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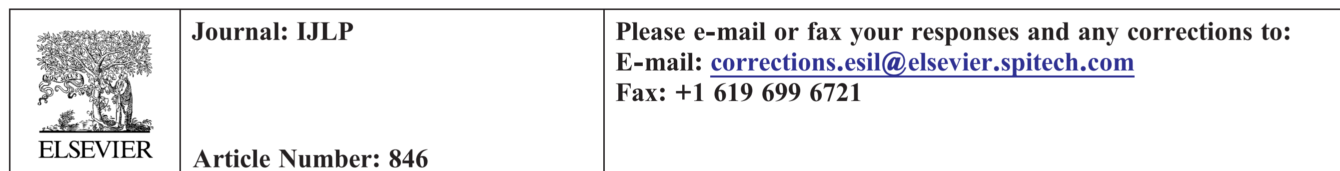

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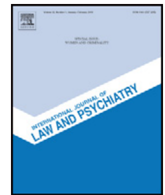

French lay people's views regarding the acceptability of involuntary hospitalization of patients suffering from psychiatric illness

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ABSTRACT

Purpose: To understand how lay people and health professionals in France judge the acceptability of hospitalizing a psychiatric patient against his will.
Methods: 123 lay people, 20 nurses, 5 psychologists, and 6 physicians judged the acceptability of involuntary hospitalization in each of 36 scenarios consisting of all combination of 4 factors: patient's adherence to treatment (agrees to take his medications or not); risk of suicide (none, immediate, multiple past attempts); risk of harming others (none, immediate, history of violence against others); attitude of patient's family (favorable to involuntary hospitalization or not). The judgment data were subjected to cluster analysis and subsequently to analysis of variance.
Results: 4 clusters were identified and labeled according to the factors that affected judgments: Never Favorable (7 participants, with mean acceptability judgment of 1.30 on a scale of 0–10); Threat to Others (35, with mean judgment of 8.68 when risk high, 2.94 when risk low), Threat to Others or Self and Adherence (88, with mean judgment of 6.89), and Always Favorable (24, with mean judgment of 8.41).
Conclusions: 95% of participants agreed that involuntary hospitalization is acceptable under certain conditions, especially – in accordance with French law – when the patient presents a risk to others.

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1. Introduction

The involuntary hospitalization of psychiatric patients has a long tradition in Western countries. It is legal under circumstances that vary from one country to another (Dawson & Kämpf, 2006; Habermeyer, Rachvoll, Felthous, Bukhanowsky, & Gleyzer, 2007; Kallert, Rymaszewska, & Torres-Gonzalez, 2007; Steinert & Lepping, 2009), although the basic requirement is, of course, that the patient suffers from a mental disorder.

Article 5 of the European Convention on Human Rights provides that "Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law: …(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants." Article 8 reiterates, more generally, that there can be "no interference by a public authority with this right [to respect for private and family life] except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others." (European Court of Human Rights, 2010). The United Nation's Convention on the Rights of Persons on Disabilities of 2006 enjoins signing states to "undertake to ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability" (Article 4) and, in particular, to ensure that persons with disabilities "are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty" (Article 14) (United Nations, 2006). It provides strong support for limiting the involuntary institutionalization and treatment of people with mental illness and other disabilities (Lee, 2011). Meanwhile, the European Court of Human Rights has repeatedly ruled that involuntary confinement is valid only if it is accord with national law and if it complies with the requirements set forth in the Court's 1979 judgment in *Winterwerp v the Netherlands*: "it must have been reliably established, through objective medical expertise, that the patient has a true mental disorder; the mental disorder must be of a kind or degree warranting compulsory confinement; the validity of continued confinement depends upon the persistence of such a disorder" (European Court of Human Rights, 2011).

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In France, legislation in 1990 established that patients with capacity must give their consent to be admitted to a hospital (Dawson & Kämpf, 2006; Loi no 90–527 du 27 juin, 1990). The patient's family (or another person acting in the patient's interest) can, however, obtain involuntary hospitalization under two conditions: if, as confirmed by two psychiatrists, the patient's mental illness renders him or her incapable of "consent" (and, by implication, of the capacity to make decisions) and if his or her condition requires immediate care under constant supervision in the hospital. In addition, the civil authorities can require hospitalization when, as confirmed by a psychiatrist or by public notoriety, the psychiatric patient poses an imminent threat to others' safety or, more generally, to public order. This legislation has been upheld in recent decisions of French courts of appeals concerning psychiatric patients who refused treatment (Cour d'appel d'Aix-en-Provence, 2008) and who presented a threat of violence against others (Cour d'appel de Bordeaux, 2006). France ratified in February 2010 the UN Convention on the Rights of Persons with Disabilities. Nonetheless, the recent alteration of the 1990 law (Loi n° 2011–803 du 5 juillet, 2011) did not change the law's basic principles regarding involuntary hospitalization.

