Clinical practice guidelines

Emergency involuntary commitment of a mentally disordered person

April 2005

This publication by the Haute Autorité de santé contains the guidelines produced by ANAES (the former French Agency for Accreditation and Evaluation in Healthcare, now part of HAS). The guidelines were validated by ANAES’ Scientific Council in November 2004.
Synopsis

<table>
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<tr>
<th>Title</th>
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<td>Publication date</td>
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<td>Intended for</td>
<td>All professionals involved in admitting an adult to hospital against their will</td>
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<tr>
<td>Objective</td>
<td>To provide guidance on the procedure to be used when deciding whether emergency involuntary commitment of a mentally disordered person is warranted</td>
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| Assessment method | - Systematic review of the literature  
- Discussion among members of an ad hoc working group  
  - External validation by peer reviewers  
- Literature search Period: 1993-2003 |
| Literature search | Period: 1993-2003 |
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- Working group (Chair: Guy Gozlan MD, psychiatrist, Aulnay-sous-Bois)  
- Peer reviewers |
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| Related HAS publications | The full report (in French) on which the present guidelines are based is on the HAS website (www.has-sante.fr). ("Modalités de prise de décision concernant l'indication en urgence d'une hospitalisation sans consentement d'une personne présentant des troubles mentaux") |
Contents

I. Scope of the guidelines..................................................................................................... 5
II. Assessment method........................................................................................................... 5
III. Background..................................................................................................................... 5
   III.1. Involuntary commitment: a derogation from the general principle of consent........... 5
   III.2. Legal situation............................................................................................................. 6
   III.3. Epidemiological data.................................................................................................... 6
IV. General principles of care.............................................................................................. 6
V. Assessment of the patient and of their family and carers .............................................. 7
   V.1. Clinical assessment (physical and psychiatric) of the patient........................................... 7
   V.2. Assessment of social and family environment................................................................. 8
VI. Assessment of ability to give consent........................................................................... 9
VII. Indications for involuntary commitment..................................................................... 9
VIII. Procedures for involuntary commitment................................................................. 11
   VIII.1. Commitment at the request of a third party............................................................... 11
   VIII.2. Commitment by the public authorities (HO)............................................................... 12
   VIII.3. Informing the patient and their family on procedures............................................... 12
   VIII.4. Choice of HCO and admitting department............................................................... 13
   VIII.5. Transport ................................................................................................................ 13
   VIII.6. Admission to hospital ............................................................................................. 13
IX. Conclusion and proposed future action....................................................................... 14

Annexes
Annex 1. Participants
Annex 2. Assessment method
Annex 3. Legal texts
I. Scope of the guidelines

These guidelines provide guidance on the procedure to be used when deciding whether emergency involuntary commitment of a mentally disordered person is warranted. They do not concern minors.

II. Assessment method

The guidelines were produced using the method described in Annex 2:
- a critical appraisal of the literature published from 1993-2003
- discussions within a multidisciplinary working group (5 meetings)
- comments by peer reviewers.

In view of the low level of evidence provided by available publications on the subject of these guidelines, all the recommendations given below were proposed by agreement among professionals.

III. Background

III.1 Involuntary commitment: a derogation from the general principle of consent

According to French law¹, consent to care is a key prerequisite for all treatment. However, consent to care can vary during a relationship between patient and health professional. In patients with mental disorders, it may not be given definitively and may change over very short periods of time, as their awareness of their problems fluctuates, particularly if they are psychotic.

Accordingly, the earlier law² relating to the rights and protection of individuals committed to hospital because of mental disorders still remains current and relevant today. It is based on the premise that it is absence of care rather than enforcement of care that constitutes harm to a patient satisfying the conditions specified by this law. It does not distinguish care from detention by a healthcare organisation (HCO) (full-time hospitalisation or trial discharge). Its preamble states that consent to care remains the rule and that the use of detention should remain the exception.

The negative impact of involuntary commitment has received little study, but it should not be overlooked. A decision to hospitalise a patient without their consent should therefore be made only in cases where it is absolutely necessary.

The French regional psychiatric hospitalisation committee (Commission Départementale des Hospitalisations Psychiatriques, CDHP) and the public prosecutor ensure that patients do actually receive care and that their continued hospitalisation is not simply arbitrary detention.

