures taken on behalf of hospitalised people, through, on the one hand, safety issues, and, on the other hand, through training.

With regard to the issue of safety (safety of patients with regard to themselves, other patients, professionals and society), the plan focuses on the fact that it is directly linked to the quality of care and good treatment. Institutions are invited, in order to manage risks, to incorporate "clinical and ethical discussions, to focus on the quality of the organisation and treatment, the quality of the way in which the institution operates and to plan for [and] institutionalise the perspective of third parties" and to incorporate the CGLPL's opinion. The paragraph concludes, "the risk management approaches, which include management of professional risks, must relate to, in connection with caregivers: [...] practices of restraint and isolation, which are always high-risk practices, and which can also reveal difficulties in anticipating crisis situations...".

In addition, the plan capitalises on the opportunity to implement continuing professional development (CPD) with its scope for evaluating professional practices, indicating that "with regard to CPD themes, professionals will be able to usefully retain the improvement of professional's abilities to manage the risks of patients undergoing treatment transitioning to self-harming or aggression towards others. The evaluation will focus in particular on the reduction in the number of workplace accidents and suicide attempts and in recourse to restraint (events which can be subject to a systematic evaluation of professional practices)".

Even though the restraint practices which are likely to violate the respect of fundamental rights are not ignored by the plan, they are therefore hardly dealt with.

The national health authorities did not consider explicitly implementing an information collection, either within each establishment or at national level, in order to assess the reality in the evolution of these practices and follow an explicit strategy to reduce how often these measures are resorted to.

As these practices are such powerful violations of fundamental rights and their therapeutic nature has not been proven, the Ministry of Health needs to state a clear policy to reduce the recourse to these practices; the policy requires the effective mobilisation of different drivers enabling professionals and teams to develop alternative approaches in their day-to-day work.

In particular, the supervision authority should not have contradictory requirements to this policy: in one institution visited, the capacity for isolation was considered insufficient and new rooms were requested to be built, something which the nursing staff had great difficulty understanding.

II – The environment and professional impact of practices are not institutionally studied

Every nurse in a psychiatric unit knows that he/she will have to manage a patient in crisis, who will be dangerous or agitated. The CGLPL notes, without having confirmed it, that the choice to isolate or restrain a patient during this phase hardly ever crops up in debates in France these days.

The visits and interviews carried out have enabled the CGLPL to ascertain that, within units, there is less unanimity regarding the duration of these measures or their application in non-emergency situations. Once again, at what point the duration is considered excessive varies greatly according to the person asked – beyond a few hours for some and beyond a few days for others; but in all cases, discomfort and discrepancies appear and divide the teams over and above this duration.

Some confide "I feel bad attaching people", "I would rather avoid it", others persuade themselves "it is for the good of the patient, it calms him/her" or defend themselves "we don't do it just for fun". For all of them, obedience to the "prescription" gets in the way of the overt expression of discomfort or disapproval but the lack of consensus can cause problems for harmony in the way in which teams work. None of the nursing staff dispute that it would be better to not resort to it but the institution does not always have a place to express these difficulties. According to one interviewee "an "isolated" team is a team who isolates".

Evidently, each institution should study the treatment factors favouring or leading to crisis situations in order to minimise the occurrence or rates of such situations. As an example, it has been indicated that patients attack nursing staff when the nurses are unavailable as this lack of availability distresses them; yet, the nursing staff, who are fearful of violence or who do not feel sufficiently strong or supported, respond to patients' aggressive behaviour by putting them in isolation. An analysis of the causes of the nurses' unavailability (not enough staff or too many administrative tasks carried out far away from the patients or inappropriately organised activities for example) would have enabled them to better respond to the patients' needs and avoided fuelling the causes of agitation.

On the contrary, and equally, the conditions enabling crisis situations to be prevented, or, when they do occur, to be managed differently should be explored and searched for. All of the people interviewed questioned the significance of a large enough medical and nursing presence, of nurses' technical skills and training, of adapted architecture, of the number and quality of the therapeutic activities and of access to the outdoors. Even though it is impossible to measure the relative significance of these factors and their exhaustiveness, the fact that this questioning has not been taken up by the institutions is at least cause for surprise.