Involuntary hospitalization is, however, among the most controversial and debated issues in mental health care. It has, repeatedly and increasingly, been the focus of criticisms from human rights advocates, political bodies, and patients' families (Kallert, Glöckner, & Schützwohl, 2008). It clearly involves an ethical conflict (Alexius, Berg, & Aberg-Wistedt, 2002; Monahan, Swartz, & Bonnie, 2003; Putkonen & Vollm, 2007; Wynn, Myklebust, & Bratlid, 2007). The principle of autonomy of the patient is superseded by the principles of beneficence toward the patient and responsibility to society, i.e. to those who might be affected by the patient's actions. Autonomy is demoted on the grounds, first, that the patient lacks insight into his or her psychiatric illness and, as a result, refuses or is unable to adhere to appropriate treatment, and/or, second, that the patient is likely to harm him- or herself or others if not hospitalized and adequately treated. If autonomy were allowed to supersede public safety, violent patients would end up being handled through the system of criminal law (Szmukler & Holloway, 1998). As observed by Monahan et al. (2003), the process of deinstitutionalizing mentally ill patients in the US has resulted in a 90% reduction in the mental hospital population, but it also has resulted in a concomitant increase in the number of inmates with serious mental troubles.

Involuntary hospitalization has also been the focus of criticisms from psychological and sociological researchers (Monahan, 1992; Taylor & Monahan, 1996). Involuntary hospitalization is mostly decided on the basis of the anticipation of future violence to oneself or others, which is a much more difficult prediction to make than is usually appreciated by the public and by the clinicians themselves (Lidz, Mulvey & Gardner, 1993; Monahan, 2006), even if main risk factors are better known now than 25 years before (Skeem, Miller, Mulvey, Tieman, & Monahan, 2005); clinicians systematically over-predict violence among psychiatric patients. Valid, standardized instruments for predicting future violence are available (e.g., Monahan et al., 2006), but the extent to which these instruments are used by health professionals at the time of recommending mentally ill patients' hospitalization is limited (Monahan, 2006) or unknown (e.g., in European countries).

Psychological and sociological researchers also argue that involuntary hospitalization is not the only option that can be considered when patients do not adhere to treatment and, as a result, are liable to become violent (Monahan et al., 2003). Patients can be led to adherence in a contractual way rather than in a coercive way. They can be offered housing or money (disability benefits) in exchange for treatment adherence. They can avoid being incarcerated for the troubles for which they are responsible if they agree to be treated; that is, a court can make treatment adherence a condition for suspending their sentence. Even if in practice, the distinction between coercion and contract may be considered as artificial, this distinction can be made real (Bonnie & Monahan, in press).

1.1. Lay people's and professionals' attitudes concerning involuntary hospitalization

Pescosolido, Monahan, Link, Stueve, and Kikuzawa (1999) examined American lay people's opinions about the use of legal coercion to force treatment of persons with mental health problems. Most people considered that patients suffering from schizophrenia are not very able or not able at all to make treatment decisions (74.3%), are somewhat likely or very likely to do something violent to others (60.9%) or to self (86.5%), and should be admitted to the hospital if dangerous to others (90.5%) or to self (94.8%). More educated people were less likely to express these views than less educated people.

Elger and Harding (2004) compared law students' and medical students' views regarding the involuntary hospitalization of suicidal patients suffering from Huntington disease. There were few differences between the two groups: 44% of the law students and 49% of the medical students agreed with involuntary hospitalization. Luchins, Cooper, Hanrahan, and Rasinski (2006a) examined the opinions of psychiatrists regarding involuntary hospitalization and found that decisions to hospitalize were positively associated with the level of possible harm and differed as a function of the psychiatric diagnosis. In a subsequent study, Luchins, Hanrahan, and Heyrman (2006b) examined the opinions of lawyers and had findings consistent with those of Elger and Harding (2004): decisions to hospitalize were positively associated with perceived level of risk of causing harm to others and with adherence to treatment.