Little information has been published on the role played by the patient’s family and social environment when an individual is committed to hospital, and on their necessary involvement in

¹ Law no. 2002-303 of 4 March 2002 relating to the rights of patients and the quality of the healthcare system
² Law no. 90-527 of 27 June 1990 which was modified by the law of 4 March 2002
care. In particular, there is no mention of the problems arising from certain disorders (paranoia) or situations (marital or family conflict) that may follow a request for involuntary hospitalisation made by a third party involved in a direct relationship with the individual, even though these problems appear to be common.

III.2 Legal situation

There are two forms of involuntary commitment in France:

(i) Commitment at the request of a third party (hospitalisation à la demande d'un tiers, HDT). The law states that:
- the person must have a mental disorder
- the person’s consent to hospitalisation cannot be obtained
- there must be a need for immediate care and constant surveillance in a hospital environment.

For HDT in an emergency situation, the law introduces the concept of imminent danger, i.e. a risk of severe deterioration in the individual's condition if they are not admitted to hospital.

(ii) Commitment by the public authorities (hospitalisation d'office, HO). The laws states that:
- the person must have a mental disorder
- the person must need care
- there must be a threat to the safety of individuals or a serious threat to public order.

The law does not define criteria for the need for care. Clinical criteria should therefore be used, with recourse to involuntary commitment if refusal to be admitted to hospital could lead to a deterioration in the patient's condition or prevent them from receiving appropriate treatment.

French law, unlike the law in other countries, does not automatically set aside certain psychiatric diagnoses for involuntary commitment.

III.3 Epidemiological data

There are no accurate estimates of the French population concerned by involuntary commitment. The main trends are:

- There has been an overall trend towards an increase in the number of involuntary commitments since 1992. It is not known whether the number of patients concerned is also increasing (each hospitalisation of the same patient is counted separately).
- The relative proportion of involuntary to total number of admissions to a psychiatric hospital department has remained stable (11% in 1992; 13% in 2001).
- The number of HDT hospitalisations of more than 3 months and of HO hospitalisations of more than 4 months has remained stable since 1997 and 1994, respectively.
- There are discrepancies between different départements (administrative regions in France) that are not explained by demographic or epidemiological factors.

France and Portugal are the European countries which make least use of involuntary commitment. The level of involuntary hospitalisations in France is 2.4 times lower than that in Sweden.

IV. General principles of care

Care should begin immediately for any patient who might need to be committed to hospital.

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When a decision to commit a known and/or monitored patient, the health professionals in charge of the patient should be included in the decision-making process. These professionals include:
- hospital units in the sector
- a psychiatric centre (centre médico-psychologique, CMP)
- a psychiatrist (outside hospital practice) or a general practitioner.

If there is no person in charge or this person cannot be contacted, a psychiatrist from the nearest accident & emergency (A & E) department or psychiatric centre should be contacted either directly or through the emergency services (Centre 15-SAMU).

Implementing a decision to commit a person to hospital may involve a number of pre-hospital and hospital participants (medical and allied health professionals, the forces of law and order, the fire brigade⁴). Only one coordinator or coordinating body (Centre 15-SAMU, emergency department psychiatrist or psychiatric centre (CMP) psychiatrist) should be contacted to minimise loss of information, errors, or delays in referral.

The patient’s pre-hospital pathway and time in the emergency department should be as short as possible.

Initial and continuous training for pre-hospital and hospital participants should be introduced, to cover:
- the law in force⁵;
- procedures for committing a person to hospital
- the immediate care of a person with a psychiatric disorder.

V. Assessment of the patient and of their family and carers

Assessment is carried out before admission to hospital or at the time of admission, as appropriate.

V.1 Clinical assessment (physical and psychiatric) of the patient

Assessment may be hindered by cultural factors and/or by the inability of the patient or their family and/or carers to speak French adequately. These points should be borne in mind to avoid making an incorrect diagnosis.

• Physical examination

The physical examination (Table 1) should be carried out as soon as possible.

If the patient is agitated, SpO₂ should be measured (pulse oximetry) as soon as possible.

Any sign of a significant abnormality should prompt a more thorough investigation in a hospital.

• Role of sedation

If the patient has behavioural problems and refuses or protests, sedation may be indicated to facilitate the physical examination. Sedation should never replace but always complete a relational approach. Such an approach benefits from specific training. Sedation might be needed from the outset in some patients.

