Opinion of 15 February 2011
by the Controller General of Places of Deprivation of Liberty
on certain aspects of compulsory hospitalisation

1. Under the law, persons suffering from a mental disorder who “endanger people’s safety or pose a serious threat to public order” may be admitted to hospital against their will by order of the prefect on the basis of a specific medical certificate. This special measure (over fifteen thousand such measures are taken every year), known as “compulsory hospitalisation”, can be renewed indefinitely, with the result that the patient remains in hospital. The patient leaves hospital when the psychiatrist, believing that it is possible to release the patient, makes a proposal to that effect to the prefect, who decides whether or not to lift the compulsory hospitalisation order. Even before the patient leaves hospital, however, he may be released on a trial basis, subject to the prefect’s authorisation, for periods which generally increase in length before his final release. The average period of compulsory hospitalisation is 95 days. There is currently a trend towards an increase in that period.

2. The exercise of these powers, henceforth with help from the regional health agencies, involves maintaining a delicate balance between public order requirements, the need for treatment and consideration of the vulnerability of the individuals concerned. The danger they may pose to themselves or to others – which is not necessarily in proportion to the sometimes spectacular external manifestations of their condition, with which it should not be confused – undoubtedly calls for coercive measures. For this reason, compulsory hospitalisation is indeed a measure of deprivation of liberty, and is judged as such both in domestic law (eg Paris Court of Appeal, 1st Chamber, A, 13 April 1999) and by the European Court of Human Rights (eg ECHR, 3rd Section, 16 June 2005 *Storck v. Germany*, no 61603/00). The need to provide treatment for the individuals concerned cannot mask this reality, contrary to what health-care staff might sometimes say – which is not at all the same as equating a hospital with a prison. This deprivation of liberty must therefore be surrounded by all the necessary safeguards, especially as the individuals concerned may experience difficulties in asserting their statutory rights. That is the central task of the Controller General of Places of Deprivation of Liberty.

In such cases, individuals may only continue to be deprived of their liberty if two conditions are met: there must be a serious threat to public order and hospital-type care must be necessary.

3. There are currently four factors which upset the balance referred to earlier.

4. First, the management and medical staff of the establishments concerned must take particular care to ensure that compulsorily hospitalised persons are able to exercise the right to challenge the hospitalisation order before a competent court.

That is not the case where, as often happens, the rights of which patients should be notified immediately upon admission to hospital are presented in an abstract and perfunctory manner, or the notification of rights is actually postponed. Or where it is not always immediately possible to have recourse to a lawyer, some psychiatrists taking the view that a period of adaptation to hospital is necessary, the length of which they determine in the light of the patient's condition. While an adaptation period may be prescribed, it does not apply to the lawyer, access to whom must be unconditional. Or lastly where the newly admitted patient is not informed – as is the case in roughly half the establishments visited to date – of his right under the legislative provisions governing patients' rights to appoint a "person of trust" to "assist with formalities". Such persons can provide useful assistance to those subject to compulsory hospitalisation who no doubt represent a threat to public order but, at the same time, are often highly vulnerable and sometimes deprived of all family support.

5. Secondly, in contrast to the policy commenced in the 1960s, the doors of an increasing number of psychiatric hospitals are now locked. Their patients are not free to go out, even to walk in the grounds, go to a cafeteria or attend a religious service. These restrictions are not without an impact on patients' lives (eg in terms of the range of therapeutic activities available or the difficulties facing smokers) and on relations with family and friends. However, there is just one point to which we would like to draw attention here: when hospital doors are locked, patients subject to compulsory hospitalisation and voluntary patients, ie those who have come to hospital of their own free will, are effectively placed in identical conditions.

We must therefore ask ourselves what becomes of that freedom if voluntary patients are actually no freer than the others to go out as they wish, in other words are in practice deprived of their freedom of movement. Above all, it should be noted that this confinement is not the result of a particular procedure, but merely of the choice made by the managers of the unit to which these patients are assigned (as we know, allocation is by geographical area) to seek and obtain permission to keep its doors locked. No individual decision, no appeal procedure and *a fortiori* no judicial intervention was involved in bringing about this situation. The approach adopted here prompts some legitimate questions. It seems appropriate to offer "voluntary patients" at least a choice between an open or closed unit and, if they choose the latter, to ensure that they are informed of their rights, in particular their right to appeal quickly against the measure to which they are subject.

6. Thirdly, in a growing number of French *départements*, fear of disturbances of the peace makes it more difficult to obtain trial release and renders the lifting of compulsory hospitalisation orders more uncertain.

Traditionally, prefects based their decisions very extensively on the medical opinions submitted to them and granted the measures requested. That is no longer the case today in three areas.

a) The first is that of trial release.

It is implicitly but necessarily borne in mind by the authorities responsible for authorising the release of involuntary patients that when a request is made for trial release, the patient remains as dangerous to himself and others as he was on the day of his admission. However that may be, they sometimes order a police investigation, which, because it is conducted in the places where the person lived prior to his compulsory hospitalisation, can only restate the facts that initially prompted his hospitalisation. And because those facts disclose a danger, there is a great temptation to reject the psychiatrist's proposal out of hand.

This is tantamount to saying that nothing has happened between the day when the person was admitted to hospital and point at which the psychiatrist makes an informed proposal for the relaxation of coercive measures.