No study at national level has dealt with the circumstances and consequences of resorting to the physical restraint of patients on the way units and institutions operate. Two approaches to discussion led at local level are worth mentioning. Their conclusions highlight the value of extending this type of study to a larger scale; the relevance of their conclusions would be validated and they would be more likely to be taken up by the profession as a whole.

In 2008, an inter-hospital audit of therapeutic isolation was organised by the Nord Pas-de-Calais Regional Federation for Mental Health Research (Fédération régionale Nord Pas-de-Calais de recherche en santé mentale)¹. 17 institutions were involved in this survey: 47 sectors were volunteers (44 sectors sent back their questionnaire, two did not and one sector indicated that they did not practice therapeutic isolation).

Following this audit, a certain number of recommendations have been enacted, including:

– **Type of room:** the possibility of a seclusion room should be systematically subject to a discussion during the design of the service care project.

– **Circumstances for using the seclusion room:** using the seclusion room should remain a treatment response for psychopathological disorders. The diagnosis, even when temporary, should be clearly laid out.

– **Risk factors:** for each risk identified a monitoring programme is put in place. However the systematic monitoring of the temperature of the seclusion room was not found in the vast majority of institutions surveyed. Each risk monitoring programme should adhere to an identified protocol.

– **Conformity to the hospitalisation method with isolation:** as soon as therapeutic isolation or even restraint is needed as part of voluntary hospitalisation, it should assume an exceptional nature and be limited as much as possible in terms of time.

1. Fédération régionale de recherche en santé mentale Nord-Pas-de-Calais, 3 rue Malpart, 59000 Lille France – www.santementale5962.com

The issue regarding the validity of changing the hospitalisation status thus arises: does the patient still have the discernment required to give informed consent for the treatment?

– **Information provided:** the patient should receive accessible and faithful information regarding the reasons, aims, and methods of his/her placement in isolation. The nursing staff team should assess the need to inform the patient's family systematically. Patients in the department may need to be informed in order to make the stressful and confusing situation less dramatic.

– **Physical restraint:** disparity in equipment is noted. In a third of situations this equipment is not adequate in terms of the patient's comfort and sometimes in terms of safety.

– **Measure punctuated with brief release periods:** brief release periods are not sufficiently established. The aim involves, above all, humanising the isolation with brief release periods (contact with other people and opportunity to smoke for example) and enables the improvement in the behavioural disorders to be evaluated.

– **Leaving the seclusion room:** the majority of cases do not involve a systematic consultation focusing on the experience of the isolation measure. Make the possibility of having a feedback consultation of the patient's experience of isolation systematic. This type of specialised consultation should be handled by a professional managing this situation."

A second audit was carried out in 2010 in order to evaluate the potential changes in practices with regard to the recommendations drawn up in 2008. The main findings were:

- a 38% decrease in the instances of resorting to therapeutic isolation, evaluated from two test weeks before the two audits;
- greater conformity of the hospitalisation status (change in the status within 12 hours) for voluntary patients put in isolation;

- the security services were more often informed when a patient was put in isolation in real time (61% rather than 56%);
- the restraint equipment used corresponded each time to safety standards and was more comfortable for the patients;
- the medical examination to confirm or overturn the placement in isolation was carried out more quickly than it had been beforehand;
- the number of patients not receiving a daily medical examination had halved. However in 2010, there were two patients who had not received a medical examination, this continued to be the situation for one of the patients for one day, for the other patient for 11 days (not consecutive). A clinical and contextual study¹ was carried out in the Sainte-Marie de Rodez hospital (Aveyron). A prospective survey regarding 60 placements in seclusion rooms had been carried out based in particular on the reference document published by ANAES in 1998. This survey's questionnaire, comprising 25 items, studied various parameters such as the cause and circumstances triggering the measure, the indication, the diagnosis, the duration, the support conducted in the seclusion room, the frequency of mental and somatic monitoring, the patient's progress and his/her relationship with the team as well as the emotional and countertransference experience of the team. The results of this study revealed that isolation on average lasted 87 hours (i.e. three days and 15 hours) with the duration varying greatly. The authors stated that these differences were caused by the state of the patient but also by many other factors including the way in which the department was organised, the type of population and the nursing staff's customs. Physical restraint had to be used in nine situations in the seclusion room (15%) for an average of six hours. The main reasons for this were psychomotor agitation and aggression towards others.