The drug classes that may be used for sedation are:
- neuroleptics, which are effective if the patient displays agitation, particularly psychotic agitation, even though there may be no clear diagnosis when sedation is given (the atypical neuroleptics are contraindicated in dementia);

⁴ In France, the fire brigade provides an emergency ambulance service.
⁵ Law of 27 June 1990 modified by the law of 4 March 2002
- benzodiazepines, which should not be used without considering possible paradoxal reactions.

The combination of benzodiazepines and neuroleptics seems to enhance sedation, but also increases the incidence of iatrogenic events.

The choice of drug should be guided by the patient’s history and the situation. If the patient refuses to take the drug orally, the intramuscular route is the most common alternative.

Intervention by a third party may be needed for:
- administering an injection
- managing agitation
- possible immobilisation.

Immobilisation must be prescribed by a doctor and should be as carefully controlled as extended physical restraint in both its implementation (number of competent staff) and surveillance (protocol, specific surveillance form). While relatively easy in a hospital environment, it is more difficult to carry out at home. It may require the intervention of the police or, by force of circumstance, of anyone who happens to be present (ambulance staff, relatives, etc). The main concern is the safety of the patient and of those involved. This governs whether the intervention is immediate or postponed until the arrival of reinforcements.

Any drugs prescribed before the patient reaches hospital should be entered in the patient’s record and/or the shared record that will accompany them (drug, dose, route and place of administration). If known, the patient’s usual medication and their usual doctor’s details should also be recorded.

- **Psychiatric examination**

A psychiatric examination (Table 1) should be carried out as soon as possible in a calm and secure place. The examination should not be curtailed simply because the patient requires urgent admission to hospital.

<table>
<thead>
<tr>
<th>Physical examination (minimal requirements)</th>
<th>Psychiatric examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>• level of consciousness</td>
<td>• assess risk of suicide</td>
</tr>
<tr>
<td>• blood pressure</td>
<td>• look for:</td>
</tr>
<tr>
<td>• pulse</td>
<td>- history of harm to self and others</td>
</tr>
<tr>
<td>• temperature</td>
<td>- behavioural and/or adaptation disorders</td>
</tr>
<tr>
<td>• respiratory rate</td>
<td>• routinely investigate:</td>
</tr>
<tr>
<td>• capillary blood glucose</td>
<td>- cognitive abilities (memory, orientation),</td>
</tr>
<tr>
<td></td>
<td>- the patient’s thoughts (delusions, hallucinations) and thought processes (disorganisation, incoherence, psychomotor retardation or acceleration, i.e. acceleration or slowing of the train of thought).</td>
</tr>
</tbody>
</table>

**V.2 Assessment of social and family environment**

Before a decision to commit a person to hospital is made, the understanding and quality of support of family members and social contacts should be assessed (Box 1). Any physical and mental exhaustion they are experiencing should be taken into account. Although this may take time, developing cooperation with the patient’s family, friends and carers may facilitate involuntary commitment. An assessment should include the items in Box 1.
VI. Assessment of ability to give consent

The 5 criteria for assessing a patient’s ability to give his or her consent are given in Box 2.

Box 2. Criteria for assessing a patient's ability to give consent

- ability to take in appropriate information
- ability to understand and listen
- ability to reason
- ability to express their decision freely
- ability to keep to a decision over time


The patient should therefore be informed of:
- any disorders they have at the time of assessment
- possible repercussions of these disorders
- treatment needed and its administration.

In the case of legally incapable adults under guardianship, the following apply:
- consent should always be sought if they are able to express their wishes and to participate in making the decision;
- they have the right to be informed themselves and to take part in making decisions concerning them, according to their discernment level;
- a guardian’s consent is not a prerequisite when deciding whether to admit a patient to hospital without their consent. A legal representative’s powers relating to consent to care have not been clarified in legislation or in jurisprudence. However, like family members and carers, they should be informed and involved in implementing involuntary hospitalisation.

