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Use of Seclusion and Restraint in Hospitals Providing Psychiatric Care in France in 2022: An Unprecedented Overview of the Affected Population and of Practice Variations Across Facilities

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The use of seclusion and restraint during psychiatric inpatient care is intended as a last resort in response to a crisis and should only be implemented in exceptional circumstances, in accordance with clinical practice guidelines. In France, the reduction in the use of these measures, which is a high priority on the global political agenda, is one of the objectives of the national roadmap for mental health and psychiatry launched in 2018. This objective is supported by a recent dissuasive legislative framework. In this context, this study provides recent data on the use of seclusion and mechanical restraint in hospitals providing psychiatric care on a national scale in France. This includes an unprecedented overview of the affected population and of the variations in the use of these measures between hospitals. A second study will subsequently be conducted to identify the factors contributing to these variations. In 2022, 76,000 individuals were involuntary admitted to inpatient care in hospitals providing psychiatric care. 37% of these people (n=28,000) were secluded at least once, and 11% (n=8,000) were mechanically restrained. The use of these measures exhibited considerable variability between hospitals, with some facilities never resorting to these practices. The extent of the variations suggests that they cannot be solely explained by different patients' needs, and this raises concerns in line with the ethical and legal implications associated with the use of seclusion and restraint. Complementary qualitative research has revealed the existence of know-how, practices, and patient representation, which are supported by specific work organisation, human resources policy, and values that encourage a lower use of coercive measures in hospitals that provide psychiatric care. More ambitious public policies, supporting healthcare teams in achieving a reduction in the use of seclusion and restraint, are required so that this reduction can be observed in all hospitals.

The use of seclusion and restraint measures during psychiatric hospital care is a practice employed as a last resort in response to a crisis. The implementation of these measures should be reserved for exceptional circumstances, in case of an immediate or imminent danger to the patient or others, with a proportional and progressive application, following the failure of all other de-escalation strategies, for the shortest possible duration, and on the basis of clinical arguments (Article L.3222-5-1 du Code de la Santé Publique). Seclusion is the practice of isolating a person, for protective purposes, in a locked room, away from other patients, during a critical phase of care. Mechanical restraint involves the immobilisation of an individual – whose behaviour poses a serious threat to their physical integrity or that of a third party – using devices such as bed straps. Recent clinical practice guidelines from the National Authority for Health (*Haute Autorité de Santé*, HAS) focus on the use of these measures in hospitals providing psychiatric care in France. It is only permitted during involuntary inpatient care, which is a public service task delivered in a number of designated facilities according to the patient's place of residence. Furthermore, mechanical

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restraint can only be used in individuals who are secluded (HAS, 2017).

The reduction in the use of coercive measures during psychiatric care is a high priority on the global political agenda (WHO, ONU, 2023) in line with the will to promote a human rights-based approach to mental health, the lack of robust evidence regarding their therapeutic benefit, and their well-documented potential adverse effects, in particular for restraint (circulatory and skin problems, muscular atrophy, post-traumatic stress disorder, exacerbation of the symptoms of the mental illness, etc.), which can even lead to death (Aragonés-Calleja and Sánchez-Martínez, 2023; Kersting et al., 2019; Sailas and Fenton, 2000). However, the definition of coercive measures, their regulation, and the policies designed to reduce their use vary significantly across countries (see Inset 1). In France, the reduction of the use of seclusion and mechanical restraint is one of the objectives of the national roadmap for mental health and psychiatry (*Ministère des Solidarités et de la Santé*, 2018). This objective is supported by a dissuasive legislative framework, which has evolved since 2016 (see Inset 2). This regulatory framework is distinctive in that the legislator is typically not involved in decisions related to medical practices. This particularity underlines the ethical and legal implications associated with the use of seclusion and restraint measures, which provide tangible expression to the ongoing debates surrounding the balance between individual liberties and the protection of health and persons.

In line with these recent evolutions, a mandatory register of seclusion and mechanical restraint measures has been made mandatory for all hospitals providing involuntary psychiatric care since 2018. Initial estimates based on this register indicate that, despite ambitious political objectives to reduce the use of these measures, their implementation remains high in France. In 2021, one-third of patients admitted involuntarily to psychiatric inpatient care were secluded, and one-tenth were mechanically restrained (Coldefy et al., 2022). Nevertheless, the ongoing political commitment to reduce the use of these practices, coupled with recent legislative amendments, and the growing reliability of the register recording this use, may result in a shift in these figures, which necessitate ongoing monitoring. Furthermore, the reports of the General Controller of Places of Deprivation of Liberty (*Contrôleur Général des Lieux de Privation de Liberté*, CGLPL) [CGLPL, 2023], as well as the Plaid-Care research project (Saetta et al., 2023) [See Inset Context] – which has identified hospitals with lower use of coercive measures in psychiatry –, support the hypothesis of significant variations in the use of these practices amongst healthcare providers, which remain to be objectified on a national scale.