1. *Utilisation de l'isolement thérapeutique : une étude clinique et contextuelle* – Kivits P., Thémines J., Rohmer G., Unité intersectorielle fermée, CH Sainte Marie, Rodez.

The mental monitoring recommendations for patients (visit from a nurse once per hour and by a psychiatrist once per day) had been carried out. However, the somatic monitoring was problematic in 13 situations (22%) as the recommendations were not adequate and because of the difficulty in applying them to agitated or resisting patients; seven patients (12%) were suffering in addition from an organic condition which had not been stabilised.

This study gave rise to an adaptation in professional practices:

- harmonisation of the mental and somatic monitoring of patients;
- systematic consultation targeting how the patient feels after a period of isolation;
- make the weekly exchanges on the team's experience longer.

The almost general lack of involvement from the institutions' authorities in these objectives to minimise coercive measures is astonishing given that they are responsible for ethics and optimising the management of human resources.

III – Even though their cost in terms of human resources is not neutral

The implementation of practices which the teams do not adhere to fuels turnover: in some institutions, locked units, those where patients are restrained the most, are not popular amongst nursing staff who look to leave them. Thus, in one institution visited, an implicit classing of units had been established and new nursing staff recruited had to spend several years in the most closed off – the least requested – if they wanted then to join the more open units, or even, in the best situation, the sector's out-patients activities (medico-psychological centre (CMP), day hospital, part-time treatment centre, etc.).

Furthermore, the cost in terms of the work time a nurse spends on an isolated, confined and/or restrained patient is significant: the application of monitoring protocols disrupts the way the unit functions, or it should do if they are applied rigorously. The regular monitoring – once an hour as a minimum – of an isolated and/or restrained patient requires at least one nurse and sometimes two are required by the protocol. Add to this the time spent managing the file – registering recommendations in the file and now in a record, recording vital signs and observations in the monitoring sheet and monitoring medical examinations. In addition, each nurse is likely, at any time, to have to interrupt his/her work to directly intervene or to support a colleague or to respond to a patient's call. If the patient does not have a call button, he/she shouts, makes noise or knocks on the door to get someone to intervene.

Ultimately, a patient in isolation is an inconvenience not only for the teams but also for other patients.

Even though the use of isolation and restraint is the physician's responsibility in terms of the decision and the nursing staff's responsibility in terms of the implementation, the institution is not completely devoid of responsibility in terms of factors favouring recourse to these measures. It therefore has its part to play in looking to limit these measures: it is down to the institution in particular to initiate or support policies likely to favour limitation.

This lack of institutional evaluation and incapacity to ensure that the teams do not lose sight of the meaning of their tasks is all the more incomprehensible given that the nursing staff often feel uneasy practising these restraints, which has no small impact on the way in which units and institutions work.



Chapter 4

Restricting resorting to physical restraint to strictly set out circumstances

Even though it does not fall to the CGLPL to assess the therapeutic pertinence of resorting to physical restraint, it notes however that this effectiveness is not always proven – even if it sometimes has positive effects for the treatment of severe anorexia – and that health authorities have not undertaken significant research aiming to verify this.

However, it notes that these measures violate the fundamental rights of those who are subject to them, more or less seriously and to a greater or lesser extent depending on the circumstances.

As such, the following principle, presiding over all discussions regarding this issue, must be asserted: no person suffering from mental disorder should be submitted to isolation or restraint, because of their behavioural problems; however, the CGLPL cannot overlook the fact that sometimes the actions of patients in crises can be a danger to those surrounding them or to themselves. In that case, and after having looked in vain for alternative solutions, with a last resort rationale, the CGLPL admits that a physical restraint measure can be resorted to, as an exception and for a strictly limited period of time. Nevertheless the reduction in resorting to these isolation and restraint measures must be urgently sought after.