Steinert, Lepping, Baranyai, Hoffmann, and Leherr (2005) conducted a cross-cultural study involving psychiatrists, other professionals, and lay people from four European countries: England, Germany, Hungary, and Switzerland. Participants were presented with scenarios describing patients with schizophrenia and indicated whether they should support involuntary hospitalization in each case. In the case describing a first episode associated with social withdrawal, 74% of the participants agreed with compulsory hospitalization. In the case of recurrent episodes and moderate danger to others, 87% of the participants agreed with compulsory hospitalization. Psychologists and social workers were, however, significantly less in agreement with that decision than psychiatrists, nurses, and lay people. Overall, there were only small differences in percentages of agreement from one country to the other (see also Lepping, Steinert & Röttgers, 2004).

Wynn, Myklebust, and Bratlid (2006) used three scenarios to examine the opinions of Norwegian lay people regarding the involuntary admission of schizophrenic patients. Their findings nicely complemented those of Steinert et al. (2005). In the case of a patient in an early phase of schizophrenia, 39% of the participants supported compulsory admission. In the case of a violent patient with delusions, 80% of the participants supported compulsory admission. Wynn et al. (2007) found basically the same results when they examined Norwegian psychologists instead of the general public.

1.2. The present study

The present study examined the views about involuntary hospitalization of lay people and health professionals in France. It differed from the other studies in that, as in several studies recently conducted on other aspects of medical ethics (Guedj, Muñoz Sastre, Mullet, & Sorum, 2009; Teisseyre, Duarte dos Reis, Sorum, & Mullet, 2009; Teisseyre, Mullet, & Sorum, 2005), it examined the mental process by which a person arrives at the conclusion that compulsory hospitalization is acceptable or not. In addition, the present study aimed at delineating the possibly diverse positions that individuals – both lay people and health professionals – may have regarding involuntary hospitalization. As stated by Steinert et al. (2005, p. 635),

"compulsory procedures are based on traditions and personal attitudes to a considerable degree" (see also Monahan, 1992). In other words, among the same population, different philosophies about coercion may co-exist.

The present study, like many previous studies (e.g., Steinert et al., 2005), used scenarios; that is, participants were instructed to consider concrete cases and indicate each time whether, in their view, involuntary hospitalization was an acceptable solution. The factors incorporated in the scenarios were those more commonly encountered in the literature as associated with decisions to hospitalize involuntarily: (a) patient's lack of insight and inability to adhere to treatment (e.g., Putkonen & Vollm, 2007; Swanson, Van McCrary, Swartz, Van Dorn, & Elbogen, 2007), (b) patient's risk of harm to self (e.g., Carter, Safranko, Lewin, Whyte, & Bryant, 2006; Dammak & Ayadi, 2009; Elger & Harding, 2004; Swanson et al., 2007), (c) patient's risk of harm to others (e.g., Dammak & Ayadi, 2009; Steinert et al., 2005; Wynn et al. 2006), and (d) attitude of the relatives or substitute decision makers (Dawson & Kämpf, 2006; Elger & Harding, 2004; Kallert et al., 2007).

We expected that, at the overall level, the less patients adhere to treatment, the more patients pose a risk to self and/or others, and the more the relatives' attitude is favorable to hospitalization, the more acceptable will be compulsory admission; such effects have been separately demonstrated in earlier studies. At the individual level, we expected to find multiple positions, based on different ways of valuing and combining the pieces of information. We hypothesized that a small group of people would consider involuntary hospitalization as unacceptable irrespective of circumstances. Such a minority group has already been found by Wynn et al. (2007), and minority groups of this kind have been found in ethics studies over a range of problems (e.g., Esterle, Munoz Sastre, & Mullet, 2008; Guedj et al., 2005; Guedj et al., 2009). We hypothesized that another group of participants would take into account only the threat to others, in accordance with the main thrust of French law. Finally, we hypothesized that a third group of persons would take into account all factors, and we expected this group to include most of the health professionals, who would be sensitive to the multiple factors involved in deciding to hospitalize a patient against his or her will.