In this context, the objectives of this study are to provide recent estimates on the use of seclusion and mechanical restraint measures in hospitals providing psychiatric care on a national scale in France, as well as an unprecedented overview of the variations in this use between hospitals. This represents a prerequisite for a subsequent study of the factors contributing to

I1

The use of seclusion and restraint in psychiatry in Europe is characterized by a considerable degree of heterogeneity in practices

The use of coercive measures in psychiatry, which may infringe the rights and liberties of the persons concerned, is observed throughout Europe. However, there are significant variations in the regulation of these measures, even if the implication of a judge to monitor their use is shared by a number of countries, such as France (see Inset 2), Germany, Spain, and the Netherlands. The latter is a specific case as it also controls the use of chemical restraint, i.e., the forced administration of psychotropic drugs. Other variations between countries include the prohibition of the use of all types of seclusion and restraint (solely in Iceland), or mechanical restraint, such as in England. Other countries still allow the use of coercive measures in hospitals providing psychiatric care outside the sole framework of involuntary care, as in Norway. Furthermore, different definitions exist for the same practice. In most national settings, seclusion is complemented by the constant surveillance of a healthcare professional, while in France the person is placed on their own in a locked room. Moreover, the durations of the implementation of these measures and mandatory re-evaluation of the relevance of their extension vary greatly according to countries. Variations are also observed in the information systems that document the use of these measures. For instance, the Northern European states, such as Finland and Norway, have made the reporting of this data mandatory in a national register for a number of years. Similarly, France and Portugal have also made this reporting mandatory more recently. However, this is not the case in some other countries such as Italy. Finally, while the reduction in the use of seclusion and restraint measures in hospitals providing psychiatric care is a shared objective, the incentives and dedicated policies vary. In particular, only Norway and England use the data relating to the use of these measures as indicators of care quality in psychiatric wards. Furthermore, while numerous initiatives and national plans (in particular in Scandinavia) have been developed in Europe with the objective of reducing the use of these measures, their effects are relatively short-term. In contrast, other countries, such as Slovenia, have not yet implemented any dedicated policy (Savage et al., 2024; Fostren, 2023; Lepping et al., 2016; Steinert et al., 2010).

I2

A recent and evolving regulation of seclusion and restraint in France

The legislation that regulates involuntary care in psychiatry in France was reinforced at the beginning of the 2010s with the introduction of the intervention of the Liberty and Custody Judge (*Juge des Libertés et de la Détention*, JLD) to monitor the resort to this type of care. Nevertheless, it was not until 2016, with the enactment of the law to modernise the healthcare system, that seclusion and mechanical restraint measures were subjected to specific and dissuasive legislation. These measures must be employed as a last resort, following medical determination. Furthermore, the legislation sets out objectives designed to regulate and reduce their use, as reaffirmed in the national roadmap for mental health and psychiatry (*Ministère des Solidarités et de la Santé*, 2018). Additionally, the legislation has made the collection of data relating to the use of these measures mandatory within hospitals providing psychiatric care. This was further reinforced by the 2021 Social Security Financing Law, which permitted patients subjected to seclusion or mechanical restraint in psychiatry to refer their case to a Liberty and Custody Judge (JLD). In addition, the judge must be informed in the event that these measures are extended. This text was subsequently amended by the 22 January 2022 law, which addressed the management of the health crisis associated with the Covid-19 pandemic. The aforementioned legislation mandates the implementation of seclusion and mechanical restraint measures during psychiatric care to be overseen by a JLD, after a maximum of 72 hours for seclusion, and 48 hours for restraint. Consequently, the judge is empowered to revoke the measure immediately if the requisite legal conditions are not met. These developments were prompted by urgent constitutional issues, which obliged legislators to rule hastily without meaningful consultation. Consequently, the implementation of this new legislative framework proved to be particularly complex for healthcare teams, notably in terms of regular re-evaluations and written renewals of the use of seclusion and restraint measures.

these variations, which will be carried out in a second phase.

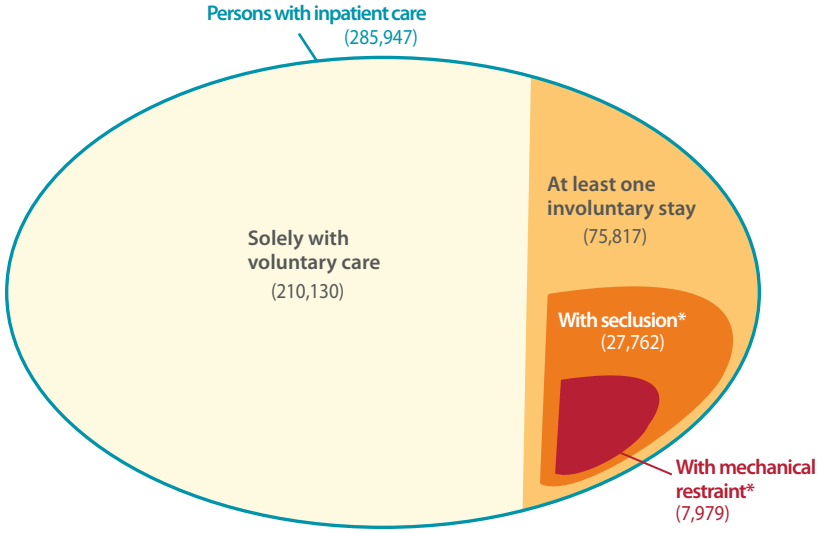
The use of seclusion and mechanical restraint measures is a phenomenon that is far from being negligible