The CGLPL is therefore glad that Article 72 of the Act of 26 January 2016, codified with Article L.3222-5-1 of the Public Health Code, calls psychiatric institutions to commit to a policy aiming to limit the recourse to isolation and restraint.

But this incitement risks remaining only a pious vow if it is not supported by measures, on the one hand, to prevent problematic situations, and on the other hand, to encourage alternative practices through collective discussion amongst all of the stakeholders involved in treating patients.

Section 1

The effectiveness of prevention involves strengthening the capacities to manage outburst situations and put in place "de-escalating" strategies

I – Consider and teach other possible practices

There are institutions where a few units – or all in exceptional cases – do not have a seclusion room, some have made the choice to do without one, or to continue to do without one. Even so, in the majority of cases, their teams will use, as a last resort, the rooms available in other units, a fact which the proponents of the essential nature of isolation and restraint highlight as an argument to support their convictions.

The fact remains that, without a seclusion room, the nursing staff are called upon to implement other crisis management methods.

Relational "restraint", through the nursing staff speaking and being present, is one such method but the CGLPL has often been told that it is difficult to implement given staff shortages. However, the use of a seclusion room or restraint requires significant human resources, to carry out as well as to subsequently monitor patients.

The fact that patients may need to be isolated from others or ask to be isolated is not contested. But this isolation could be provided in less coercive conditions than confinement in a seclusion room. Architectural resources can be asked for in order to make facilities or features available in which patients can be sheltered from stimulations without however being locked up or restrained. The isolation of others, in particular in cases of agitation, can also be obtained, in the opposite way, in other available spaces and by going outside.

It is remarkable to note that units housing patients suffering from pervasive development disorders or serious deficit disorders can have radically opposed practices. Either, as happens relatively frequently, they only exceptionally resort to these measures, even though their patients are often agitated or develop behaviour which can be perceived as violent; during inspections, some of these units explained: "if we restrained these patients when they are agitated or behaving unpredictably, we would restrain them all the time". Or, on the contrary, they argue that their patient's pathologies and behaviour authorise lead to greater or even constant recourse to physical restraint.

II – Support the nursing staff teams

According to Jean-Claude Pénochet, Chairman of the Psychiatrist Union¹, "if a team is scared the physician is definitely going to prescribe restraints", he continues "restraint is an indicator of the good or bad health of psychiatry. The worse psychiatry is doing, the more restraint will be used". A representative of users (FNAPSY²) has noted, for its part, that "a mistreated team will start to mistreat".

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1. SPH: Union of Hospital Psychiatrists (syndicat des psychiatres des hôpitaux).
 2. FNAPSY: National Federation of Associations of Users of Psychiatry

The implementation of methods as an alternative to isolation and restraint means that the nursing staff teams in these units are both aware of the problem and trained. Feeling that they know about other tools is likely to lead professionals to change their analysis of agitation and violence and to enable them to deal with them, depending on the case, more calmly.

Isolation and restraint decisions are the physician's responsibility. However, in practice, as soon as they are made in an emergency and in a crisis situation, in the majority of cases the initiative comes from the nurses and the decision is then validated by a physician as soon as possible. No nurse enjoys confining patients, none of them feel very effective in professional terms when they attach patients. However, when these practices are repeated, they become common-place and the nursing community can lose perspective regarding the analysis of its implicit choices and their effects. The phenomenon will be increased if the team is stable and if external staff do not work there often enough, or in large enough numbers, or are not authorised to question these habits. As it becomes routine, the reference to patients' rights and the perception of the violation of these rights wane. In this context where these measures become common-place, not without kindness, the patients abandon their need for dignity.

During visits, the inspectors have noted an astonishing dependency on coercive practices, on the part of patients and nursing staff alike: the placement of patients in seclusion rooms or in restraints for months ended up being part of a daily exercise and, in the long run, not thought about in terms of its scale.

The role, and therefore the responsibility, of a unit's physician(s) in the regular review of a team's professional practices is vital. Even though the alternative to isolation or restraint is seen as taking a risk, it will only be pursued, or even proposed, by the team if they feel supported by the physician in the approach.