VII. Indications for involuntary commitment

When assessing the severity of a mental disorder and the need for immediate care, the factors in Table 3 should be investigated.
### Table 3. Indications for involuntary commitment

<table>
<thead>
<tr>
<th>Factor</th>
<th>Whether reason for involuntary commitment</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td>Very high risk of suicide</td>
<td>Can be an indication for immediate involuntary commitment</td>
<td>See text for patient profile</td>
</tr>
<tr>
<td>Risk of potentially causing harm to others</td>
<td>Insufficient reason*</td>
<td>There must be a mental disorder</td>
</tr>
<tr>
<td>Acute or chronic alcohol consumption or drug abuse</td>
<td>May be a reason</td>
<td>Must be combined with: psychiatric disorders AND/OR a history of suicide attempts AND/OR a foreseeable danger to themselves and/or to others</td>
</tr>
<tr>
<td>Delusions or hallucinations</td>
<td>Insufficient reason</td>
<td>Need to take into account severity of related criteria (see text)</td>
</tr>
<tr>
<td>Mood disorders other than depression with risk of suicide (see above)</td>
<td>May be a reason</td>
<td>e.g. a manic episode with tachypsychia, especially if associated with megalomania</td>
</tr>
<tr>
<td>Lack of proper self-care</td>
<td>May be a reason</td>
<td>Must be combined with: cognitive disorders AND/OR mood disorders AND/OR delusions and/or hallucinations</td>
</tr>
</tbody>
</table>

* Law of 27 June 1990, modified by the law of 4 March 2002

**Very high risk of suicide**

There may be an indication for immediate involuntary commitment if the patient:
- is determined, i.e. has planned to commit suicide in the next few days and intends to do so;
- is either detached from their emotions, giving reasons for their decision, or is very emotional, agitated or disturbed;
- is completely immobilised by depression or in a state of great agitation;
- feels constant pain and mental suffering or refuses to admit to any pain and suffering;
- has easy and immediate access to a way of committing suicide (drugs, firearms, etc.);
- feels that they have done and tried everything;
- is very isolated.

The increase in danger when several risk factors are present (particularly age >75 years) should also be taken into account.

**Alcohol consumption or drug abuse**

In the event of acute intoxication requiring hospitalisation, it is recommended that care should initially be given in an A & E department, as the physical risk predominates. The indication for involuntary commitment should be assessed during physical care for acute intoxication.

**Delusions**

The following related criteria of severity should be taken into account:
- the degree of belief and emotional involvement in the delusions (with a past history of acting out delusions);
- the subject of the delusions: delusions of ruin or guilt, persecution by a specified person, Cottard’s syndrome (nihilistic delusion – feeling that an organ has been lost or, most commonly, that it is not functioning, or feeling of not existing as a person), megalomania, delusion of passion (belief of being loved) including jealousy or erotomania;
The mechanism of the delusion ("mental automatism"): the patient is subject to commanding ideas and/or actions; this may present a danger to themselves or others; delusions combined with a disordered train of thought (see subsection III.1) and/or a mania and/or alcohol consumption or drug abuse.

VIII. Procedures for involuntary commitment

VIII.1 Commitment at the request of a third party

• Definition of third party

A third party may be any person likely to act in the interest of the patient:
- family member or person close to the patient;
- another person who can show that a relationship existed prior to the request, excluding care staff working in the admitting HCO department.

According to recent jurisprudence, the third party requesting involuntary hospitalisation must be able to show that a relationship existed prior to the request, thereby qualifying them to act in the patient’s interest. The relationship may be personal or professional.

• Making a request

The request by the third party should be handwritten on plain paper and signed by them. If this person is unable to write, the request should be received by the Mayor, commissioner for police or HCO director, who will produce the written request. The request should include the surname, forenames, profession, age and home address of both the person requesting hospitalisation and the person whose hospitalisation is requested. It should also state the nature of the relationship between them and whether they are related in any way.

If possible, the third party should go to the admitting HCO at the same time as the patient in order to confirm their identity and facilitate the patient's admission.

• Medical certificates

Two medical certificates issued within the previous fortnight are required. Each certificate should be made out by a doctor with a medical doctor's thesis who is a member of the Conseil de l'Ordre des médecins, or by a medical student licensed as a locum tenens.

Doctors signing these certificates must not be relatives (fourth degree or closer). They must have no links with each other, with the director of the HCO authorised to admit patients against their will, with the third party requesting hospitalisation, or with the patient. The first certificate must not be produced by a doctor practising in the HCO to which the patient is admitted. The second certificate should not in any way be bound by the observations and conclusions of the first.

Each certificate must be legible and written in French on plain paper (e.g. on a non-hospital practitioner's prescription form or a hospital prescription giving the doctor's surname, first name and function, and the hospital’s address). The certificate should give the patient's name, date of birth and home address. As it is not covered by medical confidentiality, it should be written in simple language, avoiding technical terms and suspected diagnoses.

