

FRANCE

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I. Executive Summary

- [1]. Mental health covers various statuses which form a legal patchwork.¹ It is characterised by two main features: first, the distinction between mental disorders and the overall issue of disability, even if the law has aimed recently at reducing this; and second, the fact that the legal system appears to be still much subject to the principle that it is impossible to gain the consent of a patient suffering from a mental disorder and the various consequences of this. Setting out the relevant definitions underlines these features.
- [2]. An analysis of the legal framework through the issue of anti-discrimination clarifies the place of disability. However, upon deeper examination one observes a lack of information and case law relating to mental disability or illness. The most important provisions of the government's anti-discrimination plan benefits people with physical disabilities especially in employment.
- [3]. When we examine the fundamental rights of people with mental disorders, a difference appears between the French legal framework and international and especially European texts in this field. Even if the rights and freedoms entrenched in the latter are directly applicable, they are not recognised as such in the French Constitution or law in general (right to life, right to freedom from torture or cruel, inhuman or degrading treatment or punishment, right to have children). This does not mean that these rights are not recognised under another form or are not applicable, but we should point out that France has been found guilty of violating the rights of prisoners with mental disorders. However, case law related to mental health remains limited.
- [4]. Involuntary placement in hospital and treatment are currently being reformed. Much criticism has been addressed at the main features of the system in force, particularly at the fact that emergency hospitalisation procedures have become the rule and at the monopoly of the administrative authorities on deciding compulsory hospitalisation. In addition, the protection of liberty mainly depends on *a posteriori* control. From this point of view the increasing number of emergency forced placements has not only led to several proposals of reform but has also made it more necessary to think of reform.
- [5]. The legal framework applicable to adults lacking legal capacity was reformed by the Act of 5 March 2007. Like the previous act, it includes three regimes for protecting mentally incapable adults. All three are determined by necessity and proportionality. The criteria for deciding which type of protection is appropriate have been modified and favour a medical approach. The recent enactment of the law and its administrative regulations means that case law is still largely undeveloped.
- [6]. For several years reports have been denouncing the worsening situation of prisoners suffering from mental disorders. Their rights and freedoms are often violated. The main problem is here that the medical treatment is mixed with an approach that regards the prisoners as criminals. A security-driven vision of mental illness regularly emerges – often after striking cases covered by the media. In particular, this led to the Act of 25 February 2008 on preventative detention on the grounds of public safety [rétenion de sûreté], while the treatment of sexual offenders is currently being debated.

¹ Most French law in this area has undergone significant reforms over recent years through the enactment of reform acts.

II. Definitions

- [7]. A focus on the definitions used in the French legal framework sheds light on its specificities. One is the close link between psychiatry and the creation of the asylum at the beginning of the 19th century which set apart – and continues to set apart – this branch of medicine. Nevertheless the psychiatric treatment of people with mental disorders until the second half of the 20th century was holistic, taking into account the social aspects of their lives, albeit in a limited manner. This was the result of the recognition of the concept of ‘chronicity’ being applied to seemingly incurable mental disorder.² Mental disorders are still treated by psychiatry but are now implicitly regarded as curable. In contrast, the notion of ‘mental disability’ indicates a permanent and definitive state that needs to be managed in society as proved by the fact that this is the responsibility of the *Ministère des affaires sociales* [Department of Social Affairs] while mental health is still the preserve of the *Ministère de la santé* [Department of Health]. This partly explains the still important distinction made in the French system between mental disorder and mental disability. The recent legal recognition of mental health/psychiatric disability (*handicap psychique*) has reduced the gap. However the Disability Act of 11 February 2005 and the bill on mental health constitute two separate pieces of legislation. In addition we read in the Mental Health Services Users’ Charter that a mentally ill person ‘must not be considered as physically or mentally disabled’. The following expressions are by far the most commonly referred to in law and official sources: 1) *santé mentale* 2) *troubles mentaux* 3) *handicap mental* 4) *handicap psychique* 5) *maladie mentale* and may be translated as follows: 1) mental health 2) mental disorder 3) mental disability (i.e. intellectual disability) 4) mental health/psychiatric disability 5) mental illness. The notion of ‘mental health’ appeared explicitly for the first time in 1992 in the ‘Massé report’ on psychiatry called after its author.³ In 2005 the authorities enshrined the expression in the *Plan psychiatrie et santé mentale: 2005-2008* (Psychiatry and Mental Health Plan: 2005-2008). According to this programme, there are three dimensions of mental health: ‘positive mental health which covers personal fulfilment, reactional psychological distress which corresponds to trying situations and existential difficulties, and psychiatric disorders which refer to diagnostic classifications based on medical criteria and targeted therapeutic actions and which are of variable duration and may be severe and disabling to a greater or lesser extent.’⁴ The Act of 11 February 2005 recognises for the first time mental health/psychiatric disability (‘*handicap psychique*’) alongside physical, mental, cognitive and sensory disability. It introduces into the *Code de l’action sociale et des familles* [Social Policy and Families Code] Article L. 114 that provides a general definition of disability. Under this article a disability is ‘...any limitation on activity or restriction on participation in the life of society suffered in his environment by a person owing to a substantial lasting or permanent deterioration of one or several physical, sensory, mental, cognitive or mental health (*psychique*) functions, of a polydisability or an incapacitating health difficulty’.⁵ The difference between a mental and a mental health disability is not always easy to determine. It is nevertheless considered that a person suffers from a mental disability from birth whereas a mental health disability appears during his/her life and causes very serious and often permanent mental disorders. The first often has genetic causes and the second is closely linked to psychiatric illness. The late appearance of this form of disability is possibly the reason for reluctance to regard it as incurable.⁶ It was long considered that the aim of treatment of disability is autonomy whereas the final objective of the treatment of illness is

² N. Henckes (2009), ‘Psychiatrie et institutions, les dynamiques de changement’ in *Regards sur l’actualité*, n°354, p. 8.

³ France/*Regards sur l’actualité*, n°354 (October 2009), p. 49.

⁴ France/Programme Psychiatrie et santé mentale, 2005-2008, p.4

http://www.unafam.org/telechargements/plan_sante_mentale_20_04_2005.pdf

⁵ France/ Rapport du Gouvernement au Parlement relatif au bilan et aux orientations de la politique du handicap (12.02.2009), p. 7. The number of persons with a mental health disability would amount to 600 000.

<http://lesrapports.ladocumentationfrancaise.fr/BRP/094000070/0000.pdf>

⁶ See http://www.cofemer.fr/Article.php?id_Article=643 (26.10.2009)

recovery. From a terminological point of view, the French response to the *Report on the effective respect for human rights in France* is quite surprising for it specifies that ‘use of the expressions “mentally disabled people” (*personnes handicapées mentales*) and “mentally disabled” (*handicapés mentaux*) is not satisfactory. We should speak of the “mentally ill” (*malades mentaux*) or “psychiatrically disabled” (*handicapés psychiques*). Mental health disability was indeed recognised in the Act of 11 February 2005 on the equality of rights and opportunities, participation and citizenship of disabled persons.’⁷ National case law does not clarify these definitions.

III. Anti-discrimination

A. Incorporation of United Nations standards

- [8]. France signed the Convention on the Rights of Persons with Disabilities on 30 March 2007 but has not yet ratified it. The bill authorising ratification has not been enacted yet despite a ‘deliberation’ (decision) issued by the HALDE encouraging the Government to do so in March 2009.⁸ The bill drafted to ratify the CRPD states that French law already contains most of the provisions of the Convention. However, ratification would require an amendment to domestic law as the obligations are aimed not only at public authorities but also at private persons.⁹ Other amendments were outlined in the bill. These addressed access to tourist services and should have been taken into account through the administrative regulations implementing the Act of 22 July 2009 on the modernisation of tourist services. The bill also recalled that the State and local entities (regions, counties, etc) should follow the example of private employers as regards employment to be more respectful of their obligations. To comply with the Convention the refusal of reasonable accommodation in every field should be recognised as constitutive of discrimination and accordingly liable to the sanctions laid down in Article 225-2 of the *Code penal* [Penal Code].¹⁰
- [9]. Several legal provisions of the Act of 5 March 2007 ensure compatibility of Article 12 CRPD with the French legal framework. According to these provisions, the guardianship judge (*juge des tutelles*) may not now order guardianship without medical advice. All forms of guardianship are of a limited duration and the supervision exercised by the guardianship judge has been strengthened (see below, VI, Competence, Capacity and Guardianship).

B. The Anti-Discrimination National Framework

- [10]. Disability is the second most widespread ground of discrimination after origin.¹¹ About half of cases of discrimination are related to employment while nearly 40 per cent concern access to goods and services.¹² The Constitution focuses mainly on the principle of equality

⁷ <https://wcd.coe.int/ViewDoc.jsp?id=965741#e>

⁸ France/HALDE/Délibération 2009-114 (02.03.2009): <http://halde-prod.gaya.fr/IMG/alexandrie/4434.PDF> (29.10.2009)

⁹ France/Projet de loi autorisant la ratification de la convention relative aux droits des personnes handicapées/1777 (24.06.2009): <http://www.assemblee-nationale.fr/13/pdf/projets/pl1777.pdf> (29.10.2009)

¹⁰ <http://www.droits-fondamentaux.org/IMG/pdf/df6cdlhch.pdf> (28.10.2009)

¹¹ France/HALDE/ Annual Report 2008, p. 13: <http://lesrapports.ladocumentationfrancaise.fr/BRP/094000212/0000.pdf> (24.11.2009)

¹² France/Projet de loi autorisant la ratification de la convention relative aux droits des personnes handicapées/1777 (24.06.2009), p. 4.

and provides that France ‘shall ensure the equality of all citizens before the law, without distinction of origin, race or religion’ (Article 1 of the 1958 Constitution).

- [11]. At legislative level, the national anti-discrimination framework may be considered generally satisfactory in so far as anti-discrimination rules clearly appear in the law. These rules are entrenched in the Penal Code and the *Code du travail* [Labour Code]. Article 225-1 of the Penal Code provides a global prohibition of discrimination. Mental health disability now appears in the Act of 11 February 2005 on the equality of rights and opportunities, participation and citizenship of disabled persons.
- [12]. Case law related to the implementation of the anti-discrimination legal framework for people with a mental disability is so modest that it seems inexistent. One can observe however that it will be possible for an applicant to invoke some provisions of the above-mentioned CRPD before a judge, once the Convention is definitively ratified. However, the French Parliament has indicated that the Convention provisions imply obligations mainly for States and that individuals cannot invoke them before a court. Only Articles 15, 17, 18 and 22 of the CRPD entail direct rights that do not require the intervention of the State for their implementation.¹³
- [13]. The Constitution provides no arrangements for the preferential treatment of persons with mental disorders and disabilities. One must refer to the legislative level.
- [14]. The Act of 11 February 2005 is very often presented as an important step forward for persons with a mental disability. Besides the first recognition of mental health disability, the Act provides various plans targeting people with a mental health disability. These mainly consist of increasing the number of places in specialist establishments working with people with a mental disability.¹⁴ The Act also created *groupes d’entraide mutuelle* (GEM) [mutual aid groups] as a new tool for compensating for mental health disability and which provide support by organising collective activities.¹⁵ In addition, the mechanism provided by the 2005 Act for compensating mental health disability may be viewed as a means of combating discrimination on the ground of mental health disability, even though this mechanism is applicable to all kinds of disabilities. It is based on the principle that ‘a disabled person has the right to compensation for the consequences of her/his disability whatever the origin and the nature of her/his impairment, age or way of life’ (Article L. 114-1-1 of the Social Policy and Family Code).¹⁶ This right is intended to be universal and go beyond the various administrative statuses. This compensation has a very wide scope, ranging from childhood to professional integration. This right is implemented through a *prestation de compensation du handicap* (PCH) [disability compensation allowance] which takes over from the former *allocation aux adultes handicapés* (AAH) [disabled adults’ allowance]. This new scheme is managed by *maisons départementales des personnes handicapées* (MDPH) [county homes for disabled people], created in 2006. At the same time the recently created *commissions des droits et de l’autonomie des personnes handicapées* (CDAPH) [commissions for the rights and autonomy of the disabled] are vested with the power to take decisions related to all disabled rights. The Labour Code also provides that any disabled worker may benefit from rehabilitation, re-education or professional training (Article. 5213-3). There is no case law available dealing specifically with arrangements for preferential treatment for people with mental disorders or mental disabilities.