On the contrary, when the physician only rarely comes to the unit, the routine surrounding less bold or more cautious solutions, such as isolation, is established as a necessity. The diversification in teams' composition would be likely to change the way in which teams perceive themselves. Working with others watching is a valuable resource in terms of self-control and self-evaluation. In this respect, professionals asked agree about the place of relatives and users. According to the Chairman of the Conference of the Commission of Medical Institutions (CME) Chairman of Specialised Hospitals, the families of patients are an essential influence in the improvement of treatment.

For their part, the representatives of families (UNAFAM¹) and users (FNAPSY) encountered want caring partnerships to develop, locally, between them and the professionals. According to them, this practice fosters the resolution of some complex situations with the development of alternative approaches to restraint; it could also enable them to get involved in an ethical collective discussion which must be all the more rigorous given that, in the majority of cases, the patients concerned find it difficult to express their points of view.

The institution's role is no less decisive: it is up to the institution to regularly offer nursing staff the opportunity to re-evaluate their practices with their peers, to open up to other approaches and, essentially, to train themselves in order to usefully experiment with these approaches. The institution must enable, or even organise, exchanges between teams, and stimulate mobility to enable employees to act in other contexts. It must also offer staff the opportunity to refer to a clinical nurse (or any other professional) with clinical expertise on these subjects, to help to analyse a situation within a unit or department and to enable alternative treatments to be developed within this unit/department for the patient concerned.

1. UNAFAM is a recognised public interest association which receives, supports and informs families coping with a relative's psychiatric disorders.

III – Preventative measures must be studied

Decreasing the recourse to physical restraint also involves identifying the processes which lead to taking these measures, in order to avoid them or decrease their harmful effects.

It seems that institutions and teams would gain from identifying the locations and circumstances which are the sources of increased violence or agitation, and also from working with other institutions to understand what is conducive to these increases in terms of the organisation of treatment.

These circumstances are partly attributable to the rules that patients must follow, which can include anxiety-inducing measures or measures causing excessive stress such as excessive rationing of tobacco, insufficient access to the outside area and strict rules preventing patients from freely going to their rooms. These measures induce anxiety if they are unjustified, leading to the feeling that they are arbitrary, or if they are implicit – in which case the rules may be broken unintentionally. In terms of treatment methods, the lack of activities, outings in the fresh air or of nice spaces to receive visitors aggravate these difficulties.

SITUATION MENTIONED IN THE 2013 CGLPL ANNUAL REPORT

A man had just been admitted to the hospital and had gone to smoke at 9:30pm on the patio even though it was theoretically forbidden after 9:00pm. On this occasion, the exchanges between the staff and this patient had led to violence, which in turn led to the patient being placed in a seclusion room after a neuroleptic intramuscular injection.

The architectural layout of the accommodation facilities, where the patients spend the majority of their days, can lead to tensions rising when a patient can never get a break from other patients, watch television without being disturbed or listen to music in peace.

Humiliating situations, such as wearing pyjamas outside of the room or restraints, and the lack of privacy in basic activities, are sources of aggravation for those submitted to them.

In the same way, the behaviour and feelings of the nursing staff should be noted as they also foster growing anxiety or frustration in the patients, pushing them to lash out. Fear, worry, tiredness, too much work and staff shortages are always reported as risk factors for patients' outbursts, who are insufficiently or poorly managed by a too uncommon, too lax and improperly asserted therapeutic relationship. In this respect, the supervision of teams must be generalised and carried out by experienced professionals.

The factors regarding these staff difficulties must be analysed in order to minimise their occurrence.

Finally, it has often been claimed that the treatment of a patient in an emergency welcome unit without a seclusion room, when he/she arrives, enabled the crisis situation to be responded to and calmed in a place where the intention is not for the patient to stay and therefore avoids putting him/her in a restraint context.

Section 2

The qualitative and quantitative evaluation of these measures is necessary

The requirement given by the Act of 26 January 2016 to decrease the instances of resorting to physical restraint can only be welcomed. But, as observed, there is no information system currently enabling the scale of this recourse to be evaluated – not even in quantitative or local terms.