In 2022, a total of 285,947 adults were admitted to inpatient care in psychiatric wards in France. 27% of them (n=75,817) were involuntarily admitted at least once. The use of seclusion was observed for 27,762 persons, representing 37% of individuals who were involuntarily admitted at least once and 10% of those admitted at least once in inpatient care in a psychiatric ward. During the period of seclusion, 7,979 individuals also experienced mechanical restraint, representing 11% of the persons involuntarily admitted at least once and 3% of those admitted at least once in inpatient care in a psychiatric ward (see Figure 1). These rates are comparable to those observed in 2021 (Coldefy et al., 2022), although further long-term monitoring would be necessary to reach conclusions regarding potential evolutions. Furthermore, seclusion and restraint measures were observed in cases where individuals were not involuntarily admitted (0.9% of the admissions in inpatient care in psychiatric wards for seclusion and 0.2% for restraint measures). These measures may correspond to temporary emergency measures (for a maximum of 12 hours), authorised by law, before the resolution of the critical situation, or practices used outside the legal framework.

Hence, in France, in 2022, the use of seclusion measures during psychiatric care affected approximately 52 individuals per 100,000 adult inhabitants, while the use of mechanical restraint measures affected almost 15 individuals per 100,000 adult inhabitants. A comparison of these rates with those observed in other national contexts may provide insight into France's approach to the use of these last-resort practices in psychiatry. However, such comparisons require caution due to the potential for differences in measurement methodologies and practice definition (see Inset 2). Furthermore, a significant number of countries lack a dedicated, exhaustive, and regularly updated register. Nevertheless, the most recent estimates available in nine countries indicate that France is above the median of these countries with regard to the use of seclusion and mechanical restraint measures per capita, and particularly for restraint (Savage et al., 2024).

F1

The use of seclusion and mechanical restraint in hospitals providing psychiatric care in 2022



Scope: Adult patients admitted to inpatient care in hospitals providing psychiatric care, including patients with involuntary admissions (excluding those reported in hospitals that are not designated to deliver this type of care), throughout France, in 2022. The data on seclusion and restraint measures reported in the dedicated register but implemented outside of involuntary care were excluded from the calculation of the use of these measures.
* Persons with at least one seclusion/restraint measure during involuntary care
Source: Rim-P

Measures that mainly affect young men during complex care

In 2022, the use of seclusion and mechanical restraint measures during psychiatric care in France involved men in more than two-thirds of cases. The population involuntarily admitted to psychiatric inpatient care that had not been subject to a seclusion measure (nor one of mechanical restraint) also mostly comprised men, but in a less pronounced way (see Table 1, p. 4). Furthermore, the use of seclusion and mechanical restraint measures affects relatively young individuals (with a median age of 35 and 37 respectively). This is lower than that of other persons undergoing involuntary care (see Table 1), which raises questions about the potential impact on their future care and life pathways. More than a quarter of individuals with seclusion or restraint measures had an identified socio-economic vulnerability, as evidenced by their enrolment in the publicly subsidized complementary insurance scheme (*Complémentaire Santé Solidaire*, C2S), which aims to enhance the financial accessibility of healthcare for individuals with the lowest income. This proportion was higher among patients who had been subjected to a seclusion measure compared with the remainder of the

CONTEXT

This study represents the first phase of the Ricochet project focused on the use of seclusion and restraint in hospitals providing psychiatric care, the analysis of the variations between hospitals and of the contributing factors on a national scale. It forms part of a long series of studies conducted by IRDES on practice variations in psychiatric care in the French context, with a particular focus on those that are controversial. An initial internship was conducted at IRDES in 2023 on this topic which will be further explored in a Master's degree internship, supported by a grant from the French Congress of Psychiatry, more specifically centred on the factors contributing to the variations in the use of seclusion and restraint between hospitals, objectified in this first study. This work was conducted in collaboration with the Plaid-Care research project (Research into the reduced use of coercion in France) (Saetta *et al.*, 2023), which employs a multidisciplinary approach combing sociological, nursing and geographical perspectives and qualitative methods, such as interviews, observations and documentary analysis. This approach is highly complementary to the quantitative approach adopted by IRDES. The complementarity of the disciplines and methods is also at the core of a forthcoming initiative, the 'Transpsyco' project (a transdisciplinary approach in hospitals providing psychiatric care: determinants, impacts, and action levers in support of a reduced reliance on coercive measures).

T1

Socio-demographic and clinical characteristics of patients involuntarily admitted to inpatient care and corresponding stays in 2022, depending on whether or not seclusion or restraint measures were used

	Patients with at least one involuntary inpatient stay in 2022 (n = 75,817)			
	With at least one seclusion measure n = 27,762	Without seclusion measure n = 48,055	With at least one mechanical restraint measure amongst persons with at least one seclusion measure n = 7,979	Without mechanical restraint measure amongst persons with at least one seclusion measure n = 19,783
	Median (± IQR[1]) or n (%)	Median (± IQR[1]) or n (%)	Median (± IQR[1]) or n (%)	Median (± IQR[1]) or n (%)
Age (years)	37 ± 22 ***	45 ± 26 ***	35 ± 21 ***	38 ± 22 ***
Sex: male	18,843 67.9% ***	25,523 53.1% ***	5,645 70.8% ***	13,198 66.7% ***
Enrolment in the health insurance scheme for people with low incomes (C2S)	7,949 28.6% ***	11,078 23.1% ***	2,228 27.9%	5,721 28.9%
Annual number of days spent in psychiatric inpatient care	47 ± 87 ***	29 ± 51 ***	53 ± 101 ***	45 ± 80 ***