2. Method

2.1. Participants

The 154 participants (106 females, 48 males) were unpaid volunteers from the region of Toulouse, France, who were informed about the goals of the study and gave their consent. Their mean age was 36 years ($SD = 14.37$, range = 18–77). One hundred twenty-three participants were lay people, 20 were nurses working in hospitals, 5 were psychologists, and 6 were physicians. None of the nurses or physicians worked with psychiatric patients.

Among the 123 lay people, 41% had a university degree, 59% had completed secondary education but did not have university degree, and 16% had been directly confronted with this kind of problem in their family.

The lay people were approached by two trained research assistants while they were walking along the main sidewalks of Toulouse. Overall, 200 persons were contacted, and after having received a full explanation of the procedure, 61.5% of them agreed to participate. The professionals were contacted at the hospital.

2.2. Material

The material consisted of 36 cards containing a scenario of a few lines, a question, and a response scale. The scenarios were composed according to a four within-subject factor design, presented in the following order: (a) the patient's level of adherence to treatment (agrees to take his or her medication on a regular basis or completely refuses to take the drugs that have been prescribed), (b) the level of risk of suicide (no real risk, intermediate risk, or multiple prior suicide attempts), (c) the level of risk of serious harm to others (no real risk, intermediate risk, or history of violence against others), and (d) the extent to which the patient's relatives are favorable to coercion and forced treatment (favorable or unfavorable), $2 \times 3 \times 3 \times 2$. Gender and age were constants: all patients were aged 55–60 years and identified as "Mr."

Under each scenario were a question and a response scale. The question was, "To what extent do you believe that the physician's decision to undertake involuntary hospitalization is acceptable in this case"? The response scale was an 11-point scale (0–10) with a left-hand anchor of "Not acceptable at all" and a right-hand anchor of "Completely acceptable." Two examples are given in the Appendix A. The cards were arranged by chance and in a different order for each participant.

2.3. Procedure

The site was a vacant classroom in the university. Each person was tested individually by one of the research assistants. As recommended by Anderson (1982), the session had two phases. In the familiarization phase, the experimenter explained to each participant what was expected and presented him or her with 18 scenarios taken from the complete set. The participant then provided an acceptability rating for each story. After completing the 18 ratings, the participant was allowed to compare responses and change them. In the experimental phase, the whole set of 36 scenarios was presented. Each participant provided ratings at his or her own pace, but was no longer allowed to compare responses nor to go back and make changes as in the familiarization phase. In both phases, the experimenters routinely made certain that each participant, regardless of age or educational level, was able to grasp all the necessary information before making a rating.

The participants took 15–30 min to complete both phases. The experimental phase went quickly because they were already familiar with the task and the material. The participants knew in advance how long the experiment would last. None of them complained about the number of vignettes they were required to evaluate. The research was approved by the Ethics and Work laboratory of the Institute of Advanced Studies, and informed consent was obtained from all participants in the study.

3. Results

A cluster analysis was performed on the raw data. Four clusters were identified. Three of these fours clusters are shown in Fig. 1. No significant difference in the composition of these clusters as a function of age and gender was found. ANOVAs were performed on the data from each cluster. Their design was Adherence to treatment × Risk of homicide × Risk of suicide × Relatives' attitude, $2 \times 3 \times 3 \times 2$. The results are shown in Table 1.

The first cluster ($N = 7$) was termed Never Acceptable since the responses were always close to the left side of the scale. The mean value of the responses was 1.30. The cluster is not depicted in Fig. 1 because the responses were very low for every combination of patient characteristics. The cluster was composed of six (of 20) nurses and one physician.

In the other three clusters, responses varied to some degree for different scenarios. The second cluster ($N = 35$) was termed Threat to Others since the only factor that had a strong effect was the risk of homicide (see top panels in Fig. 1). Acceptability was judged much higher when the risk was high ($M = 8.68$) than when it was low ($M = 2.94$). The mean value of the responses was 5.82. This cluster was composed of 32 (of 123) lay persons, two nurses, and one