This idea, which, moreover, disregards the professional conscience of health-care staff, is incorrect and contrary to the spirit of current legislation, which is based on the idea that even if the care dispensed to patients, and in particular the treatment prescribed or administered, does not result in a return to a stable and permanently danger-free condition, it can at least guarantee that, for periods of varying length, the patient is no longer dangerous. Based on this assumption, therefore, the law provides for an easing of coercive measures in the form of trial release. Admittedly, this is merely a possibility. But since a deprivation of liberty is involved, that possibility should only be ruled out where it is established that there is a risk of danger or of a serious disturbance of the peace. It seems impossible to base a refusal on old facts: it should only be possible to take account of current facts. The grounds for refusal cannot be substantiated by a reiteration of the past facts which led to hospitalisation.

b) The second concerns measures to terminate compulsory hospitalisation.

The authorities show a similar distrust of psychiatrists' opinions relating to the termination of compulsory hospitalisation. Likewise, investigations are ordered, but by definition they can only deal with facts prior to hospitalisation and, consequently, cannot give any indication of the patient's state of health following the treatment received in hospital. However, to quote the French Constitutional Council, only "medical grounds" and "therapeutic goals" (Decision No 2010-71 QPC of 26 November 2010, para. 25), together with current public order considerations, can justify the deprivation of liberty.

c) The third is compulsory hospitalisation of persons serving a prison sentence.

The authorities responsible for public order are concerned that the conditions for compulsory hospitalisation of prisoners, which is currently on the increase (around 1 200 cases each year), might facilitate their escape given that this hospitalisation currently takes place in an ordinary hospital setting. For this reason, in some *départements*, when the doctor responsible submits a "detailed" request for such a measure based on Articles L.3214-1 et seq of the Public Health Code and Article D.398 of the Code of Criminal Procedure, its execution is in some cases conditional on police investigations or an opinion from the prosecuting authorities. These requirements have the effect of delaying the requested admission to hospital and in some cases even lead to its rejection. The inevitable consequence is that persons who are considered to be in urgent need of more substantial treatment are deprived of appropriate therapy (and are left

in prison in the hands of the prison and health-care staff). In this case, therefore, the risk is not one of arbitrary deprivation of liberty, but one of care which is intentionally inappropriate to the patient's state of health. Yet the fundamental rights of prisoners demand that they should receive care appropriate to their state of health (European Court of Human Rights, 5th Section, 16 October 2008, *Renolde v. France*, no 5608/05).

The overall effect of these three practices as they are currently applied, in particular the first two, is to increase the number of patients hospitalised and the length of their stay, to prevent patients from being released on a trial basis where this would be warranted by their state of health, and even more importantly, to keep people in hospital whose state of health as certified by doctors does not justify keeping them there against their will. They may in some cases, as emerged from the general inspection, lead to congestion of hospital beds and possibly prevent the hospitalisation of people who, on the contrary, are genuinely in need of it. This is therefore a short-sighted policy which may have opposite effects to those sought.

7. Fourth and last, the very widespread practice of placing compulsorily hospitalised prisoners automatically, whatever their state of health (Article D.389 of the Code of Criminal Procedure, cited above), in isolation in a secure room and, especially, keeping them there for the entire period of their hospitalisation, despite the fact that they consent to being treated and no medical justification can be cited for keeping them there, also prompts some serious misgivings. This practice, which is often imposed on hospital managers and, hence, on medical officers by the authority responsible for public order, jeopardises the health of sick prisoners in two ways. First, unlike other prisoners who are not being kept in isolation, they are denied access to group therapy (support groups, occupational therapy etc). Secondly, precisely because of the restrictions imposed on the patients concerned, this practice leads them to ask to be returned as quickly as possible to prison, despite the continued need for hospital care.

There are some establishments where compulsorily hospitalised prisoners are not systematically placed in isolation, without there being a greater risk of escape (which is usually the reason for keeping them in a secure room), which makes it possible to dispense treatment appropriate to the patients' state of health. This approach should prevail over automatic isolation, which violates the requirement to tailor treatment to the prisoner's particular circumstances.

As above, it should be stressed that the increase in the number of people kept unnecessarily in hospital or in isolation may lead to difficulty in managing the beds or secure rooms available, as is sometimes observed, and make it difficult to find room in hospital for people whose condition necessitates urgent hospitalisation.

8. As pointed out at the beginning, reconciling public order requirements and health considerations is a delicate matter. There is no need to dwell here on obvious facts which would be easily accepted. But the uncertainties and risks which still remain cannot be allowed to lead to a worrying increase in the number of people whose condition no longer demands that they should be deprived of their liberty or kept in isolation, without any recognised medical justification, on public order grounds which are neither proven nor relevant to the present situation. If practitioners can be required to provide medical assurances, then the authorities can also be expected to substantiate the risk which they use to justify continued deprivation of liberty.

9. In these conflicts between medical practitioners, patients, authorities and protection of third parties, the courts should play a greater role. At the very least, therefore, it would be desirable if, in the event of a disagreement between the medical profession and the administrative authorities, the competent court were called upon to give a ruling, the director of the establishment being required to refer the matter to it without any prior formalities.

Jean-Marie Delarue