	Stays in involuntary inpatient care in 2022 (n = 108,225)			
	With at least one seclusion measure n = 34,220	Without seclusion measure n = 74,005	With at least one mechanical restraint measure Amongst the stays with at least one seclusion measure n = 9,116	Without mechanical restraint measure Amongst the stays with at least one seclusion measure n = 25,104
	n %	n %	n %	n %
Admission through the emergency services	14,302 41.8% ***	29,226 39.5% ***	4,043 44,.4% ***	10,259 40.9% ***
Principal diagnosis group that led to the hospitalisation (code of the International Classification of Diseases, ICD-10)				
Organic mental disorders (F0)	498 1.5% ***	1,264 1.7% ***	164 1.8% ***	334 1.3% ***
Disorders due to psychoactive substance use (F1)	1,940 5.7% ***	4,839 6.5% ***	494 5.4% ***	1,451 5.8% ***
Psychotic disorder (F2)	16,065 47.0% ***	33,822 45.7% ***	4,216 46.2% ***	11,864 47.2% ***
Manic episode and bipolar affective disorder (F30-31)	3,977 11.6% ***	7,656 10.4% ***	977 10.7% ***	3,000 11.9% ***
Depressive disorder (F32-33)	1,695 5.0% ***	6,682 9.0% ***	364 4.0% ***	1,337 5.3% ***
Other mood disorders (F34 à F39)	165 0.5% ***	452 0.6% ***	38 0.4% ***	128 0.5% ***
Neurotic, stress-related and somatoform disorders (F4)	1,940 5.7% ***	5,102 6.9% ***	500 5.5% ***	1,446 5.8% ***
Behavioural syndromes (F5)	91 0.3% ***	289 0.4% ***	30 0.3% ***	61 0.2% ***
Disorders of personality and behaviour (F6)	2,688 7.9% ***	4,764 6.4% ***	818 9.0% ***	1,872 7.4% ***
Mental retardation (F7)	900 2.6% ***	1,096 1.5% ***	314 3.4% ***	586 2.3% ***
Disorders of psychological development (F8)	587 1.7% ***	537 0.7% ***	211 2.3% ***	377 1.5% ***
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F9)	255 0.8% ***	271 0.4% ***	98 1.1% ***	158 0.6% ***
Others (somatic diagnoses or check-ups, examinations, unspecified, etc.)	3,419 10.0% ***	7,231 9.8% ***	895 9.8% ***	2,532 10.1% ***
Type of procedure which led to involuntary care				
Care on the request of a third party	16,714 48.8% ***	41,431 56.0% ***	4,541 49.8% ***	12,173 48.5% ***
Care on the decision of a representative of the State	5,690 16.6% ***	10,339 14.0% ***	1,564 17.2% ***	4,126 16.4% ***
Care in the event of imminent danger	9,248 27.0% ***	20,060 27.1% ***	2,438 26.7% ***	6,810 27.1% ***
Care for persons declared criminally irresponsible	378 1.1% ***	1,136 1.5% ***	84 0.9% ***	294 1.2% ***
Care for detainees	2,190 6.4% ***	1,039 1.4% ***	489 5.4% ***	1,701 6.8% ***
Antecedents during the two years preceding the start of the stay in involuntary inpatient care in 2022				
A history of treatment for addiction (addiction diagnosis recorded during hospital care in the fields of medicine, surgery, and gynaecology/ obstetrics (MSO) or in psychiatry, or during an outpatient psychiatric consultation in a public hospital)	11,591 33.9% **	25,713 34.7% **	3,018 33.1%	8,573 34.2%
A history of attempted suicide (with hospitalisation in MSO)	3,558 10.4% ***	9,321 12.6% ***	1,021 11.2% **	2,537 10.1% **
A history of involuntary psychiatric inpatient care in the same hospital ("known patient")	17,548 51.3%	38,079 51.5%	4,665 51.2%	12,883 51.3%
A history of stay in a specific unit for complex cases (UMD)	555 1.6% ***	943 1.3% ***	178 2.0% **	377 1.5% **
A history of seclusion and mechanical restraint during psychiatric care	11,443 33.4% ***	15,710 21.2% ***	3,245 35.6% ***	8,198 32.7% ***

Scope: Involuntary psychiatric inpatient stays in 2022 (excluding involuntary care reported in hospitals that are not designated to deliver this type of care) for adult patients, throughout France, in 2022. The data on seclusion and restraint measures reported in the dedicated register but implemented outside of involuntary care were excluded from the calculation of the use of these measures. **Source:** Rim-P

[1] IQR: Interquartile range

*** P-value lower than 0.0001; ** P-value lower than 0.01; * P-value lower than 0.05 (Fisher, Wilcoxon or Chi-2 tests depending on the nature of the variables), comparing the persons in involuntary psychiatric inpatient stays depending on whether or not seclusion or restraint measures were used.