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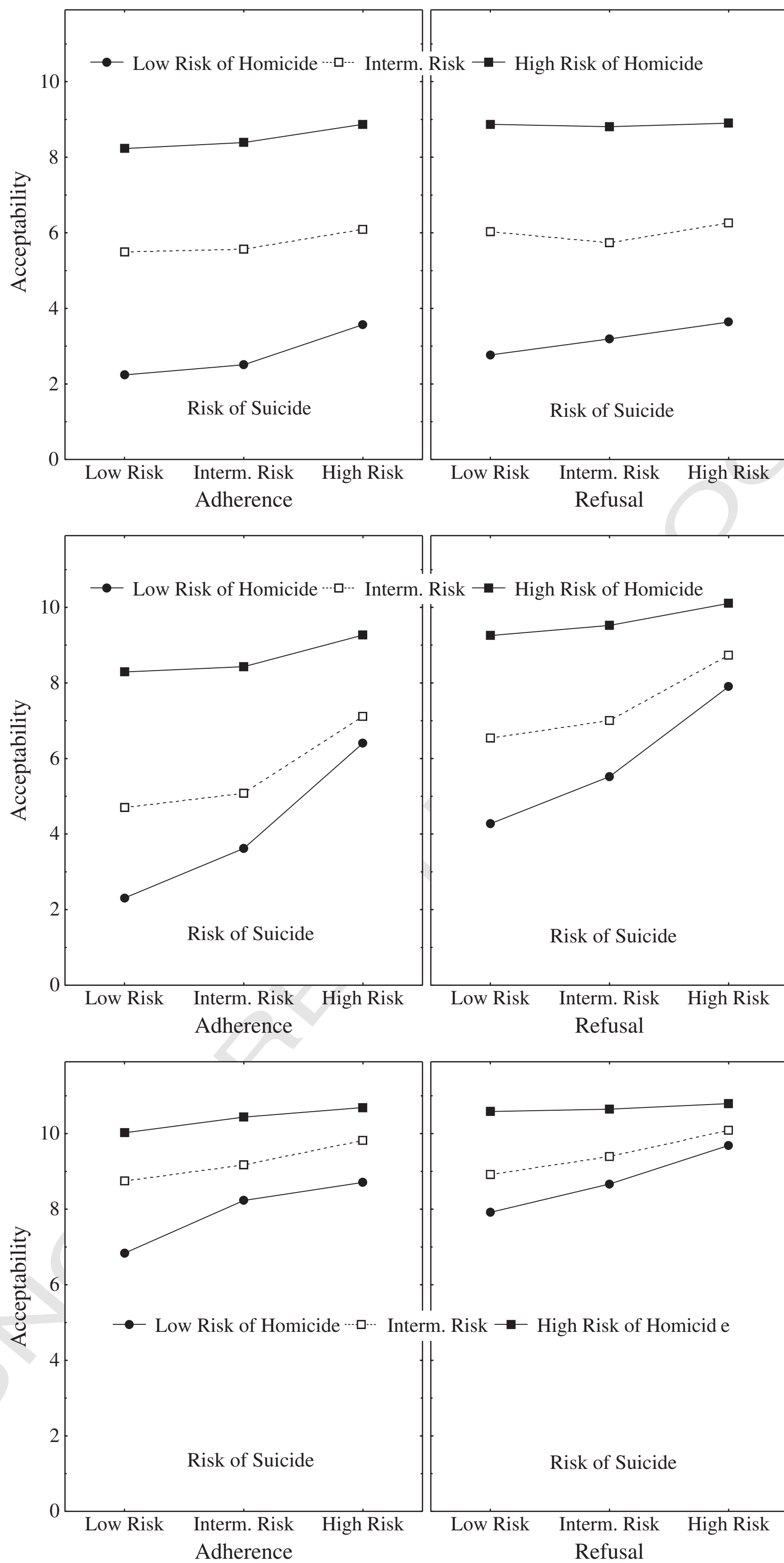

Fig. 1. Pattern of results observed for three of the four clusters: the Risk to Others cluster (top panels), the Risk for Others or for Self and Adherence to Treatment cluster (center panels), and the Always Acceptable cluster (bottom panels). In each panel, the y-axis corresponds to the acceptability judgments, the x-axis bears the three levels of risk to self, the three curves correspond to the three levels of risk to others, and the two panels correspond to the two levels of adherence to treatment.

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Table 1
Results of the ANOVAs for each cluster. The higher-order interactions, all non significant, have been omitted.