Record-keeping as provided for by this Act should enable these instances of recourse to be quantified and also, given the information recorded, "For each isolation or restraint measure, this record mentions the name of the psychiatrist who decided to take this measure, the date and time, its duration and the name of the health professionals who monitored the patient during this time", to determine some of the circumstances in which the decision was made.

The data in this record will offer each unit a self-observation tool and aspects for team discussion: indications, frequency according to the time of day or week and impact of the people making up the department's team.

The target to reduce recourse will be reached much more quickly if the units are able to evaluate the change in their own data and also compare it to the data of their peers. This supposes that a harmonised information system will be established by the national health authorities so that local data can be consolidated at regional and national levels and thus enable information to be analysed at all levels; in this respect, the CGLPL regrets that this was not taken into account by the Act of 26 January 2016.

However, the apparent contradiction between the goal of measuring, in order to decrease recourse, and that of quantification, in order to draw a conclusion regarding funding, should be noted. Indeed, the treatment of the most complicated patients, such as those who are most often subject to physical restraint, is the most costly in terms of resources. It is essential to ensure that the pricing scale methods do not lead to isolation practices being favoured financially.

This information should be communicated at each meeting of the Institution's Medical Commission (CME), this body should carry out a more thorough analysis of the information, taking into account the realities unit by unit and considering the pathology of the persons concerned.

Section 3

Recommendations for good professional practices

As we have seen, the recommendations for good professional practices are, on the whole, followed and incorporated into local protocols, which calls for two observations.

Firstly, compliance with the protocol sometimes ends up prevailing over all other evaluation aspects of the quality of the action carried out (see Chapter 3, Section 2). For example, if the protocol states that the whole unit must be locked when two members of the nursing staff enter a seclusion room, this requirement is respected even when it is not anticipated that the patient will be freed from the restraints during this visit.

Secondly, in the extreme, when the protocol which would result from the good practice recommendations cannot be implemented, another protocol is drawn up, conforming to what is possible to carry out in practice given the way the unit is currently operating: in one institution, the inspectors thus saw a protocol adapting the duration of the restraint measures to the frequency the psychiatrist visited – once per week.

Thus, "protocolisation" is sometimes accompanied by the loss of reason – confusing tool and objective of care. We cannot recommend highly enough the development of actions to disseminate the methodological guide currently being validated by the HAS ("*Mieux prévenir et prendre en charge les moments de violence dans l'évolution clinique des patients adultes lors des hospitalisations en services de psychiatrie*"), with a view to teams taking it on board. This guide is due to be published shortly, along with the tools it puts forward.

In order to avoid fostering these negative effects, the certification process must not be limited to the call for and verification of the existence of protocols, but must examine the reality of practices and introduce monitoring of the rate of recourse to isolation and restraint within each institution's Quality Account (monitoring tool of their risk management system).

Indeed, it is important to avoid a situation where an institution, with established protocols but with significant recourse to isolation and restraint, gets a better rating than an institution with no established protocol but which does not resort to these measures, as has been reported to the CGLPL.

Finally, the protocols applied should be updated each year, in particular by taking into account aspects coming from an analysis of the measures provided by the information system.

Section 4

Organise an external inspection

The collection of quantitative data on the recourse to restraint measures must also shed light on external inspections of the institution.

Some of these inspections are already provided for by the Act for institutions authorised to treat patients without their consent, including those by the legal authority which must visit the institution once per year and the one by the *Départementale* Commission for Psychiatric Treatment.

It would be useful if the legal authority, guarantor of individual liberties, was regularly made aware of the number of decisions regarding physical restraint taken in an institution, unit by unit, month by month.

The families, by means of associations present in the institutions, as well as the Commission for User Relations (CDU)¹ should equally be provided with this information.

1. In application of Article L.2223-3 of the Public Health Code, the Commission for Users is "in each health institution [...] tasked with ensuring that the rights of users are respected and contributing to improving the quality of treatment and the reception of patients and their families. This Commission facilitates these people's actions and ensures that they can, if needed, express their grievances to the heads of the institutions, receive explanations and be informed of what has been done in response to their requests.