Download the data

population involuntarily admitted (see Table 1). Moreover, individuals who had undergone seclusion or restraint measures had a significantly higher annual median number of days of psychiatric inpatient care than other persons involuntarily admitted (see Table 1). This suggests that these individuals received more intensive treatments.

The inpatient stays that involved the use of seclusion or restraint were more likely to have begun with admission to the emergency ward than the other involuntary inpatient stays (see Table 1), suggesting that this use occurred during a crisis or in instances where there had been a break in care without the possibility of referral for hospitalisation. Furthermore, stays involving the use of seclusion or restraint measures were linked in almost half of the cases with the treatment of a psychotic disorder, followed by the treatment of a bipolar disorder or a manic episode, or a personality or behavioural disorder. While the differences remain limited, the latter group of disorders is the one for which overrepresentation in comparison with involuntary stays without seclusion or restraint measures is the most marked (see Table 1), above all for the diagnosis of dissocial personality disorder (code F602 of the International Classification of Diseases (ICD-10)). In accordance with the clinical practice guidelines, seclusion and restraint measures may only be employed to prevent "imminent violence by the patient" or in response to "immediate, uncontrollable violence, with underlying mental disorders, which presents a serious risk to the safety of the patient or others" (HAS, 2017). Episodes of auto- or hetero-aggressivity and psychomotor agitation are more prevalent during manic or psychotic episodes, as well as in instances of personality disorder (Tezenas du Montcel et al., 2018). This may explain why their treatment represents the majority of stays with seclusion and restraint measures in line with current guidelines. Nevertheless, this prompts the question of the alternatives that could have been employed or that were ineffective. Furthermore, stays for intellectual deficiencies and dis-

Source

This study is based on data from the Medical Information Database for Psychiatry (*Recueil d'Informations Médicalisé en Psychiatrie*, Rim-P), a health claims database that includes the healthcare activities of hospitals authorised to deliver psychiatric care (mono or multidisciplinary, public or private), on a national scale. It contains information on patient characteristics, including clinical data (in particular the type of disorder that led to care), demographic data (age and sex), socio-economic data (enrolment in a state-funded complementary health insurance scheme for people with low incomes (*Complémentaire Santé Solidaire*, C2S)) and geographic data (postal code of residence). Furthermore, the database includes information regarding the type of care provided (e.g., inpatient, part-time or outpatient, duration of stay, voluntary or involuntary). Since 2018, the Rim-P has also included a mandatory register of the seclusion and mechanical restraint measures used in hospitals providing psychiatric care (excluding emergency services). The purpose of this register is twofold: firstly, to record the traceability data of the use of these measures within each hospital providing psychiatric care and designated to deliver involuntary care; and secondly, to monitor the implementation of clinical practice guidelines (HAS, 2017). This register was leveraged in this study for the most recent complete calendar year, namely 2022. Nevertheless, it is important to exercise caution when analysing the data, particularly in order to identify the hospitals for which the data is not exhaustive (see Inset Method). In addition, it is also important to identify the seclusion and restraint measures implemented outside of involuntary care and therefore outside the current legal framework. Furthermore, while data pertaining to the duration of the implementation of seclusion or restraint, specifically targeted by the new legislative framework regulating their use, is of particular interest for study, it cannot be robustly compared between hospitals to date, and has therefore not been used yet. Finally, longitudinal analyses relating to annual evolutions since 2018 are not recommended at this stage, due in particular to increasing reporting over time in the register of seclusion and restraint measures within hospitals.

Method

The use of seclusion and mechanical restraint measures on a national scale was estimated on the basis of data from the Medical Information Database for Psychiatry (Rim-P) for adult patients. The number of stays involving measures implemented outside the legal framework of involuntary care was estimated, but these measures were subsequently excluded from the analysis, due to the potential heterogeneity of their reporting amongst hospitals. In addition, involuntary care reported in hospitals that were not designated to provide such care was excluded. The number of patients subject to seclusion and mechanical restraint measures was then estimated on a national scale and compared with the number of patients with psychiatric inpatient care, with involuntary psychiatric inpatient care – in accordance with the current legal framework, and with the adult French population in order to enable the first international comparisons. The characteristics of these patients, or of their stays for variables that may vary during the different hospitalisations for the same patient, were compared with those of the patients with involuntary psychiatric care, but without seclusion or restraint measures. Variations in the use of these measures between hospitals were estimated for those designated to provide involuntary care. This was done by restricting the estimation to general psychiatry in order to analyse a homogeneous field of activity. This excluded stays in specific units for complex cases (*Unités pour malades difficiles*, UMD) or dedicated to detainees (*Unités hospitalières spécialement aménagées*, UHSA). It was necessary to make significant alterations to the data in order to ensure that all hospitals were analysed at the same level. The FINESS number, which identifies each hospital, was not provided in a uniform manner in the Rim-P database. This number could be provided in different ways, such as referring to the legal entity or the geographic entity, or even the hospital department. Furthermore, hospitals with deficiencies in the reporting of seclusion and restraint measures were excluded (no seclusion measure reported in the dedicated register despite the fact that seclusion measures were indicated in another dataset of the RIM-P database; no seclusion/restraint measure reported in the dedicated register despite the fact that such measures were documented by the General Controller of Places of Deprivation of Liberty (CGLPL) or in the hospital's certification report), i.e., 9 facilities representing 2% of stays in involuntary psychiatric inpatient care. Finally, variations between hospitals located outside mainland France (n=6) were excluded from the analysis, due to the absence of certain data which allow characterizing the territories they serve, which did not make it possible to conduct the second phase of the study relating to factors contributing to the variations in the use of seclusion and restraint. Hospitals that only delivered involuntary care on an occasional basis (with fewer than 30 inpatient stays of this type in 2022) (n=13) were also excluded from this analysis in order to avoid the potential for bias in the estimation of the use of seclusion and mechanical restraint measures due to small numbers. Regarding the part of the study focusing on variations in the use of these measures, a positive approach was selected. This approach involved comparing the practices of healthcare providers with average national practices. In contrast, a normative approach was deemed unsuitable due to the high uncertainty regarding the "right" level of use for seclusion and restraint measures in hospitals providing psychiatric care. Initial insights into potential factors associated with these variations were provided by a qualitative study conducted as part of the Plaid-Care research project that focused on hospitals characterised by a lesser user of coercive measures (see Inset Context). This will be subsequently complemented by a quantitative study on a national scale. The latter will enable the identification of other potential levers to limit the use of seclusion and restraint measures (factors related to patient characteristics, characteristics of hospitals and their environment).