¹³ France/Rapport sur la loi autorisant la ratification de la convention relative aux droits des personnes handicapées (23.09.2009), p. 21: <http://www.assemblee-nationale.fr/13/pdf/rapports/r1929.pdf> (28.10.2009)

¹⁴ France/Rapport du Gouvernement au Parlement relatif au bilan et aux orientations de la politique du handicap (12.02.2009). http://www.temps.travail.gouv.fr/IMG/pdf/Rapport_CNH_valide.pdf (27.10.2009)

¹⁵ At the end of 2008 the number of working GEMs amounted to 330. France/Rapport du Gouvernement au Parlement relatif au bilan et aux orientations de la politique du handicap (12.02.2009).

¹⁶ On the right to compensation see the French report in <http://ec.europa.eu/social/main.jsp?catId=431&langId=en> (21.10.2009).

- [15]. The Penal Code provides under Article 225-1 a general definition of discrimination. It refers to any distinction made on the ground of, in particular, disability.¹⁷ The 2005 Act transposes the 2000 Directive.¹⁸ A disabled worker is defined by the 2005 Act as ‘any person whose opportunities to obtain and retain employment are reduced because of impaired physical, sensory, mental or mental health (*psychique*) functions’. The Act maintains the obligation to employ disabled persons who must represent at least six per cent of the staff of a company. A difficulty was that companies too frequently resorted to the alternative possibility of paying a subscription to the relevant body, the *Association de gestion du fonds pour l’insertion des personnes handicapées* (AGEFIPH) [Association for the management of the fund for the professional integration of disabled people] instead of actually employing disabled people. The amount of such subscriptions has therefore been raised. From this point of view it is a paradox that people working in *établissements et services d’aide par le travail* (ESAT) [establishments and services for assistance through work] are not counted as disabled employees because they receive an allowance and not a salary.¹⁹ A second point to take into account is the specific nature of mentally and especially psychiatrically disabled workers. Most people with a mental disability normally work in ESATs. Since the introduction into law of the concept of mental health disability, increasing numbers of mentally ill people have been pushed toward these bodies by the commissions for the rights and autonomy of the disabled. Yet the ESATs do not always specialise in this kind of disability. They mainly provide manual and repetitive work that is suitable for people with a mental disability while mental health disability tends to cause tiredness and unstable behaviour. As their need is rather for progressive rehabilitation to work, sites specialising in professional integration should be considered, which would be accompanied by social assistance.²⁰ Provisions dealing with workplace discrimination can be found especially in the Labour Code. It also provides that differences in treatment based on incapacity certified by the company doctor owing to state of health or disability are not discrimination when they are objective, necessary and appropriate (Article L.122-45-4 Labour Code, inserted by the 2005 Act).²¹ In reality the anti-discrimination legal framework is very seldom applied to people with a mental or mental health disability in so far as they do not work in ‘ordinary’ workplaces.
- [16]. Concerning the draft ‘horizontal’ directive, the 2005 Act focuses not only on the professional life of disabled persons but also on their general quality of life and the aim of general autonomy. Thus it already addresses the scope of the draft council directive. The 2005 Act gives much room to the issue of accessibility even if much remains to do to implement the stated intention. In addition a report produced by the French Senate emphasised the importance of introducing specific training for staff working in county homes for the disabled who are tasked with drawing up a life plan/life project (*projet de vie*) for disabled clients that includes allocation of the disability compensation allowance. In particular, a member of the family should be associated to such a definition for the persons with a mental or mental health disability.²² Concerning the provision of financial services dealt with by the draft ‘horizontal’ directive (Article 2-7), French law seems to be advanced in so far as the State invites the relevant stakeholders and user associations to conclude agreements giving easier access for mentally ill and disabled persons to financial and insurance services (Article L. 1141-2 and 1141-3 of the *Code de santé publique*, Public Health Code). For example, an agreement entitled ‘Taking out insurance and borrowing

¹⁷ For a case dealing with a refusal to provide goods and services to a person with a physical disability, see France/Cour de cassation/05-85888 (20.06.2006).

¹⁸ F. Kessler (2005), ‘L’autonomie des personnes handicapées dans la loi du 11 février 2005, premières observations’, in *Revue de droit sanitaire et social*, p. 382.

¹⁹ France/Sénat/Rapport d’information sur l’application de la loi du 11 février 2005: <http://www.senat.fr/rap/r06-359/r06-3591.pdf> (03.11.2009).

²⁰ See above.

²¹ For a case involving a person with a physical disability see France/HALDE/ 2007-294 (13.11.2007): <http://www.halde.fr/IMG/alexandrie/3270.PDF> (26.10.2009)

²² France/Sénat/Rapport d’information sur l’application de la loi du 11 février 2005.

with an aggravated health risk' (S'Assurer et Emprunter avec un Risque Aggravé de Santé, AERAS) was signed on 6 July 2006.²³ The Act of 11 February 2005 takes a general approach and includes mental health disability. Nevertheless only time will tell if the means foreseen to reach the objectives are implemented and help people with a mental health disability in the same way as those with physical disability.

- [17]. The French legal framework allows 'appropriate measures' to implement Directive 2000/78/EC and achieve the professional integration of disabled workers. Under the recently inserted Article L.5213-6 of the Labour Code, the employer has a general obligation to take these 'appropriate measures' to enable disabled workers 'to have access to and retain a job corresponding to their skills, to exercise it or to progress in it, or to enable them to benefit from a professional training adapted to their needs'.²⁴ The 'reasonableness' of these measures is assessed in order to allocate the financial allowances that employers may receive to introduce them.²⁵ In order to implement 'appropriate measures' the company has to estimate the cost of physical alterations to the workplace, work organisation and adaptation to working hours. However, major alterations to improve accessibility, the cost of support workers and loss of productivity go beyond what is required and are not the responsibility of the company and so may justify public funding. The *Directions départementales du travail, de l'emploi et de la formation professionnelle*, (DDTEFP) [county departments for labour, employment and professional training] are responsible for assessing the appropriacy of such measures. However, it has been pointed out that the DDTEFP are not always able to conduct this assessment as the only information they may use is the advice of the company doctor.²⁶ The plans introduced by the 2005 Act are still under implementation and have not given rise to case law yet.
- [18]. The relevant equality body is the HALDE²⁷ which is competent to deal with all forms of discrimination. Among its countless 'deliberations' (decisions) addressing discrimination on the ground of disability, almost none deal specifically with mental disorders and disabilities. We will refer to the deliberation of 24 May 2007. In this case the HALDE was approached by a trisomic disabled person who had been unable to book a plane ticket. The air company argued that he could not travel alone. The HALDE deemed that an *in concreto* assessment is required to justify such a refusal on safety grounds. Accordingly the equality body recommended that the air company take specific measures to reminds its agents of anti-discrimination rules that prohibit refusal of access to a private service on the ground of disability. Lastly the HALDE asked the company to let it know what measures it intended to take.²⁸

IV. Specific Fundamental Rights

- [19]. The issue of specific fundamental rights should be analysed in the light of the following legal provisions. Article L.3211-3 of the Public Health Code stipulates that 'when a person with a mental disorder is hospitalised without consent [...] limitations to the exercise of his individual freedoms must be restricted to those required by his state of health and the implementation of the treatment.' Furthermore the Act of 11 February 2005 inserted Article L.114-1 into the Social Policy and Families Code, stating that 'every disabled

²³ A. Boujeka (2009), 'Egalité de traitement et handicap: à propos de la proposition de directive européenne du 2 juillet 2008', in *Revue de droit sanitaire et social*, p. 95.

²⁴ For an example of a profitable inclusion of a person suffering from autism in a company see the French case of good practice: <http://ec.europa.eu/social/BlobServlet?docId=1961&langId=en> (03.11.2009)

²⁵ See *Rapport du Gouvernement au Parlement relatif au bilan et aux orientations de la politique du handicap: La compensation du handicap, acquis essentiel de la loi du 11 février 2005*.

²⁶ France/Sénat/ rapport d'information sur l'application de la loi du 11 février 2005.

²⁷ Haute Autorité de Lutte contre les Discriminations et pour l'Égalité. It was created in 2004.

²⁸ France/HALDE/Délibération 2007-131 (24.05.2007). <http://www.halde.fr/IMG/alexandrie/2906.PDF> (03.11.2009)

person has the right to support (*solidarité*) from the entire national community, ensuring, by virtue of this obligation, access to the fundamental rights granted to all citizens and the exercise of citizenship'. Lastly, the *Code civil* [Civil Code] provides that the protection of adults lacking legal capacity must respect individual rights and freedoms and dignity (Article 415 of the Civil Code).

- [20]. The right to life. Neither the French Constitution nor legislation address explicitly the right to life as the European Convention for Human Rights does. The closest recognition is contained in the Voluntary Termination of Pregnancy Act of 17 January 1975 which stipulates that 'the law ensures respect for every human being from the beginning of life'. Notwithstanding the various opinions on this sensitive issue, one can observe that the time permitted for abortion – voluntary termination of pregnancy – is extended when the unborn child suffers from an incurable illness (Article L. 2213-1 of the Public Health Code). France was twice criticised by the European Court of Human Rights for its failure to protect the right to life of prisoners.²⁹ The national courts analysed the first case dealing with this issue in the light of Article 121-3 of the Penal Code, which deals with the offence of voluntarily jeopardising the life of others. However the prison administration were not held responsible for the death of the prisoner given that there was no sign of risk that he would commit suicide. The second case involved the offences of voluntary and involuntary manslaughter.
- [21]. The right to freedom from torture or cruel, inhuman or degrading treatment or punishment. The French Constitution recognises 'the protection of the dignity of the human being against any form of enslavement and degradation'.³⁰ Moreover, punishment of treatment forbidden in Article 3 ECHR is ensured through the criminalisation of actions against the integrity of the person (Articles 222-1 of the Penal Code). Here must be raised the question of violence against people with mental disorders. There are very few data on this issue. The National Observatory of Violence in Hospitals was created in 2005 but addresses mainly violence against medical staff.³¹ 'Acceptance' of violence against people with mental disorders or disabilities appears to result from the old mixture of treatment and constraint in psychiatric hospitals.³² For example, it appears in a judgment of the *Cour de Cassation* [Supreme Court of Appeal] that 'the injection administered to Mr Z. cannot be viewed as violence, insofar as it was due to his state of agitation'.³³ France was criticised by the European Court of Human Rights for imprisoning a person whose state of mental health required hospital treatment.³⁴ Another case dealt with the abuse of provisional compulsory hospitalisation in the Psychiatric Infirmary of the Police Prefecture of Paris in the event of imminent danger³⁵
- [22]. The right to freedom from exploitation. Forced labour was abolished by the Act of 11 April 1946. The Act of 18 March 2003 inserted into the Penal Code some provisions addressing labour and housing conditions contrary to human dignity (Article 225-14 of the Penal

²⁹ ECourtHR/5608-05 (16.10.2008), *Renolde v. France*: death of prisoner after a placement in a disciplinary cell that was not appropriate to his mental disorder. See also: ECourtHR/9375-02 (09.01.2008), *Saoud v. France*, dealing with the case of a prisoner who died after he was submitted to a measure of physical restraint incompatible with his mental illness.