Factor	Effect		Error				
	df	*MS*	*df*	*MS*	*F*	*p*	Eta²p
Never Acceptable							
Relatives	1	32.14	6	14.62	2.20	*ns*	.27
Homicide	2	46.96	12	6.59	7.13	.01	.54
Suicide	2	27.53	12	5.25	5.24	*ns*	.47
Adherence	1	44.59	6	8.12	5.49	*ns*	.48
Relatives × Homicide	2	1.75	12	1.69	1.03	*ns*	.15
Relatives × Suicide	2	5.44	12	3.18	1.71	*ns*	.22
Homicide × Suicide	4	2.95	24	1.05	2.80	*ns*	.32
Relatives × Adherence	1	0.40	6	2.33	0.17	*ns*	.03
Homicide × Adherence	2	6.86	12	2.72	2.52	*ns*	.30
Suicide × Adherence	2	1.10	12	1.72	0.64	*ns*	.10
Risk to Others							
Relatives	1	12.40	34	3.25	3.82	*ns*	.10
Homicide	2	3460.47	68	24.13	143.43	.00	.81
Suicide	2	51.50	68	3.02	17.07	.00	.33
Adherence	1	49.21	34	4.37	11.25	.00	.25
Relatives × Homicide	2	4.18	68	2.48	1.68	*ns*	.05
Relatives × Suicide	2	4.50	68	1.86	2.42	*ns*	.07
Homicide × Suicide	4	9.50	136	3.06	3.10	*ns*	.08
Relatives × Adherence	1	1.33	34	3.03	0.44	*ns*	.01
Homicide × Adherence	2	1.44	68	3.84	0.37	*ns*	.01
Suicide × Adherence	2	8.92	68	2.40	3.72	*ns*	.10
Risk to Self or to Others and Adherence							
Relatives	1	87.67	87	5.10	17.18	.01	.16
Homicide	2	4632.53	174	9.53	485.87	.01	.85
Suicide	2	1579.00	174	6.21	254.38	.01	.75
Adherence	1	1822.73	87	9.29	196.29	.01	.69
Relatives × Homicide	2	0.56	174	2.04	0.28	*ns*	.01
Relatives × Suicide	2	4.71	174	2.64	1.78	*ns*	.02
Homicide × Suicide	4	199.32	348	3.35	59.52	.01	.41
Relatives × Adherence	1	1.42	87	1.72	0.82	*ns*	.01
Homicide × Adherence	2	60.14	174	3.03	19.84	.01	.19
Suicide × Adherence	2	7.84	174	2.91	2.69	*ns*	.03
Always Acceptable							
Relatives	1	50.07	23	3.40	14.71	.01	.39
Homicide	2	345.14	46	6.05	57.03	.01	.71
Suicide	2	91.18	46	3.35	27.18	.01	.54
Adherence	1	43.56	23	3.40	12.80	.01	.36
Relatives × Homicide	2	1.87	46	0.94	1.98	*ns*	.08
Relatives × Suicide	2	1.91	46	1.13	1.69	*ns*	.07
Homicide × Suicide	4	12.11	92	2.00	6.05	.01	.21
Relatives × Adherence	1	0.12	23	1.40	0.08	*ns*	.01
Homicide × Adherence	2	8.06	46	1.37	5.87	.01	.20
Suicide × Adherence	2	1.76	46	1.09	1.61	*ns*	.07

physician. Among the 32 lay persons, only 25% had a university degree, $p < .05$.

The third cluster, the majority cluster ($N = 88$), was termed Threat to Self or Others and Adherence to treatment. The mean value of the responses was 6.89. As in the second cluster, acceptability was judged much higher when the risk to others was high (M = 8.15) than when it was low (M = 4.00). In addition, acceptability was judged much higher when the risk to self was high (M = 7.26) than when it was low (M = 4.89). The Risk to Others x Risk to Self interaction was significant. As shown in Fig. 1, acceptability was judged high either when risk to others was high or when risk to self was high. Finally, adherence to treatment has also a strong effect. Acceptability was judged much higher when the patient refused any treatment (M = 6.65) than when the patient kept taking the medications (M = 5.13). As a result, the Adherence × Risk to Others interaction was significant. This cluster was composed of 70 (of 123) lay persons, 10 (of 20) nurses, all five psychologists, and three physicians. Among the 70 lay persons, half of them had a university degree.