orders related to psychological development (including autism spectrum disorders) (see Table 1, codes F7 and F8) – for which psychiatric inpatient care is not the recommended treatment – are overrepresented in stays involving seclusion and mechanical restraint measures compared with their frequency in involuntary stays for which none of these measures were implemented (see Table 1). This indicates that seclusion and restraint measures may sometimes be employed to address challenges in providing care for vulnerable populations who require tailored support.

The disproportionate representation of detainees in the instances of seclusion implementation, in comparison with other involuntary admissions (see Table 1), also prompts further inquiry. This may reflect a greater frequency of violent episodes within this category of the population, but also suggests that these measures may have been implemented to satisfy safety concerns that were not justified by purely clinical reasons. Furthermore, previous instances of seclusion or restraint measures, or previous admissions to units for complex cases (*Unités pour malades difficiles*, UMD) were more frequently observed for stays in which seclusion and mechanical restraint measures were implemented. This may be indicative of the severity of the disorders of the individuals in question, but it may also reflect a lack of trust on the part of some healthcare teams towards these individuals, which could result in more frequent implementation of these measures. Quantitative analyses on a national scale are unable to provide answers to the aforementioned questions. Consequently, it is necessary to complement these results with qualitative studies. Initial findings from the Plaid-Care research project (see Inset Context) identified a history of systematically resorting to seclusion for detainees in one of the hospitals studied. This practice was only questioned and modified after a visit of the General Controller of Places of Deprivation of Liberty (CGLPL) highlighted their unsuitability. Nevertheless, there remains the issue of the potential refusal by hospitals to admit detainees due to the associated organisational difficulties, in particular in wards with an open-door policy.

I3

Some lessons to be learned from hospitals that provide psychiatric care with a reduced reliance on coercive measures

The Plaid-Care research project (see Inset 'Context') was based partly on an intensive study of a sample of four hospitals or psychiatric departments with a history of little resorting to coercive measures. This included the absence or very infrequent use of restraint, a use of seclusion which was exceptional or had decreased over recent years, an open-door policy in psychiatric wards, and brief and circumstantial case-by-case application of measures to restrict rights and liberties (such as the confiscation of personal belongings or obligatory pyjama wearing). The initial phase of data analysis (66 interviews, 62 days of observation, and a comprehensive review of documentation) focused on four dimensions (history, organisation, practices, and experience) and four analysis levels (ward, department, hospital, and local area). The findings indicate that this reduced reliance on coercive measures is primarily attributable to practices, patient representation, and the specific organization of care. These include the priority of availability for the patient, a strong involvement of healthcare professionals and all the hospital team (including administrative staff), the centrality and diversity of activities offered to patients, the presence of health executives supervising the healthcare team on a daily basis, a special attention paid to welcoming the patient, the quality of the links with outpatient healthcare professionals and facilities, and positive representations of patients. The aforementioned factors are further supported by a work organisation and a human resources policy at the department level. These include a policy of reception and integration, a propensity for horizontality in the relations between the different types of professionals, an emphasis on autonomy and the role played by health professionals, and the support and availability of the management team. They also included factors at the hospital level, including a policy of attractivity and retention of staff, the structuring and influence of the medical community, permeability between the medical and administrative bodies, a culture of dialogue, ongoing involvement of service users, and cooperative work with other actors in the surroundings. This results in a virtuous circle of reduced reliance on coercive measures, in which healthcare and work organisation within wards ensures the satisfaction of professionals, their commitment, and the stability of teams. Furthermore, hospital-level organisation encourages the continuation of the policy of openness and reduced use of coercion. This policy, which is driven by both individual and collective actors, is also supported in some hospitals by the integration of values in the definition of service projects at the department or hospital level as well as by organisational principles. These include a culture of welcoming, collegiality, and a "counter-culture of risk", as well as a principle of accountability with regard to relations between healthcare professionnals and patients, and amongst professional categories.