³⁰ First sentence of the Preamble of the 1946 Constitution, which has constitutional force.

³¹ Observatoire national des violences hospitalières, circulaire n°327 11 juillet 2005.

³² A. Lovell (2005), *Travaux préparatoires à l'élaboration du Plan Violence et Santé en application de la loi relative à la politique de santé publique du 9 août 2004*, p. 28 and ff. The author observes that 'a movement toward the affirmation of patients' rights is under way today through the associations and law. The defence of these rights requires investment and commitment from the public authorities, psychiatric professionals and user associations.' http://www.sante.gouv.fr/htm/actu/violence_sante/rapport.pdf (23.10.2009)

³³ France/Cour de cassation/88-84351 (04.01.1990). We can nevertheless note the report produced by the National Agency for Accreditation and Assessment in Health (*Agence Nationale d'Accréditation et d'Évaluation en Santé*, ANAES) in 1998 on 'Assessing professional practices in health establishments: use of isolation rooms in psychiatry':

<http://www.has-sante.fr/portail/upload/docs/application/pdf/CHISOL.pdf>

³⁴ ECourtHR/33834-03 (11.10.2006), *Rivière v. France*.

³⁵ ECourtHR/44568-98 (19.05.2004), *R.L. and M. JD v. France*.

Code).³⁶ No case law exists involving a person with mental disorder or disability. Such people may be protected by though offences in labour law (Article L. 120-2 of the Labour Code).

- [23]. The right to liberty and security. Involuntary placement in a psychiatric institution of a person with a mental disorder in itself deprives him of the right to liberty and security within the meaning of the ECHR. It follows that the person can be involuntarily hospitalised only in the cases foreseen by law. Furthermore as the forced placement is based on the person's state of health, it must be regularly assessed to ascertain that it is still justified. Hospitalisation which no longer complies with the law gives the right to immediate release (Article 3215-1 to 3215-4 of the Public Health Code). Based on Article 3213-1 of the Public Health Code, Article 5 of the European Convention of Human Rights and Article 9 of the International Covenant on Civil and Political Rights considered together, an administrative court judge recognised the right to be informed as quickly as possible of an order by the prefect for involuntary placement.³⁷ The European Court of Human Rights criticised France for involuntary placement of a patient in a psychiatric hospital: a court's failure to examine two requests for immediate release constituted a violation of Article 5 § 4.³⁸
- [24]. The right to fair trial. Specific guarantees appear in the Public Health Code for involuntarily hospitalised persons. Such a person, a member of his family, or any person acting on his behalf may at any time request the judge of liberties and detention in civil proceedings (*juge de libertés et de la détention*) to order immediate release (Article L. 3211-12 of the Public Health Code). The judge must apply the summary judgement procedure and deliver his decision 'within a short timescale' in order to comply with Article 5§4 of the European Convention on Human Rights according to the judgement in one case.³⁹ The excessive length of a trial may be deemed a violation of individual liberty both before French and European judges.⁴⁰ If necessary, an involuntarily detained person who wishes to question the decision to commit him may get help through organisations representing mental health care users. Besides these provisions, neither legislation nor case law provide specific guarantees for mentally disabled or ill persons in relation to Article 6 of the ECHR.
- [25]. The right to privacy. As regards correspondence, according to Article L. 3211-3 of the Public Health Code, a person involuntarily hospitalised has the right to send and to receive mail. It has been decided by an administrative court judge that the exercise of this right may not be subject to the condition of addressing the mail through a lawyer.⁴¹ As for confidential medical records, legislation on access to personal health data is applicable to mental health. The patient can get this information directly or through a doctor whom he appoints (Article L.1111-7 of the Public Health Code). The patient must be given his medical record within eight days of his request. Consultation of the record is free of charge. For involuntary hospitalisations, consultation of the medical record may be turned down if it is recommended that the patient consults his record in the presence of a psychiatrist (advised for very high-risk patients) but the patient refuses. Applications to the *Commission départementale des hospitalisations psychiatriques* [county commission for psychiatric hospitalisations] for a ruling on whether the presence of a psychiatrist is

³⁶ France was nevertheless criticised by the European Court of Human Rights in the case *Siliadin v. France* of 26 July 2005 (73316/01) for violation of Article 4 of the Convention.

³⁷ *France/Conseil d'état/264627* (01.04.2005), Ms Sylviane X. This right to receive notification of decisions by the prefect has been confirmed by a civil court judge: *Cour d'appel de Versailles/06-03350* (08.11.2006), Mr Khattar.

³⁸ *ECourHR/38287-02* (07.03.2006), *Van Glabek v. France*.

³⁹ *France/Cour d'appel de Paris/ 04-06710* (17.06.2004), M. Vermote.

⁴⁰ *ECourHR/ 686736-01* (27.10.2005), *Mathieu v. France*: violation of Article 5§4: excessive delay between the application to the court and the date of judgement.

⁴¹ *France/Conseil d'état/280494* (06.04.2007), Mr Philippe A..

necessary may be made either by the patient or the hospital.⁴² This means that this right is conditional. Lastly, we can refer to a case recognising the right to privacy of young mentally disabled people. The broadcasting of a movie showing their private daily life inside the institutions where they live, without authorisation by their legal representatives, constitutes in itself a breach of their privacy.⁴³

- [26]. The right to marry, to found a family and to respect of family life. Freedom to marry is recognised at constitutional level.⁴⁴ Article 146 of the Civil Code stipulating that ‘there is no marriage without consent’ may raise difficulties here regarding mental illness and disability. The right to marry is not specifically regulated for people with mental disorders and no official data are available.⁴⁵ On the other hand the legal framework for adults lacking legal capacity deals with this issue. The marriage of a protected adult cannot take place without the family council’s consent and the prior consent of the adult.⁴⁶ The *Conseil constitutionnel* [Constitutional Council] deduced the right to a normal family life from the Preamble to the 1946 Constitution (‘The nation ensures to individuals and family the conditions necessary to their development’).⁴⁷ The HALDE deemed that a bill which did not include disability benefit/allowance in the income necessary to benefit from familial reunification created indirect discrimination on the ground of disability and deprived the applicant of the right to private and familial life. However, the HALDE did not specify if this deliberation was applicable to people with a mental disability.⁴⁸ As regards the right to respect of family life for adults lacking legal capacity, it may be mentioned that they have the right to consent to their own adoption or to the adoption of their children and cannot be represented in decisions of this type by a guardian. The exercise of this right is however subject to their guardian’s approval.⁴⁹ Furthermore, Article 373 of the Civil Code provides that ‘A father or mother who is unable to express his or her intention, by reason of a disability, absence or any other cause shall be deprived of the exercise of parental authority’. The Supreme Court of Appeal judged that a court of appeal should have deprived of parental authority a mother suffering from serious and long-term psychiatric problems.⁵⁰
- [27]. The right to have children and maintain parental rights. For people with a mental disability or disorder, sterilisation is the main issue relating to the right to have children.⁵¹ The question is addressed for the first time in the Act of 4 July 2001 that inserts into Article L. 6121-6 of the Public Health Code the right to ‘information and education on sexuality and contraception [...] in all the establishments working with disabled persons’. This act also allows the contraceptive sterilisation of mentally disabled adults in cases where traditional contraceptive methods are strongly advised against and the impossibility of

⁴² France/Conseil d’état/289794 (10.04.2009), Mr A. The applicant asked for his medical record. The CDHP, contacted by the hospital, confirmed that the record should be consulted in the presence of a psychiatrist.

⁴³ France/Cour de cassation/ 91-13587 (24.02.1993), Luc Hayer c/ ARSEAD.

⁴⁴ France/Conseil constitutionnel/325 DC (13.08.1993), Maîtrise de l’immigration: the constitutional council judged that ‘the principle of liberty of marriage is one of the components of individual liberty.’

⁴⁵ See C. Henri-Landemaine (2009), ‘Les formes sociale et symbolique d’une parenté singulière’: http://www.msh-m.fr/Article.php?id_Article=571

⁴⁶ France/Cour de cassation/97-11252 (24.03.1998); See also France/Cour de cassation/ 91-11700 (05.05.1993): The curator’s consent to the marriage of an adult under legal guardianship is required under Article 514 of the Civil Code. However, Article 183 of the same code concerning minors under guardianship but which must be extended to protected adults, stipulates that the curator cannot ask for the marriage to be cancelled on the ground of lack of approval after one year.

⁴⁷ France/Conseil constitutionnel/93-325 DC (13.08.1993), Loi relative à la maîtrise de l’immigration.

⁴⁸ France/Halde/2006-285 (11.12.2006): <http://www.halde.fr/IMG/alexandrie/2370.PDF> (15.10.2009)

⁴⁹ France/Cour de cassation/07-16094 (08.10.2008).

⁵⁰ France/Cour de cassation/96-05136 (13.01.1998): <http://www.legifrance.gouv.fr/affichJuriJudi.do?idTexte=JURITEXT000007363426&fastReqId=1610399164&fastPos=3&oldAction=rechJuriJudi>

⁵¹ On this issue, see A. Boumaza (2002), ‘La stérilisation contraceptive et le handicap mental après la loi du 4 juillet 2001’, *Revue de droit sanitaire et social*, p. 233. In 1999 a parliamentary question gave the number of 30 000 sterilisations that were not for medical reasons in France each year. Parliamentary question n° 992, Journal officiel (20.12.1999), p.7186.

implementing them has been certified. (Article L. 2123-2 of the Public Health Code). The person's consent is always required and his/her refusal cannot be over-ruled. An organisation fighting against 'handiphobia' requested the annulment of a decree implementing the 2001 Act. The *Conseil d'état* [Council of State, highest administrative court of appeal] judged that with regards to the rules and guarantees entrenched in the 2001 Act, the applicant could not argue that this decree was incompatible with the right to marry and to found a family recognised by Article 12 of the ECHR.⁵²

- [28]. The right to property. The right to property is protected at constitutional level by Article 2 of the Declaration of the Rights of Man and of the Citizen of 1789. The implementation of this right varies according to the various legal frameworks dealing with mental health that cover a wide range of situations. Although people with a mental disorder or disability are not in principle deprived of their right to property, they do not have the opportunity to exercise it in many cases. This is the situation of people living in special institutions, which is why legal provisions aim rather to protect their assets. Mental disability makes access to property difficult, which is why ensuring access to housing and supporting independent living partly makes up for this failing. The HALDE has hence classified dissemination of information on the mentally disabled and housing to managers of social housing as a 'good practice' in the fight against discrimination on the ground of disability.⁵³ As regards people who have undergone involuntary hospitalisation, Article L.3211-7 of the Public Health Code stipulates that such a person 'retains the place of residence that he possessed previously as long as it remains at his disposal.' For adults lacking legal capacity Article 426 of the Civil Code provides that the place of residence of the protected person should remain at her/his disposal as long as possible.
- [29]. The right to vote. It is expressly stipulated by the Public Health Code that a person involuntarily placed in a hospital has the right to vote (Article L. 3211-3). Until the Act of 11 February 2005, protected adults lacking legal capacity could not be listed on electoral registers. This principle has remained after 2005 unless the guardianship judge decides differently. The Act of 5 March 2007 expressly stipulates that the judge decides whether to maintain or remove the 'right to vote of the protected person' (Article L. 5 of the *Code électoral*, Electoral Code). From this point of view a difference still remains between physical and mental disability. Article 62-2 of the Electoral Code does stipulate that 'polling stations and voting technologies must be accessible to disabled persons, whatever disability they suffer from, particularly physical, sensory, mental or mental health (*psychique*)',⁵⁴ but it seems that these provisions concern more physical disability than mental or psychiatric disabilities as the various measures of implementation focus on physical accessibility.⁵⁵

V. Involuntary placement and involuntary treatment

- [30]. Concerning the main and most relevant findings of the United Nations Committee against Torture, neither the *List of issues to be considered during the examination of the third periodic report of France* of the 30 June 2005⁵⁶ nor the *Consideration of reports submitted*

⁵² France/Conseil d'état/248357 (26.09.2005), association collectif contre l'handiphobie. For an application of the legal criterion: France/Cour de cassation/07-86623 (10.06.2008).