Finally, the fourth cluster ($N = 24$) was termed Always Acceptable since the responses were always close to the right side of the scale. The mean value of the responses was 8.41. The pattern of responses is similar to that in the third cluster except that all responses have a relatively high value. This cluster was composed of 21 lay persons, two nurses, and one physician. Among the 21 lay persons, half of them had a university degree.

4. Discussion

Our study of French lay people's and health professionals' judgments of the acceptability of involuntary hospitalization of patients with a psychiatric illness had several important findings. First, the vast majority of participants (95%) agreed that involuntary hospitalization is acceptable under certain conditions. Some (16%), to our surprise, found it acceptable in all conditions. Only a small minority (5%) was, as expected, systematically opposed to it.

Second, this minority of opponents was composed only of health professionals (in particular, 6 nurses and 1 physician). Even if the health professionals who participated in the present study did not actually work with psychiatric patients, most of them would have been exposed, at least at some point in their careers, to mentally as well as physically ill patients and, as a result, would tend to be less frightened than lay people by these patients. In addition, nurses are used to working closely with patients and developing empathy for them. It is also possible that these health professionals were aware of the criticisms of and the alternatives to involuntary hospitalization proposed by psychological and sociological researchers (as discussed in the Introduction). Nonetheless, the majority of health professionals in our study (70% of the nurses, 83% of the physicians, and 100% of the psychologists) were not systematically opposed to involuntary hospitalization. In comparison, Steinert et al. (2005) found, in their study of four European countries, that psychologists and social workers, but not nurses, psychiatrics, or other doctors, were less in favor of involuntary hospitalization than lay people.

Third, as expected, by far the most important factor in judging the acceptability of involuntary hospitalization was the risk to other people (in particular, the danger of committing a homicide). This was in accordance with French law that allows the civil authorities, with advice of and, in practice, at the request of, the patient's psychiatrist, to hospitalize such a patient against his or her will. In contrast, the attitude of relatives was taken into account either very little (by the majority cluster) or not at all. Even though French law allows the family to instigate involuntary hospitalization, in actual practice, as reflected in the participants' responses, request by the family was not considered as a relevant criterion after controlling for the influence of the factors of risk to self and risk to others.

Fourth, as also expected, the majority of both lay people (57%) and health professionals (58%) took into account multiple factors. They were sensitive to the patient's risk to himself or herself (the danger of suicide) as well as to others (the danger of homicide), and they combined these two factors in a complex way, so that a high level of only one of the two risks was sufficient to make involuntary hospitalization acceptable. Even though French law speaks in general terms of hospitalization at the request of a third party if "his condition requires immediate care in addition to constant surveillance in a hospital setting," lay people as well as health professionals realize that threat of suicide is such a condition. This finding was consistent with the findings by Pescosolido et al. (1999) that coercion was readily endorsed by American lay people for patients suffering from schizophrenia in case of either threat to self or threat to others (more than 90% favorable to coercion in each case).

Our study has limitations. First, our samples, especially of health professionals, were of modest size; were, in the case of the health professionals, quite heterogeneous; were convenience samples; and were composed only of people living in the south of France. Generalizations of our findings to other groups must be made with caution, and further studies of health professionals, particularly of nurses,

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need to be done. Second, we presented the participants with scenarios, not with real patients. While scenarios are less realistic than patients, their use is more feasible, allows more precise statistical analyses of the variables, and has been repeatedly defended (Froberg & Kane, 1989; Ulrich & Ratcliffe, 2008). Third, all the scenarios were about a patient suffering from severe psychiatric illness. As in Pescosolido et al. (1999), other conditions – alcohol dependence, drug dependence, and depression – could have been considered, and future studies should assess to what extent our results can be generalized to these conditions.

In spite of these limitations, our study is useful in showing that most French lay people and health professionals, at least in our study, are in agreement with the implications of French law and of the European Convention on Human Rights that beneficence and public safety must supersede patient autonomy when mentally-ill persons pose a grave risk to themselves and, more importantly, to others. Future studies should be conducted to assess the extent to which people think that accurate prediction of future violence among people suffering from mental illness is feasible and that alternative, "contractual" solutions (Monahan et al., 2003) can be put in place. In addition, it will be important to watch the impact of the UN Convention on the Rights of Persons with Disabilities on judicial rulings, legislation, and public opinion in countries, like France, that ratify it (as well as in countries, like the United States, that may not) (Lee, 2011).