The following conditions apply to the certificate:
- the doctor should examine the patient and observe any mental disorders for themselves: the doctor should therefore interview the patient, or at least attempt to do so;

6 Except for military doctors. They are not registered with the Ordre des médecins but are qualified to order involuntary hospitalisation.
Emergency involuntary commitment of a mentally disordered person

- when, in exceptional circumstances, the patient cannot be interviewed or approached, the certificate should mention this and state the origin of the facts reported, without identifying the individuals reporting them;
- the facts should be described in detail: the doctor should describe the symptoms suggesting that the patient has a mental disorder and the behaviour that suggest danger to self;
- the doctor should state that the patient's disorders make it impossible for them to give their consent.

Certificates should be sent to the director of the admitting HCO. They may be sent by fax, provided that the originals reach the director within 24 hours.

- **Imminent danger**

Exceptionally and only if the patient is in imminent danger, the director of the HCO may accept involuntary hospitalisation on sight of a single medical certificate issued by a doctor practising in the receiving HCO. The request by a third party nevertheless remains essential. The certificate should mention the risk of imminent danger, i.e. immediate danger to the patient's health or life.

**VIII.2 Commitment by the public authorities (HO)**

- **Non-emergency situation**

Orders for commitment by the public authorities (HO) are issued by the prefect of police in Paris or by the prefect in other départements, on sight of a detailed medical certificate. The terms of a medical certificate for the HO procedure are the same as those recommended for certificates for the HDT procedure. The certificate should state that the patient's mental disorder requires immediate care and seriously compromises the safety of individuals and public order. The certificate cannot be issued by a psychiatrist practising in the HCO to which the patient is admitted.

- **Emergency situation**

If there is an immediate risk to the safety of individuals, confirmed by a medical opinion or, failing this, by common knowledge, the Mayor, or in Paris the commissioner of police, may order temporary emergency measures. In practice, these measures usually take the form of an HO procedure.

The decision should be supported by a medical certificate rather than based on opinion alone, although the law does not insist on this. A doctor may be mandated by the Mayor or the commissioner of police to produce the certificate as soon as the situation allows it. The certificate should mention that the patient's behaviour constitutes an imminent threat to the safety of individuals or to public order.

**VIII.3 Informing the patient and their family on procedures**

Families and carers of patients committed to hospital should be given information about the law and its application.

- **HDT procedure**: If the patient wishes to know the identity or address of the third party, the psychiatrist in charge of the patient during their hospitalisation should assess the benefits and risks of disclosing this information. In case of doubt, the opinion of the regional psychiatric hospitalisation committee (CDHP) should be sought. Disclosure comes within the scope of providing support for the patient.

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7 Law of 27 June 1990 modified by the law of 4 March 2002
Commitment by the public authorities (HO): The administrative decision should be notified to the patient. If there is a risk to the safety of the certifying doctor, the prefect should be informed so that he/she can take this in to account when drafting the order.

All doctors should be aware of the procedures allowing patients to access their medical records. The patient may do so either directly or through a doctor of their choice, after applying to:
- the manager of the HCO
- or a health professional in the HCO
- or the person/establishment holding their record.

Exceptionally, if the risk is particularly serious, the patient may consult the information collected during an HDT or HO procedure only in the presence of a doctor they have nominated. If the patient does not agree to this, the regional psychiatric hospitalisation committee (CDHP) should be informed. Its opinion is binding on the holders of information and on the patient making the request.

VIII.4 Choice of HCO and admitting department

Patients with an acute physical disorder combined with a mental health disorder, should be managed initially in an A & E department, particularly if they are acutely intoxicated, until the physical problem has been resolved.

Direct admission of a patient to a hospital psychiatric department from their home is not possible unless they have an identified psychiatric disorder and only if no significant disorders have been found on physical examination.

VIII.5 Transport

Individuals subject to an HO or HDT may be conveyed to the receiving HCO without their consent and, when this is strictly necessary, by methods appropriate to the individual's condition. This transport must be provided by an approved ambulance service. Restrictions on individual liberties should be limited to those required by the individual’s condition and the carrying out of treatment prescribed.

In the case of an HDT procedure, transport can only take place after at least one medical certificate and the request by the third party have been produced.