⁵³ http://www.halde.fr/spip.php?page=Article&id_Article=10751 (15.10.2009)

⁵⁴ France/Rapport du Gouvernement au Parlement relatif au bilan et aux orientations de la politique du handicap/ (12.02.2009), p.55 sur ' L'accès à la citoyenneté '.

⁵⁵ See for example Articles D.56-1 to D56-3 of the electoral code related to the wheeling chairs.

⁵⁶ See: [http://www.unhchr.ch/tbs/doc.nsf/\(Symbol\)/CAT.C.35.L.FRA.En?OpenDocument](http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/CAT.C.35.L.FRA.En?OpenDocument);

by States parties under Article 19 of the Convention concerning France in 2008 deal with the issue of involuntary placement or treatment.⁵⁷

- [31]. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment and Punishment addressed the issue of involuntary placement and treatment in France after its visit in 2006. It focused on psychiatric care and hospitalisation of prisoners in some prisons.⁵⁸ The CPT observed some improvements in treatment since its last visit but also noted a lack of dignity in the psychiatric care of prisoners and insufficient follow-up care for prisoners suffering from serious mental disorders (too few psychiatrists for the number of prisoners, reducing effective access to treatment).

A. Legal Framework

- [32]. The legal framework applicable to ‘involuntary placement’ mainly consists in the Act of 27 June 1990 on the rights and protection of persons hospitalised due to mental illness and conditions applicable to their hospitalisation.⁵⁹ This replaced the old Esquirol Act of 30 June 1838.⁶⁰ The current Act still provides a structure for the law in this area, but it been adapted to be more protective of individual rights. The Act stipulates that hospitalisation with consent is the principle while hospitalisation without consent is the exception and must be limited to those persons whose mental disorder make consent impossible. The 1990 Act was then complemented by the Act of 4 March 2002 on patients’ rights and the quality of the health system.⁶¹ Under this act all involuntary placements must be motivated by the necessity of treatment and threat to public safety, or by a potentially ‘serious’ breach of public order.⁶² All these provisions were inserted into the Public Health Code in Articles L.3212-1 to L.3213-10. Several official reports and draft bills have since proposed a general or partial reform of psychiatric and mental health policy.⁶³ A new bill is currently under examination in Parliament. It was initially planned to be included in the Hospital, Patients, Health and Territories Act, n°2009-879 of 22 July 2009,⁶⁴ but should eventually be enacted separately.⁶⁵
- [33]. French law makes no distinction between involuntary hospitalisation and involuntary treatment in general.⁶⁶ However, compulsory treatment must be distinguished from treatment without consent.⁶⁷ The first results from an administrative decision while the

⁵⁷ See: <http://www2.ohchr.org/english/bodies/cat/docs/AdvanceVersions/CAT.C.FRA.4-6.doc>

⁵⁸ Council of Europe/CPT (10.2006): <http://www.cpt.coe.int/documents/fra/2007-44-inf-fra.pdf>

⁵⁹ Hospitalisation is no longer the main form of psychiatric treatment. Today 68 per cent of patients are never hospitalised and 88 per cent are hospitalised with their consent. See: *Regards sur l’actualité*, n°354 (October 2009), p.39.

⁶⁰ Journal Officiel de la République française (hereafter JO), 30 juin 1990, p. 7664.

⁶¹ JO, 5 mars 2002, p. 4118.

⁶² France/Report Inspection générale de l’administration, inspection générale de la police nationale, inspection de la gendarmerie nationale (IGA, IGPN, IGN) (2004), *Rapport sur les problèmes de sécurité liés aux régimes d’hospitalisation sans consentement*, p. 13: <http://lesrapports.ladocumentationfrancaise.fr/BRP/064000271/0000.pdf> (18.10.2009)

⁶³ See for example: Proposition de loi n°1261 27 novembre 2003, Dominique Paillé: <http://www.assemblee-nationale.fr/12/pdf/propositions/pion1261.pdf> (18.10.2009) ; IGA, IGPN, IGN, *Rapport sur les problèmes de sécurité liés aux régimes d’hospitalisation sans consentement*, May 2004 ; Inspection générale des affaires sociales, Inspection générale des services judiciaires (IGAS, IGSJ), *Propositions de réforme de la loi du 27 juin 1990 relative aux droits et à la protection des personnes hospitalisées en raison de troubles mentaux et à leurs conditions d’hospitalisation*, May 2005.

⁶⁴ Loi n° 2009-879 du 21 juillet 2009 portant réforme de l’hôpital et relative aux patients, à la santé et aux territoires J.O., 22 juillet 2009.

⁶⁵ *Regards sur l’actualité*, *Psychiatrie et santé mentale*, n°354 (October 2009), p. 1.

⁶⁶ One can see in this lack of distinction a link with the concept of involuntary placement inherited from the 19th century, when isolating the insane was considered as a means of treatment. See N. Henckes (2009), ‘Psychiatrie et institutions, les dynamiques de changement’ in *Regards sur l’actualité*, n°354, p. 8.

⁶⁷ France/Sénat/Rapport sur la prise en charge psychiatrique en France (08.04.2009).

second concerns respect for patients' rights.⁶⁸ With regards to the first, involuntary treatment may be the consequence of involuntary hospitalisation. However, in criminal law compulsory treatment may be ordered independently of a compulsory placement but this provision does not specifically apply to prisoners with mental disorders. A clear division between compulsory placement and compulsory treatment has been suggested in order to avoid systematic hospitalisation.⁶⁹ Treatment without consent has long been covered up by the belief that people with a mental illness were unable to give their consent to treatment. When a patient refuses the treatment needed, the sole way out appears to be compulsory hospitalisation. The recent report delivered by the Senate in 2009 points out that 'psychiatry must follow the development of other medical disciplines towards the strengthening of patients' rights.'⁷⁰

- [34]. The law does not provide for involuntary hospitalisation without treatment.
- [35]. The French legal framework aims at reaching a balance between public safety and the treatment of people suffering mental disorders.
- [36]. There are two categories of aftercare stipulated by the legal framework: trial release and 'post-treatment' ('post-cure') care. The first aims to prepare the patient for the end of hospitalisation. The law thus reads that 'in order to contribute to their recovery, rehabilitation and social reintegration', persons involuntarily placed may benefit from a 'trial release' (Article L. 3211-11 of the Public Health Code).⁷¹ This entails medical supervision and its duration cannot exceed three months but is renewable. Trial releases are considered as an adjustment to treatment and although the person is allowed to return home, he retains the status of a patient involuntarily hospitalised.⁷² It has been pointed out that this procedure may give rise to a circumvention of the 1990 Act by being too long (in some cases, several years ...). The trial release plays *de facto* the role of a compulsory treatment that the patient must follow, failing which he will be re-hospitalised.⁷³ Abuses have raised various problems and have been criticised accordingly. In particular, trial release leads to breaches of the administrative and medical monitoring of patients. A patient who does not comply with the trial release conditions is not always put back in hospital. Hospitalisation decisions are sometimes annulled even if the patient has run away.⁷⁴ Another difficulty comes from the legal status of the trial release. The Council of State has judged that trial release is a measure that forms part of a patient's treatment and therefore may not be annulled by an administrative court judge.⁷⁵ The second main form of aftercare is placement in post-treatment centres (*centres de post-cure*), provided by a

⁶⁸ Since the 2002 Law the principle is that 'neither medical act nor treatment may be practiced without the free and informed consent of the patient. This consent may be withdrawn at any time.' (Article 1111-4 of the Public Health Code).

⁶⁹ France/*Regards sur l'actualité*, n°354 (October 2009), p. 43 ; France/ Report IGA, IGPN, IGN (2004), *Rapport sur les problèmes de sécurité liés aux régimes d'hospitalisation sans consentement*, p. 44 ; IGAS, IGSJ, *Propositions de réforme de la loi du 27 juin 1990 relative aux droits et à la protection des personnes hospitalisées en raison de troubles mentaux et à leurs conditions d'hospitalisation*, May 2005, p.38.

⁷⁰ France/Sénat/ *Rapport sur la prise en charge psychiatrique en France*, (08.04.2009), p.11.

⁷¹ See Ministère de la Santé, Circulaire DGS/MC4 no 2008-140 du 10 avril 2008 relative aux hospitalisations psychiatriques sans consentement en 2005. http://www.sante.gouv.fr/adm/dagpb/bo/2008/08-05/ste_20080005_0100_0073.pdf (16.10.2009)

⁷² France/Report on *Compulsory Admission and Involuntary Treatment of Mental Ill Patients – Legislation and Practice in EU-Member States* (2002).

⁷³ See, among others, *French Report on Compulsory Admission and Involuntary Treatment of Mental Ill Patients – Legislation and Practice in EU Member States* (2002) and *Inspection générale de l'administration ..., Rapport sur les problèmes de sécurité liés aux régimes d'hospitalisation sans consentement*, May 2004, p. 6. In 2004, trial releases in Paris gave rise to about 65 per cent of involuntary hospitalisations and to about 50 per cent in other counties (*départements*). See: IGA, IGPN, IGN, *Rapport sur les problèmes de sécurité liés aux régimes d'hospitalisation sans consentement*, May 2004, p. 35.

⁷⁴ For an example of a lack of medical monitoring with serious consequences, see France/Cour administrative d'appel de Marseille/07MA03488 (01.10.2009) M. Michel: a patient on trial release escaped and went to his grandmother's house, where he killed her companion. The hospital responsible for monitoring him was judged responsible for these events.

⁷⁵ France/Conseil d'état/170531 (17.11.1997), *CHS d'Erstein*.

circular of 14 March 1990. These centres ensure continuity of treatment after the most difficult period of the illness and permit a transition between hospital and home. They provide medical, psychological, educational and social supervision/follow-up in order to achieve a progressive return to life in society and autonomy.⁷⁶

[37]. Minors may be hospitalised involuntarily.⁷⁷ Among various measures the children's judge can order this (Article 375-3 of the Civil Code). The 2002 Act applies the principles already applicable to other types of placements without consent to minors' hospitalisation. Hence medical advice (provided by a doctor from outside the hospital) is required prior to the placement, which lasts for a maximum duration of 15 days (Article 375-9 of the Civil Code). The decision is renewable for one month on the medical advice of a psychiatrist from the hospital. The list of people entitled to ask for the minor's release is laid out in the Public Health Code (Article L. 3211-10 of the Public Health Code). In the case of disagreement between these people, the judge for family affairs decides. Case law indicates that both procedures (under the Civil Code and Public Health Code respectively) are applicable.⁷⁸ The legal guardian of a minor hospitalised without consent can apply to the judge of liberties and detention for an order for immediate release if appropriate. Both the person who asked for the hospitalisation and the judge of liberties can also request the minor's release (Article L.3211-12 of the Public Health Code).