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Chapter 5

Recommendations

Principles

- Any deprivation of liberty is a violation of fundamental rights; everything must be tried in order to calm the person in crisis down with alternative approaches to a physical restraint measure. If, as a last resort, the decision to use a seclusion room or restraint must be taken, the methods for implementing this must guarantee the greatest respect of patients' rights.

- Isolation and restraint within the patient's room must be prohibited in particular with regard to the risk of this becoming common-place and there being a lack of traceability in terms of this measure.

- The requirement to wear pyjamas and not have any personal effects in the seclusion room should not be systematic but must be clinically justified.

- An end must be put to the systematic nature of isolation practices, whether for detained people, for patients arriving at a care unit or in any other situation.

Traceability

- The record provided for by Article L.3222-5-1 of the Public Health Code must be filled in every time an isolation or restraint measure is implemented, no matter where the person concerned is being treated.

- Any decision to use isolation or restraint must be documented in the patient's file: the institution must be able to provide proof of the fact the measure was taken as a last resort.
- The information collected by the institutions must be consolidated regionally and nationally, which requires the creation of a coherent and integrated information system.

Rights

- The person concerned must be informed the moment a decision to use isolation or restraint has been made and given written material specifying their rights and the treatment and support methods brought about by this measure. This information must also be displayed in the seclusion room.
- The person must, systematically, be asked to give the name of the person to inform that the measure has been taken (trusted person or parents in the case of minors) or *to not inform* depending on the case.
- The methods for appealing against the decision to use isolation or restraint must be defined within each institution (mediator physician in the institution for example and administrative judge). They must be displayed in all the seclusion rooms and in the written outline notifying the rights given to the person. They must be communicated to the trusted person, the parents of a minor or to any relative informed at the patient's request.

Medical monitoring and decision

Form of the medical decision

- The medical decision to use an isolation or restraint measure can only be taken after an actual psychiatric medical examination of the person, taking into account, as far as possible, the opinion of the members of the nursing staff team.

- The grounds for the decision must be given in order to justify the:
 - "adapted, necessary and proportionate" nature of the measure; the information regarding the clinical state of the patient when the decision is made must be explained.
 - The decision must specify what had previously been tried in vain in order to justify that it is taken as a last resort.
 - As soon as the measure has been taken, the health professionals involved in the treatment of the patient concerned must search, as part of a multidisciplinary framework, for ways of bringing it to an end in the shortest possible time.
 - No decision regarding physical restraint can be taken in anticipation or with the indication "if needed".
 - The terms for evaluating the benefits with regard to the risks must be explicit in the patient's file.

Monitoring and surveillance

- The duration of the physical restraint measure must be as short as possible and should not exceed the crisis situation; in any case, prolonging the isolation measure over 24 hours and the restraint measure over 12 hours should not be possible without a new decision being made, with the reasons set out as before.
 - Somatic treatment and monitoring must be ensured with, in particular, a mandatory somatic examination during the first hour of the measure to evaluate the contraindications.
 - Beyond the monitoring of vital signs and assistance to satisfy basic needs, the presence of nursing staff must guarantee that the therapeutic response is adapted to the clinical situation of the patient¹ and to his/her needs.

1. In the report submitted following its visit in 2010 in France, the CPT feels that in restraint cases, a member of the nursing staff should be present at all times to maintain the therapeutic link with the patient and to help him/her (disposal of urine and stools/ access to the toilet and bathroom, hydration, food, etc.). Video-surveillance should not replace such a continuous staff presence.

- A medical examination twice per day must be guaranteed for any person subjected to physical restraint.
- Stays in a seclusion room or the use of restraint must be regularly interrupted by short release periods in the open air; only exceptional circumstances can justify it being impossible to be released and thus must be explained.
- A consultation must be carried out with the person concerned when the restraint measure comes to an end for the purpose of talking about the clinical context of his/her suffering, his/her experience of this measure and the methods likely to prevent it in the future.