It is recommended that transport arrangements should be made through a Centre 15 (SAMU) which coordinates transport arrangements with the people involved before and after hospitalisation, ambulance services and the attending doctor in the receiving HCO.

VIII.6 Admission to hospital

The procedures recommended in section III. 1 also apply to the admission process.

To prevent any delay in the psychiatric examination:
- channelling within the hospital A & E department should be facilitated;
- qualified psychiatric nurses should be present in the department.

Departments admitting patients that may be subject to involuntary commitment should develop protocols for managing these patients (Box 3).

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8 Law of 4 March 2002 and its application decree dated of 21 May 2003
9 Article L. 3222-1-1 of the Public Health Code
10 Article L. 3211-3 of the Public Health Code
Box 3. Protocols needed to improve management of patients subject to involuntary commitment

- upstream and downstream coordination with existing sector services
- physical examination and assessment by allied health professionals
- assessment of the patient's psychiatric state
- assessment of family members and provision of information for them
- procedures for surveillance, immobilisation or restraint
- training for care personnel
- promotion of distribution of information leaflets relating to psychiatric hospitalisation

IX. Conclusion and proposed future action

There is an urgent need for studies and epidemiological analyses of involuntary commitment to make up for the current lack of usable data.

The following proposals are prompted by current problems in implementing involuntary commitment:
- discuss ways of facilitating requests by a third party;
- clarify the concept of serious disruption of public order for the HO procedure;
- promote discussion and commission pilot studies on the benefit of an observation period (length yet to be determined) before endorsing an indication for involuntary commitment;
- assess the possible role of home intervention teams (mobile intervention team) or of crisis centres, in preventing repeated involuntary commitment;
- consider social changes and, in particular, the role of local elected representatives in mental health policy;
- include health professionals in discussions about possible changes in the law on involuntary commitment;
- see that these guidelines and information documents on involuntary commitment are disseminated widely;
- promote cooperation with patients' associations and representatives of patients' families;
- facilitate the processing of complaints sent to the CDHP and to the public prosecutor by patients who have been admitted to hospital without their consent, and by their family.
Annex 1 – Participants

Learned societies consulted

Société française d'alcoologie
Fédération française de psychiatrie
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Dr Jean-Pierre Vallée, general practitioner, Colleville-Montgomery
Dr Emmanuelle Wollman, CNRS project leader, Paris, former member of ANAES Scientific Council
Stéphanie Wooley, patients’ representative, France Dépression, Paris.
Annex 2 – Assessment method

The method for producing these clinical practice guidelines\(^{11}\) comprised the following steps:

**Defining the scope of the guidelines (Steering Committee):** The sponsor appointed members of the Steering Committee from among proposals made by professional societies concerned by the topic, and nominated a scientific chair and a coordinator. These societies were also contacted to form a working group that would include their representatives and other experts. The Steering Committee drafted specific questions and appointed experts to answer these questions.

**Literature search.** The scope of the literature search was defined by the Steering Committee and the project manager.

**Drafting the guidelines (Working group).** A critical appraisal of the literature was performed and a provisional report was written by 2 members of the working group. Guidelines were drafted by all members of the group and were based on agreement among members.

**Peer review.** Peer reviewers were appointed by the Steering Committee. They were either experts in the subject of the report or practitioners in the private or public sector. They were consulted by post, primarily with regard to the readability and applicability of the report conclusions and guidelines (scores from 1 to 9). Their comments were summarized and submitted to the working group which then drew up definitive conclusions. Peer reviewers were asked to sign the final document.

**Validation by the ANAES Scientific Council.** The ANAES Scientific Council validated the report. The working group finalized the guidelines with due regard to their comments.

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\(^{11}\) Full details are given in “Recommandations pour la pratique clinique – base méthodologique pour leur réalisation en France – 1999” (ANAES)
Annex 3 – Legal texts

Law no. 68-5 of 3 January 1968 reforming the rights of legally incapacitated adults.

Law no. 90-527 of 27 June 1990 relating to the rights and protection of individuals hospitalised because of mental disorders and the conditions under which they are hospitalised.


Law no. 2002-303 of 4 March 2002 relating to the rights of patients and the quality of the healthcare system.


Circular DHOS/O1 no. 2003-195 of 16 April 2003 relating to the management of emergencies.


Law no. 2004-806 of 9 August 2004 relating to public health policy.