[38]. Besides prisoners⁷⁹ the 1990 Act does not expressly address the involuntary placement of other groups of patients. The Act of 9 September 2002 acknowledges that it is possible for prisoners to consent freely to hospitalisation for treatment of a mental disorder (Articles L. 3214-1 to L. 3214-5 of the Public Health Code). However, both hospitalisations with or without the consent of a prisoner may take place in a special unit inside the hospital (Article L. 3214-1 of the Public Health Code). Forced placement is decided by the prefect 'when a prisoner suffering from a mental disorder making his consent impossible needs immediate care with constant supervision in a hospital setting' (Article L. 3214-3 of the Public Health Code). When the judge of liberties and detention orders the immediate release of a prisoner 'the prison must be informed of this without delay via the public prosecutor'. The prison administration is responsible for custody and transport when prisoners return to prison. In addition, the law states that prisoners have the same legal rights as other hospitalised patients, except for the limitations due to their status as prisoners (Article L. 3214-2 of the Public Health Code). New establishments are currently being planned for prisoners: (*unités hospitalières spécialement aménagées* (UHSA))specially equipped hospital units]. They are set up in normal hospitals but security is ensured by the prison administration. These units are provided for hospitalisations with and without consent.⁸⁰ A prisoner may be subjected to compulsory treatment during a criminal trial, which is not automatically linked to hospitalisation.⁸¹ Before the verdict, compulsory treatment is regulated by Article 138-10° of the *Code de procédure pénale* [Code of Penal Procedure]. People who are subject to legal restrictions pending trial (*contrôle judiciaire*) may have to undergo medical examination and treatment, particularly in the case of drug

⁷⁶ France/Sénat/*Rapport sur la prise en charge psychiatrique en France* (08.04.2009), p. 61.

⁷⁷ The infrequency of legal cases could be a sign that this kind of measure is rarely used.

⁷⁸ France/Cour de cassation/92-05018 (29.05.1996): the administrative procedure for compulsory hospitalisation provided by the Public Health Code is not the sole procedure applicable. The judge for children is also entitled to entrust a minor to a psychiatric hospital under Article 375-3 of the Civil Code.

⁷⁹ The 2008 report by the national medicine Academy (*Health in prison*, October, 21st, 2008) gives those figures: 96 suicides and suspect deaths registered since January 1st 2008; 25 per cent of the prisoners suffer from mental disorder; the prevalence of schizophrenia in prison is of 13 per cent (versus one per cent of the general population). See Sénat, *Rapport sur la prise en charge psychiatrique en France*, (28.05.2009), p. 106. In 2005 1805 compulsory placements were ordered for prisoners. See Rapport E. Couty *Missions et organisation de la santé mentale et de la psychiatrie*, (January 2009): France/Report E. Couty (2009): http://www.sante-sports.gouv.fr/IMG/pdf/Rapport_Missions_et_organisation_de_la_sante_mentale_et_de_la_psychiatrie.pdf

⁸⁰ 17 of these centres are currently planned; 9 are being built and the first one should open in January 2010 in Lyon. See the report by E. Couty, *Missions et organisation de mental health and psychiatry*, January 2009, p. 31.

⁸¹ France/Ministère de la justice, Ministère de la santé, *Guide des injonctions de soins*, (2009), p. 13.

addiction, even if they are already hospitalised. After a person has been found guilty, the same treatment is provided by Article 132-45 of the Penal Code. After a visit to France in 2006 the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) produced a report where it underlined the poor conditions for mental healthcare in French prisons.⁸²

B. Criteria and Definitions

- [39]. There are two different procedures for involuntary placements in France: *Hospitalisation d'Office* (HO) [compulsory hospitalisation by official order (HOO)] and *Hospitalisation à la Demande d'un Tiers* (HDT) [compulsory hospitalisation at the request of a third party (HRTP)]. Both procedures relate to the general level of risk. Compulsory hospitalisation by official order applies to people 'whose mental disorder requires treatment and jeopardises the safety of others or seriously threatens public order' (Article L. 3213-1 of the Public Health Code). It is based on the idea that these people may cause harm to others. Compulsory hospitalisation at the request of a third party is relevant as a person with a mental disorder cannot be placed involuntarily unless 'his disorder makes his consent impossible' and 'his state requires immediate care with constant supervision in a hospital setting' (Article L. 3212-1 of the Public Health Code). HRTP entitles family members or other people close to him acting in the patient's interest to request his placement in a hospital. This procedure aims above all at protecting the patient. The third party must be able to allege the existence of a relationship with the patient prior to hospitalisation.⁸³ The Public Health Code also provides two fast-track procedures in emergency situations when immediate intervention is necessary.⁸⁴ For HRTP, 'exceptionally and in the case of imminent danger to the patient's health established by a doctor, the manager of the hospital may admit a person on the basis of a single medical certificate' (Article L. 3212-3 of the Public Health Code). Under the procedure for HOO, if there is imminent danger confirmed by medical advice or, failing that, common knowledge, a mayor – or the police commissioners in Paris – may take provisional placement measures (Article L. 3213-2 of the Public Health Code). The law provides no definition of 'common knowledge'. The rare case law in this area indicates that testimonies by local residents may constitute 'common knowledge'.⁸⁵ In order to allow provisional compulsory hospitalisation in the case of imminent danger, the Prefect of Paris set up the *Infirmierie Psychiatrique de la Préfecture de Police* (IPPP) [Psychiatric Infirmary of the Police Prefecture of Paris]. Admission to this infirmary is a type of compulsory hospitalisation permitted under Article L. 3213-3 of the Public Health Code.⁸⁶ It has been widely pointed out that emergency procedures represent an increasing part of the general number of involuntary hospitalisations and have become the rule.⁸⁷ This has mainly been seen as the consequence of the overly restrictive procedure for 'normal' involuntary placement that in particular requires two medical certificates.⁸⁸

⁸² <http://www.unhcr.org/refworld/publisher,COECPT,COUNTRYREP,FRA,475d51af2,0.html> (26.10.2009)

⁸³ France/Conseil d'état/244867 (03.12.2003): having the status of general nurse at a hospital does not entitle someone to request hospitalisation.

⁸⁴ Between 1992 and 2001, a significant increase in 'emergency hospitalisations' without consent was recorded. In 2005, they represented 45 per cent of compulsory hospitalisations on request of a third party (out of 73 809 such hospitalisations in total) and 63 per cent of compulsory hospitalisations by official order (out of 13 443 such hospitalisations in total). See Circulaire DGS/MC4 n° 2008-140 du 10 avril 2008 relative aux hospitalisations psychiatriques sans consentement en 2005.

⁸⁵ France/Conseil d'état/164453 (11 March 1996), Commune de Saint-Herblain. On this issue see also European Court of Human Rights/44568/98 (19 May 2004), *R.L. and M. JD v. France*.

⁸⁶ France/Cour administrative d'appel de Paris/07PA00168 (21.12.2007), Police Prefect of Paris.

⁸⁷ National Ethics Advisory Committees, *Treatment refusal and autonomy of the person*, Advice n°87, 14 April 2005, p. 11; IGAS, IGSI, *Propositions de réforme de la loi du 27 juin 1990 relative aux droits et à la protection des personnes hospitalisées en raison de troubles mentaux et à leurs conditions d'hospitalisation*, p. 18

⁸⁸ See Ministry of Health, Circular n° 2008-140 10 April 2008 relating to involuntary psychiatric hospitalisations in 2005, p. 6.

Lastly, the law regulating involuntary hospitalisations does not suggest use of less intrusive alternatives before an involuntary placement is ordered.

- [40]. The law does not take into account the patient's opinion or require it to be given during involuntary hospitalisation. The legal procedures involved in involuntary placement rest on the principle that the mental disorders make the patient's consent impossible. Nevertheless an order by the prefect is illegal if passed without a verbal statement by the patient, if it has not been proved that his state of makes this impossible.⁸⁹

C. Assessment, Decision Procedures and Duration

- [41]. It is the administrative authorities who decide on HOO: a prefect, hospital manager, or mayor. As regards H RTP, the request must be written and signed by the person asking for hospitalisation and indicate the nature of relationship with the patient. The request must be accompanied by two recent medical certificates (less than 15 days old). One of the two certificates on the mental state of the patient must be issued by a doctor not practising in the establishment where the person will be hospitalised. In the 24 hours following admittance, a psychiatrist issues a medical certificate rejecting or confirming the need for hospitalisation. This certificate is sent by the director of the establishment to the prefect and to the county (*départementale*) commission for psychiatric hospitalisations. It follows that initial placement under this procedure may last only 24 hours. A psychiatrist examines the patient again three days before the end of the first 15 days of hospitalisation. The psychiatrist can either decide to release the patient or continue hospitalisation for a maximum period of one month. Beyond one month, the patient can be kept in hospital for a maximum renewable period of one month according to the same conditions. In addition, it must be emphasised that H RTP may be transformed into HOO by the prefect through a temporary decision if the patient fulfils the criteria for this kind of involuntary placement. To be valid this decision must be confirmed within a period of 15 days (Article L. 3213-6 of the Public Health Code). HOO is carried out through an administrative order issued by the local prefect to commit a person to a hospital in view of a detailed medical certificate issued by a psychiatrist not practising in the hospital where the patient will be admitted (Article L. 3213-1 of the Public Health Code). In the 24 hours following the patient's admittance, the director of the hospital sends to the prefect and the county (*départementale*) commission for psychiatric hospitalisations a second medical certificate issued by a psychiatrist of the hospital. It may be decided at this moment to end the hospitalisation, which means that the duration of the initial placement may be 24 hours. Then the patient is regularly examined by a psychiatrist in order to verify that forced hospitalisation is still justified (after 15 days, then at least every month). The medical certificate issued each time is sent to the prefect. In the three days preceding the end of the hospitalisation, the prefect can, on the advice of a psychiatrist, decide to extend hospitalisation for a period of three months. Beyond these three months, hospitalisation can be maintained for a period of six months renewable on the same conditions (Article L. 3213-4 Public Health Code).⁹⁰ For emergency hospitalisation under the HOO procedure, either medical advice or 'common knowledge' is sufficient. Then the mayor – or police commissioners in Paris – may take provisional placement measures but must refer the matter to the prefect within 24 days. The local prefect must then issue a decision within 48 hours if involuntary hospitalisation is to be continued (Article L. 3213-2 of the Public Health Code). This means that a person may be involuntarily hospitalised without the intervention of a medical expert. In the

⁸⁹ France/Cour administrative d'appel de Lyon/07LY02624 (09.07.2009), Monsieur André X.

⁹⁰ In 2005 compulsory hospitalisation on the request of a third party over three months accounted for 15 per cent of all hospitalisations of this type. Hospitalisations on official order renewed after the fourth month accounted for nearly 29 per cent of all hospitalisations of this type. Source: Ministry of Health, Circular no^o2008-140 of April 10th 2008 relating to psychiatric hospitalisations without consent in 2005.

emergency procedure for H RTP in the case of imminent danger to the patient's health, a doctor must confirm the risk. A hospital manager may hence admit a person on the basis of a single medical certificate. This single certificate may be drawn up by a psychiatrist practising where the patient will be hospitalised (Article L. 3212-3 of the Public Health Code). The intervention of an administrative instead of a judicial authority has led to numerous debates and criticisms. In 1990 the Parliament debated this but finally decided that administrative authorities would continue to decide on placement, and that court judges would safeguard personal rights and freedoms. It has been nevertheless criticised by the Council of Europe Commissioner for Human Rights A. Gil-Roblès in his *Report on the effective respect for human rights in France in 2005* (§373).⁹¹ The French authorities pointed out in their response that the Recommendation of the Committee of Ministers of the Council of Europe on the protection of the human rights and dignity of persons with mental disorder allows the intervention of 'a court or other competent body' (Article 20 of the Recommendation). The French authorities added that the explanatory report accompanying the Recommendation specifies that 'the underlying principle is that the decision is made by a party who is independent from the person or body proposing the measure,' which is the case in France.