Evaluation

- To reach the goal of limiting recourse to physical restraint measures in care facilities, as part of an explicit strategy, the health authorities must have the required steering and monitoring tools.
- At national level, gathering, monitoring and evaluating information must be entrusted to a body which guarantees that a multidisciplinary approach and multi-factorial analysis are carried out.
- At regional level, the recourse to isolation and restraint measures must be a systematic consideration in the multi-year contracts specifying objectives and resources (CPOM) between the regional health agency (ARS) and the health institution authorised in psychiatry.
- The ARSs receive the institutions' annual reports provided for by Article L.3222-5 of the Public Health Code and carry out a critical comparative analysis of the methods of resorting to isolation and restraint in the institutions in their region; this document must be circulated annually to the *départemental* commissions for psychiatric treatment and competent legal authorities in the region.

In cases where seclusion rooms are used without restraint, the member of staff can be outside the seclusion room, provided that the patient can see him/her and that he/she can observe and hear the patient at all times. It is also vital to carry out a consultation at the end of the isolation period with the patient concerned.

- At institutional level, this same Article L.3222-5-1 imposes precise requirements in terms of record-keeping, drawing up a policy to limit the recourse to isolation and restraint practices and evaluating its implementation.

- The institution's medical commission (CME) must be involved in this matter in terms of monitoring the situation in each of its meetings, taking into account the realities per care unit and the pathology of the people concerned. This policy must be incorporated into the institution's policy for care safety and quality.

- Any instance of restraint must be declared as an adverse event and be subject to a systematic review.

- Institutional work must be carried out with third party professionals, on all cases of seclusion room use as part of a supervision mindset; this work must enable an analysis of the issues in the relationship between the patient and the nursing staff (submission, resignation, reward).

Information

- The Chairman and the Prosecutor of the Court of First Instance, as part of their jurisdiction provided for by Article L.3222-4 of the Public Health Code, must receive a monthly list statistics of the decisions to use isolation and restraint taken in mental health institutions under their jurisdiction.

- Similar information should be provided monthly to the members of the *départemental* commission for psychiatric treatment and to the members of the institution's users' commission.

Physical conditions

- The architecture of the seclusion rooms must guarantee suitable accommodation conditions in terms of, for example, surface area, light and access to water and washing facilities. The layout of these rooms must be conducive to calming patients down and enable high quality bedding to be provided with the possibility of lying down with a raised head; it must enable the patient to sit and eat in dignified conditions and allow the patient to see a clock. Television and music equipment must be able to be used in these rooms in complete safety.

- Video-surveillance devices in seclusion rooms must be prohibited as they violate dignity and privacy. In addition, these devices are not necessary if the nursing presence is adapted to the patient's condition.

- Anyone placed in a seclusion room or restrained must always have access to a call button which must be responded to immediately.

- Patients placed in seclusion rooms must be able to receive their visitors in respectful conditions.

- Anyone placed in a seclusion room must keep their bed in an ordinary room during the entire isolation period.

- The institution's fire-safety services must be informed in real time of any use of or releases from the seclusion rooms or restraint. The staff of these services must not take on roles as helpers in the management of the care given to the patient.

Studies and training

- The development of medical and nursing research on preventative professional practices must be encouraged with the aim of reducing recourse to isolation and restraint measures.

- Physician, nurses and team training, in particular on violence and the patients' fundamental rights, must be strengthened.
- The professional recommendations drawn up by the HAS must be made widely available as they are likely to limit the recourse to physical or chemical restraint measures and to guarantee better quality of treatment for people concerned by these practices. At the same time efforts must be made to ensure that the recommendations are taken up by the staff concerned.
- A postgraduate (third cycle) programme in treatment must be set up in order to enable nurses to develop recognised clinical expertise.

Prevention

- Therapeutic and occupational activities must be developed within psychiatric departments in order to reduce boredom and tensions.
- The rules that patients must follow within these units must be made available to them in order to avoid arbitrary situations conducive to the emergence of risk situations (likely to bring about physical or chemical restraint measures in response).
- A nursing staff presence, adapted to the specificities of the treatment units and the patients hospitalised in these units, must be guaranteed.



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