Significant variations were observed between hospitals in the use of seclusion and mechanical restraint

The 220 hospitals designated to provide involuntary care analysed were predominantly multidisciplinary public hospitals (not including hospitals with teaching activities) or hospitals with a specialisation in psychiatry (see Table 2).

T2

Type of hospitals providing involuntary psychiatric care (n=220)

	Number of hospitals		Average number of psychiatric inpatient beds	
	n	%	n	Standard deviation
Type of hospital				
Multidisciplinary public hospital	93	42.3%	72	41.4
Public hospital specialized in psychiatry	79	35.9%	243	117.3
Private-non-profit hospital (ESPIC)	24	10.9%	170	86.4
Public hospital with teaching activities (CHU)	20	9.1%	104	67.5
Private-for-profit hospital	4	1.8%	144	40.9

Scope: Hospitals designated to deliver involuntary psychiatric care (excluding those with involuntary inpatient care that only took place in specific units for complex cases (UMD) or dedicated to detainees (UHSA)), in mainland France, after exclusion of the data of hospitals for which the register of seclusion and mechanical restraint measures was of poor quality or which only provided involuntary care on an occasional basis (see Inset Method).

Source: Rim-P

Download the data

On average, the use of seclusion measures in these hospitals concerned almost 30% of the involuntary inpatient stays, while the use of mechanical restraint measures concerned nearly 8% of these stays. Nevertheless, these average rates mask significant differences, as illustrated by the high values of the coefficients of variation, in particular for the use of restraint, and the position of the different hospitals compared with the national values relating to the use of these measures. This indicates that the observed variations are not solely attributable to a few hospitals with extreme values (see Figure 2).

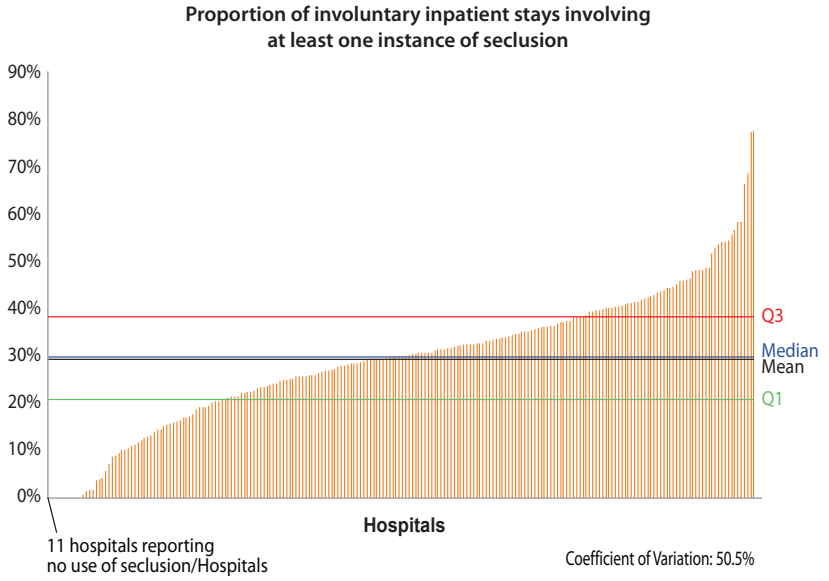
Moreover, there are significant differences in the minimum and maximum rates of utilisation of these practices. Some hospitals have reported no use, while others have reported high rates (14 hospitals have employed seclusion measures for over 50% of involuntary inpatient stays and 18 hospitals have employed restraint measures for over 20% of these stays) [see Figure 2].

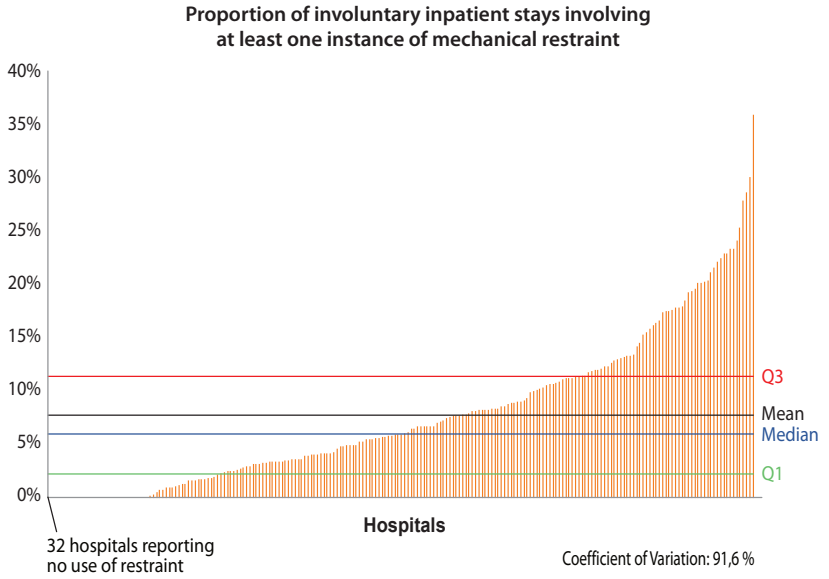
In a preliminary descriptive analysis, hospitals that did not implement seclusion and mechanical restraint measures were most frequently multidisciplinary hospitals and smaller (in terms of the number of psychiatric inpatient beds). The larger the hospital, the more challenging it may be to implement a proactive policy of reducing seclusion and restraint practices across all departments and actors within the facility, which is an important lever for succeeding in reducing these practices, based on qualitative insights (see Inset 3). These initial observations will be further elucidated in the second phase of the Ricochet project[1] through a multi-level analysis on a national scale of the factors contributing to the observed variations in the use of seclusion and mechanical restraint between hospitals. This analysis will consider a range of factors linked to patient, hospital and contextual characteristics, with the aim of identifying other potential levers to reduce the use of these measures. Nevertheless, it is also possible that variations may exist within hospitals that are not observable in the data available on a national scale. Qualitative elements from the Plaid-Care project indicate the existence of such variations within some of the hospitals studied. In these hospitals, departments or wards with a specific history and culture have experienced difficulties in maintaining a limited use of coercive measures when this is not a shared practice within the whole hospital.