- [42]. The termination of the involuntary placement may be decided by a judge (Article L. 3211-12 of the Public Health Code) or an administrative authority. An application may be made to a judge of liberties and detention at any time by the patient, the people taking care of him, his relatives, the person who asked for his hospitalisation, the public prosecutor (*procureur de la République*) or even the judge himself. This role of the judge seems however not well known and the number of requests is small.⁹² The termination may also be ordered by the prefect based on medical advice.
- [43]. The case of a voluntary placement becoming involuntary is not regulated by law.
- [44]. No indication of duration between the psychiatric assessment and the beginning of the compulsory placement is provided by law. We can only note that for H RTP, the request must be accompanied by two recent medical certificates (no older than 15 days) (Article L. 3212-1 of the Public Health Code). The law does not currently provide any clear duration before the implementation of the hospitalisation itself.⁹³
- [45]. For the H RTP emergency procedure (Article L. 3212-3 of the Public Health Code) the law does not provide for the duration of the hospitalisation. For the HOO emergency procedure the mayor – and the police commissioners in Paris – may take provisional placement measures but must refer the matter to the prefect within 24 hours. The local prefect must issue a decision within 48 hours if involuntary hospitalisation is to be continued (Article L. 3213-2 of the Public Health Code), failing which the provisional decision is invalidated.⁹⁴ Concerning the duration applicable to the initial placement under the common procedure of hospitalisation, a person may be hospitalised for 24 hours before a new approval is required (Article L. 3212-4 and 3213-1 of the Public Health Code).

⁹¹ Council of Europe/ Report by Mr Alvaro Gil-Robles, Commissioner for Human Rights, on the effective Respect for Human Rights in France following his Visit from 5 to 21 September 2005 (15.02.2006): <https://wcd.coe.int/ViewDoc.jsp?id=965765&Site=CommDH&BackColorInternet=FEC65B&BackColorIntranet=FEC65B&BackColorLogged=FFC679>

⁹² IGAS, IGSJ, *Proposals for a reform of the act of 27 June 1990 related to the rights and the protection of the persons hospitalised for mental disorder and the conditions of their hospitalisation*, (May 2005), p. 3.

⁹³ France/Cour de cassation/04-82558 (23.11. 2004).

⁹⁴ See France/Cour administrative d'appel de Paris/07PA00168 (21.12.2007), Police prefect of Paris: Despite the very brief duration of the placement without consent, admission into the Psychiatric Infirmary of the Police Prefecture of Paris is a type of hospitalisation without consent giving the right to information and, in particular, to a lawyer.

- [46]. Besides the general principle of the integrity of the human body entrenched in the Act of 27 July 1998, no express mention of the various health care interventions or coercive measures applied to persons with mental disorder can be found.⁹⁵ However, Article R4311-6 of the Public Health Code reads as follows: ‘In the field of mental health, a nurse shall perform the following acts and care: [...] 3° Supervision of persons in an isolation room.’⁹⁶
- [47]. Because forced hospitalisations undermine individual freedoms and owing to the risk of abusive placement, the legal framework offers strong guarantees. It has been asserted that ‘practical application of the law does not demonstrate that breaches of civil liberties are being committed.’⁹⁷ On the other hand, the Council of Europe Commissioner for Human Rights pointed out in his 2005 report that ‘very few appeals are filed before the president of the regional court’. These guarantees should be analysed in the light of the involvement of administrative and judicial authorities, given that in theory several administrative and judicial authorities are entitled to visit establishments where mentally ill persons are hospitalised (prefects, judges, mayors or their representatives, and county commissions). This obligation is however unequally fulfilled.⁹⁸ In addition two observations question the real independence of these bodies as required by the Recommendation Rec (2004)10 of the Committee of Ministers of the Council of Europe. On the one hand, the authorities who are entitled to decide compulsory hospitalisation are also expected to monitor possible abuses. On the other hand, the function of the *Commissions départementales des hospitalisations psychiatriques* (CDHPs) (county commissions for psychiatric hospitalisations) is not devoid of ambiguity. They are vested with important powers such as the visiting hospitalised people and assessing a patient’s situation, the power to ask for his/her release before the judge and the capacity to order the direct release of people hospitalised involuntarily at the request of a third party. They regularly provide a great deal of information through their annual reports.⁹⁹ However, they appear to be too discrete and their independence is subject to some doubt as most of their members are appointed by the prefect.¹⁰⁰ Lastly, all types of compulsory hospitalisation may be brought before a judge. A specificity of the French system must be emphasised that may become a drawback for an applicant who already belongs to a vulnerable group: matters relating to involuntary placements fall under the jurisdiction either of the administrative courts or the ordinary courts. It is clear today that the former are competent to judge the lawfulness of compulsory hospitalisation orders while the second review the grounds of the orders.¹⁰¹ The literature analyses variously – whether it benefits or not to the applicant – the possibility to go before the administrative court judge in case of serious violation of a fundamental freedom. The question of the positive effects of the legal possibility to seize the judge in emergency in case of a high breach of a fundamental freedom is variously analysed (Article L. 521-2 of the administrative justice code).¹⁰² Mental disorders do not prevent a person from receiving free legal support. The criterion to receive such support is financial and does not depend on the status of the person requiring it.¹⁰³

⁹⁵ See France/ Cour administrative d’appel de Marseille n°05MA01245 (25 January 2007), Ms X: this case indicates a kind of ‘hierarchy’ of various coercive measures and health care interventions with regard to the dignity of the hospitalised person.

⁹⁶ This issue seems to relate to medical practice but raises nevertheless the question of the violence against people with a mental disorder (see IV – Specific fundamental rights).

⁹⁷ French report on *Compulsory Admission and Involuntary Treatment of Mental Ill Patients – Legislation and Practice in EU-Member States* (2002).

⁹⁸ France/IGAS, IGSJ, Propositions de réforme de la loi du 27 juin 1990 relative aux droits et à la protection des personnes hospitalisées en raison de troubles mentaux et à leurs conditions d’hospitalisation, (May 2005), p. 38.

⁹⁹ France/IGAS, IGSJ, Propositions de réforme de la loi du 27 juin 1990, p.40.

¹⁰⁰ J. Coelho (2006) ‘Hospitalisations psychiatriques sous contrainte: plaidoyer pour une réforme’, in *Revue de droit sanitaire et social*, p. 249.

¹⁰¹ France/Tribunal des conflits/97-03045 (17.02.1997), Préfet de la Région Ile de France.

¹⁰² See J.-H. Stark, Ph. Bernardet, *Le contrôle de la légalité de l’hospitalisation psychiatrique d’office par le juge des libertés et de la détention*. http://www.groupeinfoasiles.org/allfiles/theses-etudes-doctrine/art_vermote2.pdf

¹⁰³ France/ Act 91-647 (10.07.1991), Article 2.

VI. Competence, Capacity and Guardianship

- [48]. The relevant legal framework for managing the affairs of people with mental disorders and intellectual disabilities currently consists of three levels of legal supervision for ‘protected adults’: judicial safeguard (*sauvegarde de justice* – caretaking with full capacity), ‘curatorship’ (*curatelle* – partial guardianship) and ‘tutorship’ (*tutelle* – full guardianship)¹⁰⁴.
- [49]. The legal framework does not provide precise definitions of ‘competence’ and ‘capacity’. However, Article 425 of the Civil Code mentions the causes of incapacity giving rise to the imposition of a protection procedure: a protection procedure is ordered for ‘any person who cannot provide by him/herself for his/her own interests because of a medically certified alteration of the mental or physical faculties likely to prevent expression of his/her will’. The law then indicates the level of competence for each degree of legal protection in line with the WHO resource book on mental health (7.1).
- [50]. The legal provisions do not recognise degrees of incapacity (in the meaning of the WHO resource book on mental health (7.1)) but rather focus on the consequences of the incapacity. Under Article 425 of the Civil Code, it must be ‘impossible’ to provide for one’s own interests. However, a reference to the state of health of an adult lacking legal capacity appears in Article 442 of the Civil Code which refers to the event that ‘the impaired faculties of the person are not open to improvement given current scientific knowledge’. In application of the principle of proportionality reaffirmed by the 2007 Act a protection order must be ‘proportionate and individualised depending on the degree of alteration to personal faculties [i.e. mental and/or physical faculties]’ (Article 428). Accordingly it is incumbent on the guardianship judge (*juge des tutelles*) to take into account the degree of incapacity in each case, assisted by medical advice (Article 431 of the Civil Code). The Act of 5 March 2007 substituted these criteria for the previous criteria of ‘prodigality’, ‘intemperance’ and ‘idleness’.¹⁰⁵ Thus it establishes a distinction between legal and social protection and focuses on the medical state of adults whose mental faculties are impaired.
- [51]. The basic features of each regime of legal protection and the conditions to meet are stipulated in the legal provisions relating to each. Although they all have their own features some principles are common to the three: protection is respectful of individual rights and freedoms and of dignity (its objective is to promote the interests of the adult in question; it aims, when possible, enable her/his autonomy; protection is a duty of families and the community) (Article 415 of the Civil Code); the criteria for requesting protection (see above); and the necessity for a medical certificate from a doctor featuring on a list drawn up by the public prosecutor (Article 431 of the Civil Code). The system of judicial safeguard is aimed at people in need of temporary legal protection or of representation to accomplish a specific list of actions (Article 433 of the Civil Code). The principle is that the person can still exercise his/her rights. A special representative may be appointed and will act on behalf of the person for the performance of some actions. As regards curatorship, two conditions must be met: impaired ‘personal faculties’ (i.e. physical and/or mental faculties) and the necessity of advice or supervision in the important ‘actions of daily civil life’, i.e. everyday actions with legal implications (Article 440 of the Civil Code). An adult under curatorship can accomplish by her/himself the actions of daily civil

¹⁰⁴ The Act of 5 March 2007 which modifies many provisions of the former regime came into force on 1 January 2009. In addition its implementation depends on administrative regulations (*décrets d’application*) enacted progressively.

¹⁰⁵ See French Report in *Comparative Study on the Legal Systems of the Protection of Adults Lacking Legal Capacity* (2008), p. 61.

life other than those requiring the authorisation of the family council or the guardianship judge. In fact the curator intervenes only in actions that result in a reduction of the protected adult's assets. The 2007 Act introduced a strengthened form of curatorship that implies the following conditions and consequences: the imposition of such protection may be ordered at any time; the curator is required to open an account in the name of the protected person and his/her powers are accordingly extended; the conditions of supervision are close to those of tutorship. However, although the protected adult loses access to his/her income, he/she remains the ultimate decision-maker through the requirement for a co-signature (Article 472 of the Civil Code). A tutorship order requires the protected adult to have impaired faculties and need to be constantly represented in actions of civil life. It is ordered only if all other categories of protection are insufficient (Article 440 of the Civil Code). The protected adult retains the ability to perform actions that the law and custom allow her/him to do alone. Two other forms of tutorship are possible: complete tutorship with a family council (if the management of assets requires it, Article 456 of the Civil Code) and modified tutorship (Article 473 of the Civil Code) that is characterised by an authorisation granted by the judge to the protected adult to carry out some specific acts by her/himself. Depending on the circumstances, the judge decides the appropriate level of protection.