5. Uncited references

Guedj et al., 2006
Kallert, 2008
Wynn, 2004

Appendix A

Two examples of scenarios (in English translation and French original)

#1

Mr. Duhamel is 55 years old. He suffers from very serious psychiatric problems. His capacity of judgment is greatly altered. Mr. Duhamel is willing nonetheless to take, in a regular manner, the treatments prescribed for him.

For the past several days, Mr. Duhamel has not gone to work and is living in seclusion in his apartment. His psychiatrist, Dr. Fournier, considers that his risk of suicide is low. Mr. Duhamel has never, up until now, tried to end his life.

The risk that Mr. Duhamel will commit a homicide seems equally low. He has never, it appears, acted in a violent and potentially dangerous way towards another person.

The family of Mr. Duhamel, very worried, would favor involuntary hospitalization in a psychiatric hospital.

In light of the evolution of the situation, Dr. Fournier decides to set in motion the procedure for involuntary hospitalization.

To what extent do you think that such a decision is acceptable?

Not at all acceptable o–-o–o–o–o–o–o–o–o–o–o Completely acceptable

Monsieur Duhamel a 55 ans. Il souffre de troubles psychiatriques très graves. Ses capacités de jugement sont très altérées. Monsieur Duhamel accepte néanmoins de prendre, de manière régulière, les traitements qui lui ont été prescrits.

Depuis plusieurs jours, Monsieur Duhamel ne s'est plus rendu à son travail, et vit reclus dans son appartement. Son médecin psychiatre, le Docteur Fournier, estime que le risque de suicide est, chez ce patient, faible. Monsieur Duhamel n'a jamais, jusqu'ici, tenté de mettre fin à ses jours.

Le risque que Monsieur Duhamel commette un homicide apparaît également faible. Celui-ci n'a, semble-t-il, jamais présenté de comportements violents et potentiellement dangereux pour autrui.

La famille de Monsieur Duhamel, très inquiète, serait favorable à une hospitalisation d'office en hôpital psychiatrique.

Compte tenu de l'évolution de la situation, le docteur Fournier décide de lancer la procédure d'hospitalisation d'office.

Dans quelle mesure pensez-vous qu'une telle décision est acceptable ?

Pas du Tout acceptable o–-o——o——o——o——o——o——o——o—— o——o Tout à fait acceptable

#2

Mr. Bernard is 57 years old. He suffers from very serious psychiatric problems. His capacity of judgment is greatly altered. Mr. Bernard even refuses to take the treatments prescribed for him.

For the past several days, Mr. Bernard has not gone to work and is living in seclusion in his apartment. His psychiatrist, Dr. Gramont, considers that his risk of suicide is high. Mr. Bernard has tried, on several occasions, to end his life.

The risk that Mr. Bernard will commit a homicide seems equally high. Indeed, he is well-known for having already tried to take the lives of other persons.

The family of Mr. Bernard is worried but does not favor involuntary hospitalization in a psychiatric hospital.

In light of the evolution of the situation, Dr. Bernard decides to set in motion the procedure for involuntary hospitalization.

To what extent do you think that such a decision is acceptable?

Not at all acceptable o–-o–o–o–o–o–o–o–o–o–o Completely acceptable

Monsieur Bernard a 57 ans. Il souffre de troubles psychiatriques très graves. Ses capacités de jugement sont très altérées. Monsieur Bernard refuse même de prendre les traitements qui lui ont été prescrits.

Depuis plusieurs jours, Monsieur Bernard ne s'est plus rendu à son travail, et vit reclus dans son appartement. Son médecin psychiatre, le Docteur Gramont, estime que le risque de suicide est, chez ce patient, élevé. Monsieur Bernard a tenté, à plusieurs reprises, de mettre fin à ses jours.

Le risque que Monsieur Bernard commette un homicide apparaît également élevé. En effet, celui-ci est connu pour avoir attenté déjà à la vie d'autres personnes.

La famille de Monsieur Bernard est inquiète mais ne se montre pas favorable à une hospitalisation d'office en hôpital psychiatrique.

Compte tenu de l'évolution de la situation, le docteur Gramont décide de lancer la procédure d'hospitalisation d'office.

Dans quelle mesure pensez-vous qu'une telle décision est acceptable ?

Pas du Tout acceptable o–-o——o——o——o——o——o——o——o—— o——o Tout à fait acceptable

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