1 https://www.irdes.fr/recherche/projets/richochet-recours-a-l-isolement-et-a-la-contention-en-psychiatrie.pdf

F2

The use of seclusion and mechanical restraint in hospitals providing psychiatric care in 2022





Scope: Involuntary inpatient stays in 2022 (excluding involuntary care reported in hospitals that are not designated to deliver this type of care) in general psychiatric wards (excluding inpatient care that took place in specific units for complex cases (UMD) or dedicated to detainees (UHSA)) for adult patients, in mainland France, after exclusion of the data of hospitals for which the register of seclusion and mechanical restraint measures was of poor quality or which only provided involuntary care on an occasional basis (see Inset Method).

Source: Rim-P

Reading: Each vertical bar represents the rate of involuntary inpatient stays involving at least one seclusion or mechanical restraint measure in each hospital included in the analysis. Only the hospitals that did not report any use of these measures are not represented. The horizontal bars present the national values of the rates of use of seclusion or mechanical restraint measures calculated across hospitals for comparison.

Download the data

* * *

The results presented herein provide recent data on the use of seclusion and mechanical restraint during involuntary psychiatric inpatient care in France in 2022. Furthermore, the data reveal a striking degree of variation in the use of these measures between hospitals, which is too significant to be attributed solely to the differing healthcare needs of the populations they serve. The study challenges the notion of "last resort" for these practices, which are more prevalent in certain hospitals. It suggests that the interpretation of when to use these measures varies according to the hospital. The observation that certain hospitals or wards do not utilise these measures at all or only to a limited extent serves to illustrate that there is a viable alternative to violence prevention, which avoids the deprivation of liberty.

The initial findings of the Plaid-Care research project, conducted in four hospitals with a history of less use of coercive measures, indicate that limiting the resort to seclusion and restraint is facilitated by the implementation of specific practices and the set up of an appropriate healthcare organisation. However, this must be supported by a specific work organisation, a global policy of openness, and the affirmation of specific values and culture. It is also of particular importance to consider the circumstances of detainees, as the associated safety constraints may lead facilities to employ seclusion measures for this population on a systematic basis. The second phase of the Ricochet research project will provide further insights into the factors that contribute to the observed variations in the use of seclusion and restraint.

Given the ethical implications associated with the use of seclusion and restraint measures during psychiatric care, it is imperative that more ambitious structural policies are developed with the aim of reducing the prevalence of these measures across all hospitals. For example, the systematic inclusion of objectives to reduce the use of these practices and their annual monitoring could be incorporated into the numerous facilitation tools of local, territorial, regional, and national policies with regard to mental health, as well as in the tools used to assess the quality of healthcare. This would facilitate the implementation of changes in hospital practices, while encouraging the sharing of effective preventive measures between hospitals. Nevertheless, healthcare teams must be provided with the resources to achieve the goal of reducing the use of these measures in an unfavourable demographic context for the professionals working in psychiatric wards. To achieve this, training in the management of critical and violent situations should be systematised, as well as critical exercises analysing the situations in which these practices were resorted to and tools that record the patients' preferences prior to the occurrence of these situations. This could be based on programmes developed abroad such as the "Safewards", "Six core strategies", and "Qualityright" models (Duffy and Kelly, 2023; Gooding et al., 2018). Furthermore, it is possible to support the evaluation and dissemination of organisational innovations with the aim of facilitating the management of crisis situations within hospitals. This could include the development of units dedicated to support the management of violence or reinforced psychiatric emergency services, as well as the implementation of outpatient services such as mobile crisis teams, respite facilities, and intensive home support, with the objective of preventing crises in advance.

Finally, the observed use of seclusion and restraint measures outside the legal framework of involuntary care within psychiatric wards suggests that it is important to monitor these measures in other settings, such as in general emergency services, in the health and social care sector, and in nursing homes, where their use also raises questions (Jacus et al., 2023), but is not monitored through a specific register. It would also be beneficial to be able to record and document other coercive practices during psychiatric care – such as the presence of closed wards and the use of physical restraint and forced medication – on a national scale in France via existing information systems. ♦

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