- [52]. Unlike the previous Act of 3 January 1968, the new legislation of 2007 provides maximum terms for each regime (but no minimum term). Judicial safeguards cannot exceed two years (one year, renewable once) (Article 439 of the Civil Code). For tutorship and curatorship the maximum term is 10 years (five years renewable once) (Article 441 and 442 of the Civil Code). When the impaired faculties of the person are not liable to improvement given current scientific knowledge, the judge may, through a reasoned decision and in accordance with medical advice, renew the protective measure for a longer time (Article 442 of the Civil Code).
- [53]. The people entitled to request that an adult lacking capacity be placed under a protective regime are, under Article 430 of the Civil Code: the person requiring protection; a spouse; a civil partner; cohabiting partner; a relative; a person with close and stable ties with the person; and the public prosecutor. In addition a request for judicial safeguard may be made by a doctor if he is treating a person in need of protection. He files a request to the public prosecutor with the medical advice of a psychiatrist (Article 434 of the Civil Code).
- [54]. The national authorities are vested with the power to declare an adult's legal incapacity and then to ensure and monitor the implementation of measures taken by the various guardians or the protected adult (see below). The French legal framework provides that judges are solely responsible for this oversight. It is mainly the guardianship judge who orders protection orders entailing an adult's legal incapacity. A judicial safeguard order may be also issued by the public prosecutor (Article 434). The Civil Code requires them to hear the person to be protected, unless such a hearing might cause harm to the adult or if he/she is unable to express his/her will (Article 432 of the Civil Code). Measures aiming to protect the person and her/his property are carried out by the relevant guardian for each type of legal incapacity (Article 425 and ff of the Civil Code). The guardianship judge and the public prosecutor exercise general supervision over guardianships in their jurisdiction. The former may convene statutory administrators and guardians and require clarifications from, make observations to and grant injunctions against them (Article 416 of the Civil Code).
- [55]. The appeal procedure against a protection order lacks clarity.¹⁰⁶ The Act of 5 March 2007 does not indicate who is entitled to bring an appeal against the decision. One has to refer to the provisions of Article 1256 of the *Code de procédure civile* [Civil Procedure Code]

¹⁰⁶ J.-J. Lemouland, D. Noguéro, J.-M. Plazy (2009), 'Panorama d'actualité relative aux majeurs protégés', in *Recueil Dalloz*, p. 2186.

which is still in force. This refers to the former 1968 Act which stipulated that the people who may request a protection order are also those who can bring an appeal against it.¹⁰⁷ The appeal can take two forms in so far as it may be introduced by a lawyer or a person authorised to act (Articles 1256 of the Civil Procedure Code). The matter should be brought before a *Tribunal de grande instance* [trial court]. It is however planned that from 2010 a judge ‘delegated to the protection of the adults’ will be designated within each court of appeal and will preside over the panel of judges in charge of such matters (Article L. 312-6-1 of the *Code de l’organisation judiciaire*, Code of Judicial Organisation).

- [56]. The principle is now – since the 2007 Act – that the protected adult can freely choose the person or body that will implement the measures. Under the judicial safeguard regime, the appointment of a representative is not compulsory. If intervention is necessary, he/she is chosen by the protected adult, or the judge will appoint a special representative (Article 437 of the Civil Code). Under curatorship and tutorship, the protected adult also plays an important role in designating a guardian either by choosing one by himself or, when it is incumbent on the judge to do so, by having his opinion taken into account (Article 448 of the Civil Code). The rule is that in the event that the protected adult has made no choice, the judge will choose, in order, a spouse, a registered partner, a relative or a person having close and stable ties with the adult (Article 449 of the Civil Code). Finally, if none of these people is available, the judge will appoint a person appearing on the list of judicial representatives (Article 450 of the Civil Code). The priority given to the family was partly explained by the cost of protection by a judicial representative.¹⁰⁸ A guardian external to the family becomes compulsory when the protected adult is placed in an institution. A person or department of the medical establishment taking in the adult will be in charge of performing the protection order.
- [57]. Under the judicial safeguard regime, the person in the state of incapacity retains the exercise of his/her rights. Protection may take place *a posteriori* through revision of actions that he/she has undertaken (Article 435 of the Civil Code). The guardianship judge may appoint a special representative to undertake actions necessary to manage the protected adult’s assets (Article 437). Since the enactment of the 2007 Act, this special representative may be vested with a responsibility to protect the adult lacking legal capacity beyond the strict management of assets (Article 438 of the Civil Code). Curatorship meanwhile allows the curator to support the protected adult to perform actions that would require the authorisation of the family council or the guardianship judge (Article 467 of the Civil Code). This mostly concerns the sale of assets. The judge may specify a list of transactions which the person cannot accomplish alone. In contrast, a person placed under tutorship can perform only the legal actions that the judge has enumerated in a list drawn up in accordance with the advice of the person’s doctor (Articles 467 and 471 of the Civil Code). The person is also free to act for him/herself where the law or custom allows (Article 473 of the Civil Code). In addition the 2007 Act provides that a protected adult can perform alone actions which require strictly personal consent (Article 458 Civil Code).
- [58]. The appeal procedure against a decision to appoint a guardian is identical to the procedure described above and is specifically regulated by Article 1214 of the Civil Code. The principle is that any interested person is entitled to bring the matter to court.¹⁰⁹
- [59]. The law does not provide any timescale for reviewing judicial decisions relating to incapacity. Nevertheless the guardianship judge and the public prosecutor exercise general supervision over all incapacity orders which fall under their competence. They have the

¹⁰⁷ France/Cour de cassation/0620810 (03.12.2008).

¹⁰⁸ J.-J. Lemouland, D. Noguéro, J.-M. Plazy (2009), ‘Panorama d’actualité relative aux majeurs protégés’, in *Recueil Dalloz*, p. 2188.

¹⁰⁹ France/Cour de cassation/ 0812923 (20.05.2009).

authority to visit the protected person or those who requested the incapacity order (Article 416 of the Civil Code). In addition the judge may order the end of judicial safeguard at any time if the need for temporary protection ceases (Article 442 of the Civil Code). He can do the same for the other regimes of incapacity after he has taken the guardian's advice (Article 442 Civil Code).

- [60]. The law does not provide any timescale for reviewing the need for a guardian. However the guardianship judge may give orders to the person responsible for protection and relieve them of their task if they fail to fulfil it correctly (Article 417 of the Civil Code).

VII. Miscellaneous

- [61]. The idea here is to focus on mental health as an issue linked to crime. The objective of crime prevention often leads to a security-driven vision of mental disorders and favours punishment to the detriment of medical treatment. Two issues are relevant here: lack of criminal responsibility in mental disorders and preventative detention [rétention de sûreté] for prisoners who continue to present a danger after they have completed their sentence. Under Article 122-1 of the Penal Code, 'a person is not criminally responsible when at the moment of the events he suffered from psychiatric or neuropsychiatric disorders that destroyed his judgment'. These provisions aim to protect people with significant mental disorders from a criminal sentence that they are not able to understand. Nevertheless, over the last several years, we have seen a 'current trend towards the criminalisation of mental illness. Thus, the "psychiatric acquittals" represented 0.51 per cent of criminal cases in 1990 while they amounted to 0.17 per cent in 1997'.¹¹⁰ Since the Act of 25 February 2008 a person declared free from criminal responsibility because of a mental disorder (Article 122-1 of the Penal Code), may be involuntarily hospitalised.¹¹¹ The decision is made by a judge, who must immediately inform the prefect (Article 3213-7 of the Public Health Code). The prefect remains free to order hospitalisation or not.
- [62]. In addition the 2008 Act introduced the much-discussed preventative detention (Article 706-53-13 ff of the Penal Code). This means placement in a socio-medico-judicial security centre on the grounds of public safety beyond the expiry of the term of imprisonment. It is applicable to prisoners who exhibit a particular level of danger [dangerosité] characterised by a high probability of a second offence because of a serious personality disorder and who were sentenced at least 15 years' imprisonment. The level of danger is assessed at least one year before release by the commission for public safety measures. The person is offered release on the condition that he undergoes permanent medical, social and psychological treatment. No case law is available yet.
- [63]. Very recently the question of compulsory physical castration of sexual offenders has been raised. For the time being it remains simply a matter of public debate but many psychiatrists and doctors have taken the opportunity to state that, beyond the obvious ethical objections, the effectiveness of this method has not been proved.

¹¹⁰ A. Lovell, *Travaux préparatoires à l'élaboration du Plan Violence et Santé en application de la loi relative à la politique de santé publique du 9 août 2004*, March 2005, p. 43 et seq.

¹¹¹ France/Loi/2008-174 (25.02.2008) relative à la rétention de sûreté et à la déclaration d'irresponsabilité pénale pour cause de trouble mental.
http://www.legifrance.gouv.fr/affichTexte.do;jsessionid=7D346FCD3FA10EF226CEAE5247D15416.tpdjo02v_1?cidTexte=JORFTEXT000018162705&categorieLien=id

Annex – Case Law

Case title	Mr Michel
Decision date	01.10.2009
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	Administrative Court of Appeal of Marseille, n°07MA03488
Key facts of the case (max. 500 chars)	Mr Gaillard had been hospitalised involuntarily after several acts of violence and attempted murder. Two years after he benefited of a trial release measure. He didn't go to an appointment at the hospital but was instead successful in escaping and turned to his grand-mother where he killed her companion.
Main reasoning/argumentation (max. 500 chars)	Aware of the patient being particularly dangerous, the hospital should have taken the necessary measures of survey. Therefore, it is responsible for a faulty managing of the service. A link has been also established between the murder and this fault of the hospital.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The trial release is not directly the cause of the decease. The responsibility of the State (the Prefect) cannot therefore be engaged. The decease is directly linked to the lack of survey by the hospital
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	The hospital will allocate compensation to the victim's son (Mr Michel) for the moral harm/prejudice.
Proposal of key words for data base	Involuntary hospitalisation; trial release; measures of survey;

Case title	M. André X.
Decision date	09.07.2009
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	Administrative Court of Appeal of Lyon, N°07LY02624
Key facts of the case (max. 500 chars)	By a decree in 17 June 2004, the prefect of Savoie ordered the compulsory hospitalisation of Mr. X; the Administrative Tribunal of Grenoble (2 October 2007 decision) rejected the request of the repeal of the prefectural decree. Mr. X. asks to override the abuse of power of the aforementioned order
Main reasoning/argumentation (max. 500 chars)	The prefectural decrees of compulsory hospitalisation, although subjected to the obligation of reasoning found in Article L.32131 of the aforementioned Public Health Code, remain understood in the scope of Article 24 of the law of 12 April 2000; that subjected to the general obligation of reasoning of the aforementioned 1 st Article of the law instituted for the measurements of police, they cannot intervene, in the absence of provisions of the Public Health Code organising a particular procedure, except emergency or special circumstances only after the person concerned was able to present his/her observations, one that had been determined impossible to record them; The decree of 17 June 2004, was taken without Mister X being able to present his observations, while it is not alleged that his state of health would have returned this impossible requirement and that the medical records that emerged had shown that there was not any kind of emergency, nor special circumstances; since then, this one is based on the request of repeal, as well as the judgement attacked that rejected the request of annulment of the aforementioned order.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	Except for emergency, special circumstances or impossibility for the person concerned to present his/her observations, the prefectural decrees of the compulsory hospitalisation must be explained and cannot be taken before the concerned person could present written or oral observations.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	The prefectural decree orders on compulsory hospitalisation of Mr.X as well as the judgement of the Administrative Tribunal of Grenoble of 2 October 2007 have been annulled. The State will pay 1 500 euros under Article L.761-1 of the code of administrative justice.
Proposal of key words for data base	Involuntary placement; compulsory hospitalisation; motivation of the reasoning of placement; written and oral observations of the person concerned

Case title	Lespinasse-Paoli
Decision date	28.05.2009
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	Cour administrative d'appel de Marseille, n°07MA03752
Key facts of the case (max. 500 chars)	The child had been placed in a children's home for behavioural troubles. Following a violent crisis, the child had been hospitalised immediately into a psychiatric department for adults in a hospital. The parents request for compensation of the damage resulting from the placement of their child in this department.
Main reasoning/argumentation (max. 500 chars)	The hospitalisation in a psychiatric department intended for adults, even regrettable, cannot be the responsibility of the hospital because there was an urgency to treat the child's troubles. In addition, the paediatric department of the hospital does not have accommodations for children attained for serious disturbances. However, the doctor who had originally made this decision had alerted the district attorney on the impossibility to have a suitable area for the situation.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The hospitalisation of a child into a psychiatric department for adults is not contrary to Article 3 of ECHR. The hospital can no longer recognise its responsibility in the absence of other solutions for the seriousness of the mental disturbances of a child.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	The request of the parents was rejected.
Proposal of key words for data base	Involuntary hospitalisation-children

Case title	Police Prefect of Paris
Decision date	21.12.2007
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	Administrative Court of Appeal of Paris N°07PA00168
Key facts of the case (max. 500 chars)	The Police Prefect of Paris refused to inscribe in the welcome charter of the psychiatric infirmary of the police prefecture the patient's right to a lawyer. The Group Information Asylums asked the administrative court to annul the decision of refusal of the Police Prefect of Paris. The prefect asks the annulment from the Administrative Tribunal of Paris.
Main reasoning/argumentation (max. 500 chars)	In order to allow the provisional compulsory hospitalisation in case of imminent danger, the prefect of Paris created a structure called Psychiatric Infirmary of the Police Prefecture of Paris (IPPP). The admission to the IPPP constitutes a measure of compulsory hospitalisation governed by Article 3213-3 c. public health. Despite the very brief duration of placement without consent, the admission in the IPPP is a kind of hospitalisation without consent giving the right to information and, in particular to an advocate.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The obligation to inform his/her admission of a person attainted for mental disturbances who is hospitalized without consent of his/her juridical situation of his/her rights, notably consulting a lawyer of his/her choice, does not limit himself/herself to HDT(Hospitalisation at the Request of a Third Party) or Compulsory Hospitalisation, but to emphasize the series of hospitalisations without consent.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	The request of the Police Prefect of Paris was rejected.
Proposal of key words for data base	Compulsory Hospitalisation; imminent danger; obligation to inform a patient of his/her rights; right to consult a lawyer

Case title	Mr Philippe A.
Decision date	06.04. 2007
Reference	Council of State, n°280494
Key facts of the case (max. 500 chars)	Mr A. asks the annulment of the decision refusing him a compensation for the damage which resulted from the non respect of his right to private correspondence with a hospitalised person (Mr B.)
Main reasoning/argumentation (max. 500 chars)	By deciding that Mr B. could send mails under the sole condition they would be sent through the intermediary of an advocate, the hospital limited illegally Mr B.'s right to send mails. Mr. A is entitled to ask for a compensation.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	According to Article L. 3211-3 of the Public Health Code, the person involuntarily hospitalised has the right to send and to receive mail. It has been decided by the administrative judge that the exercise of this right may not be subjected to the condition to address the mail through an advocate
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	L'arrêt de la Cour administrative d'appel est annulé. Le centre hospitalier est condamné à verser à Mr A. la somme d'un euro symbolique en réparation du préjudice moral causé par la limitation au droit de correspondre avec une personne hospitalisée d'office.
Proposal of key words for data base	Involuntary Placement (HO procedure); rights of the placed person (mail)

Case title	Ms X.,
Decision date	25.01.2007
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	administrative court of appeal of Marseille, n°05MA01245

Key facts of the case (max. 500 chars)	Ms X.s'son was involuntarily hospitalised. As he was agitated and aggressive he has been placed in an isolation room. He voluntarily let himself fall on the floor and died. His mother argues that the hospital is responsible for his death.
Main reasoning/argumentation (max. 500 chars)	It was medically justified to use the isolation room and medicines rather than the physical contention. The hospital is therefore not responsible of the death of Ms X.'s son
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	This case mentions various coercive measures and health care interventions and establishes a kind of "hierarchy" with regard to the dignity of the hospitalised person. The contention is limited to the most extreme situations and should be used after the failure of the speech, the medicines and, at last, the isolation room.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	The request of Ms X. is rejected.
Proposal of key words for data base	Involuntary hospitalisation; responsibility of the hospital; coercive measures

Case title	Mrs. Sylviane X.
Decision date	01.04.2005
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	Council of State, N°264627
Key facts of the case (max. 500 chars)	Mrs.X, application of prefect of police decree on 9 January 1997, repealed the following 17 February, the act of compulsory hospitalisation on the basis of provisions of Article L.342 of the Public Health Code when applicable; by the decree attacked 24 November 2003, the Administrative Court of Appeals of Paris annulled a judgement of the Administrative Tribunal of Paris on 8 December 2000 as it was annulled the first of these decrees for <u>the lack of notification</u> and the second owing to its <u>late intervention</u> .

<p>Main reasoning/argumentation (max. 500 chars)</p>	<p>*If it falls under the administrative jurisdiction to assess the regularity of the administrative decision ordering compulsory hospitalisation, the judicial authority controls the necessity of compulsory hospitalization into a psychiatric hospital that, when the administrative jurisdiction declared on the regularity of the administrative decision of hospitalisation, gives a ruling on the harmful consequences of this decision, including those that follow the irregularity.</p> <p><i>*The administrative authority, when it declares a decree of compulsory hospitalisation, must, in part, indicate in its decision the considerations of law, circumstances and facts that justify this measure. It arises, on the other hand, from Article L.3213-1 of the Public Health Code, combined with Article 9 of the International Covenant on Civil and Political Rights that once a decision is taken, the administration must inform the motives of the interested person as soon as possible, in a manner appropriated to its state.</i></p> <p>The unawareness of the first obligation makes the decision of the compulsory hospitalisation illegal and leads to the annulment by the administrative judge. But the lack of accomplishing the second obligation, which relates to the execution of the measure of involuntary placement, does not affect its legality.</p> <p>*concerning the decision to put an end to hospitalisation: if a psychiatrist declares on the medical certificate that the release can be ordered, the director of the establishment is required to consult to the prefect, within 24 hours, who gives immediate rulings.</p> <p>The late characteristic of the decision taken by the prefect puts an end to compulsory hospitalisation and without an impact on its legality.</p> <p>The person interested must ask a judiciary judge for the compensation of the damage resulting from the error made by the administration by not giving an immediate ruling on the release of the person compulsory hospitalized.</p>
<p>Key issues (concepts, interpretations) clarified by the case (max. 500 chars)</p>	<p>Competence of administrative jurisdiction to control the regularity of the decision ordering the compulsory hospitalisation.</p> <p>The judicial authority is alone responsible for 1) assessing the necessity of compulsory hospitalization in a psychiatric hospital 2) giving rulings on the harmful consequences of this decision, including those who follow its irregularity, after administrative jurisdiction delivered the legality of the administrative decision of hospitalisation.</p>
<p>Results (sanctions) and key consequences or implications of the case (max. 500 chars)</p>	<p>The request of Mrs. X. was rejected.</p>
<p>Proposal of key words for data base</p>	<p>Compulsory hospitalisation; rules of judicial competence; regularity and legality of a decision of compulsory hospitalisation</p>

Case title	Specialised Hospital Centre of Caen
Decision date	03.12. 2003
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	Conseil d'Etat, N°244867/Council of State, N°244867
Key facts of the case (max. 500 chars)	The patient had been hospitalized at the request of the General nurse representative of the Director of the General Hospital Centre where she must be admitted. She asked for the annulment of the decision of the Director of the establishment. The administrative tribunal, then the Administrative Court of Appeals, annulled this decision. The Specialised Hospital of Caen presented itself before the Council of State.
Main reasoning/argumentation (max. 500 chars)	If the third party that requests hospitalisation is not in the state of finding family ties with the patient attainted for mental disturbances, he/she must justify the existence of relations previous to the request. The status of the General Nurse of the General Hospital where the patient was admitted did not suffice to justify the existence giving him/her the capacity to act.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The request of hospitalisation of a person attainted for mental troubles by a third party must be presented by a family member of a person susceptible to act in the interest of the sick one, with the exclusion of medical personals at the hospital. This person must be capable of justifying the existence of relations previous to the request of hospitalisation.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	The request of the Specialised Hospital Centre of Caen was rejected.
Proposal of key words for data base	Hospitalisation at the request of a third party; notion of third party of the patient; person justifying the existence of relation previous with patient

Case title	
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Decision date	24.03.1998
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	Court of cassation (97-11252)
Key facts of the case (max. 500 chars)	Mr Y suffers from an incurable illness depriving him of the possibility to speak. His mother and legal administrator requested the authorisation to marry him with Ms Z he lives with for 30 years and has a son. The family council gave its agreement, the tutorship judge excepted.
Main reasoning/argumentation (max. 500 chars)	The tutorship judge seized the judge and put forward the lack of a substantial formality such as the audition of the adult protected by the family council and the lack of element proving the will of the protected adult to marry. If the first argument doesn't give right to an action against the family council's decision the second one can however be received.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The marriage of a protected adult cannot take place without the family council's consent and the previous consent of the adult. The court of first level did right by deciding the annulment of the council's deliberation allowing the marriage.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	The marriage of a protected adult cannot take place without the family council's consent and the previous consent of the adult. The court of first level did right by deciding the annulment of the council's deliberation allowing the marriage.
Proposal of key words for data base	Tutorship; right to marry
Case title	Centre Hospitalier Spécialisé d'Erstein
Decision date	17.11.1997

Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	Council of State, n°170531
Key facts of the case (max. 500 chars)	The manager/director of the hospital (CHS) has ordered the trial release of Mr Y.L. The administrative court of law has annulled the decision. The CHS asked the repeal of this judgement before the Council of State.
Main reasoning/argumentation (max. 500 chars)	The trial release is a measure coming within the treatment of the placed patient and is not therefore a decision that may be annulled by the administrative judge.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The trial release is a measure coming within the treatment of the placed patient and is not therefore a decision that may be annulled by the administrative judge.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	The judgment of the administrative court is annulled The claim of M. Y.L. is rejected.
Proposal of key words for data base	Involuntary hospitalisation – trial release

Case title	
Decision date	29.05.1996
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	Court of Cassation, n°92-05018
Key facts of the case (max. 500 chars)	The minor Sara X. had been entrusted to the Child Welfare Department by the decision of the juvenile judge. The Mayor made an order that involuntarily placed the minor in a specialised hospital centre. The prefect had put an

	end to the hospitalisation after a few days when the juvenile judge decided to end the placement into the Child Welfare Department and to entrust Sarah into a specialised hospital centre. This hospital challenges the juvenile judge's decision because it argues that only the prefect can order the hospitalisation of a person suffering from mental disorder.
Main reasoning/argumentation (max. 500 chars)	See below
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The administrative procedure of involuntary hospitalisation foreseen by the Public Health Code is not the only applicable one. The juvenile judge can, according to Articles 375-3 of the Civil Code, entrust a minor into a psychiatric hospital.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	The appeal of the hospital was rejected.
Proposal of key words for data base	Involuntary hospitalisation; children; powers of the judicial authority

Case title	Commune de Saint-Herblain
Decision date	11.03.1996
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	Council of State, n°164453
Key facts of the case (max. 500 chars)	The mayor has ordered the hospitalisation of Ms C arguing that it is of common knowledge that she suffers from serious troubles of behaviour breaching public peace, that her state looks harmful to her and to the others (neighbours and husband).

Main reasoning/argumentation (max. 500 chars)	If it falls inside the jurisdiction of administrative courts to consider the regularity of a decision ordering a compulsory hospitalisation, it belongs to the jurisdiction of the civil courts to review the necessity of this measure.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The legal reasoning stands here on the background what is important here is that the mayor's report ordering the hospitalisation had been signed by several residents of the town and this was considered as testifying the "common knowledge";
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	The commune de Saint-Herblain is justified in criticizing the annulations of its decision of hospitalisation.
Proposal of key words for data base	Compulsory hospitalisation; emergency procedure; motivation of the decision: notion of "common knowledge"