

Psychiatric or forensic doctors? Study of legal interventions in a mental health center of Madrid

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¿Psiquiatras o forenses? Estudio de las intervenciones judiciales en un centro de salud mental de Madrid

Summary

Introduction. *Psychiatric compulsory admission means that a fundamental right, such as individual freedom, is restricted. This has been legally regulated in Spain by the January 7, 2000 Civil Procedure Law 1/2000.*

Since the 1990's in the capital of Madrid, based on the agreements reached between Court no. 30 and the representatives of the Regional Health Service, the psychopathological assessments of supposed incapacities on which the Court has issued compulsory admission authorizations are carried out by the psychiatrists of the mental health centers instead of by the forensic physicians.

Material and methods. *This study compares the first 60 cases evaluated in a mental health center during the years 1992-1994 with the last 60 cases of patients evaluated during the years 2000-2002.*

Results. *In the second group, we found a significant increase in mean age and in the number of request for intervening in female patients.*

In addition to the number of request for civil disabilities and ordinary authorizations for compulsory admission, there were eight cases of court subjection to treatment and two requests for of psychiatric analyses for civil procedure.

In the second group the number of home interventions significantly decreased in contrast with the number of interventions developed in medical offices.

Although there was the same number of admissions from both groups, 36%, 20% of patients had no indication for treatment or admission in the second group. At 5 months after discharge, we observed a 15% loss of patients from the first group and 20% from the second group.

Conclusions. *Action protocols must be created in this type of intervention, starting in the corresponding court and going to the teams which would develop the interventions, in order to safeguard the citizen's rights.*

Key words: *Compulsory admission. Involuntary treatment. Psychiatry. Legislation.*

Resumen

Introducción. *El internamiento psiquiátrico involuntario supone la restricción de un derecho fundamental como es la libertad individual. En España está legalmente regulado por la Ley 1/2000, de 7 de enero, de Enjuiciamiento Civil.*

En Madrid capital, la década de 1990, en función de acuerdos entre el Juzgado n.º 30 y representantes del Servicio Regional de Salud, las valoraciones psicopatológicas de supuestos incapaces sobre los que el juzgado emite autorizaciones de internamientos involuntarios son llevadas a cabo por los psiquiatras de los centros de salud mental en lugar de los forenses.

Material y métodos. *Este estudio compara los primeros 60 casos que fueron evaluados a instancias judiciales en un centro de salud mental en los años 1992, 1993 y 1994 en los últimos 60 casos de los años 2000, 2001 y 2002.*

Resultados. *Encontramos un aumento significativo de la edad media y del número de demandas a intervenir en mujeres en el segundo grupo.*

Además de las solicitudes de valoración de incapacidades civiles y de las autorizaciones ordinarias de internamientos involuntarios, existieron ocho casos de sometimiento judicial a tratamiento y dos demandas de informes psiquiátricos para juicios civiles.

El número de intervenciones domiciliarias disminuyó significativamente en el segundo grupo a favor de las realizadas en consulta.

En ambos grupos > 50% fueron diagnosticados de trastorno psicótico.

Aunque fueron ingresados el mismo número de casos (un 36%), en un 20% del segundo grupo no se indicó ni ingreso ni tratamiento. Observamos una pérdida de pacientes a los 5 meses del alta de un 15% en el primer grupo y de un 20% en el segundo.

Conclusiones. *Es necesario crear protocolos de actuación de este tipo de intervenciones desde su punto de partida en el tribunal correspondiente hasta en los equipos que deban llevarlas a cabo con objeto de salvaguardar mejor los derechos de los ciudadanos.*

Palabras clave: *Ingreso involuntario. Tratamiento involuntario. Psiquiatría. Legislación.*

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INTRODUCTION

Compulsory psychiatric admission means that a fundamental right such as individual freedom, a value pro-

tected by all the rights, is restricted^{1,3}. This subject raises important ethical controversies between those who defend paternalism of the State regarding presumed incapacity and those who support the principals of autonomy and free will and denounce compulsory hospitalization as a clear violation of the person's freedom⁴.

The 1977 Hawaii declaration that established the ethical principals that should govern the action of the psychiatrists in the world was up-dated in the Oviedo agreement. This is the agreement of the European Council on human and biomedicine rights that was made on 4-4-1997 and was ratified on 23-7-1999. This is the first international instrument that has a binding legal character for the countries that subscribe to it⁵.

In Spain, legal regulation offers no differences in cases of voluntary psychiatric admission in regards to admission for other non-psychiatric diseases^{6,7}, however in the case of compulsory admission, the classic article 211 of the Civil Code has been substituted by the new January 7 Law 1/2000 of Civil Procedure, that entered into force on January 8, 2001^{1,8}.

Given the implication of the subject, the European Council White Book has been published. It regulates admission and forced treatment of the mental patient⁹. Furthermore, the authors state the need to make a protocol of the interventions as well as to train the professionals involved on the knowledge of the legislation in force^{1,2,7}.

In Madrid, as evidenced from the 19-6-1989 and 10-1-1990 Regional Service of Health records, based on the creation of Court of Law no. 30 in charge of the subjects of custody and authorizations of compulsory admission, the Illustrious Judge, the Illustrious District Attorney and two representatives of the Mental Health Service met. This gave rise to some recommendations that were sent to all the mental health centers within the jurisdiction scope of this court of law. In a second meeting, the jurisdictions and actions were specified somewhat more both for the court of law as well as the physicians and in the last paragraph of the «patient home intervention», it says: «The judge indicates that the area psychiatrist, who knows the situation of the patient, and not the forensic physician, will be the one to perform an intervention in the home ...»^{10,11}.

This concise and vague comment gave rise to the fact that not only in the case of patients known by the psychiatrist but also in any type of home intervention of a supposed mental patient who refused to be examined by the specialist, court of law no. 30, initially, that has been extended to number 65 at present, could issue a protocol authorization of admission to the corresponding mental health center. This center must act automatically to avoid being in contempt. This initial agreement, that aimed to improve the fluency of the relationships between the court and psychiatrists in benefit of the supposed incapable subject, has converted the mental health centers of the city of Madrid into a forced resource of the Ministry of Justice. In this way, the psychiatrists

are substituting the body of forensic physicians of the State in these functions without receiving any training in legal subjects and with absolute precariousness of means.

The professionals had the sensation that this type of interventions greatly distorted their health care practice and exceeded the field of their functions. Our work hypothesis was that the agreements carried out between the Court and the mental health responsible persons at the beginning of the 90's had become obsolete and were not presently the best answer for the problems of the population group in question.

The lack of publications on this problem is striking. Thus, we believe that the study of the legal actions requested and the evolution of them over the years is justified.

MATERIAL AND METHODS

This is a retrospective study comparing two patient populations seen in Area I mental health center of Madrid, in which psychiatric intervention was requested in the Court or by the district attorney.

Both populations were obtained by using all the patients registered during the years 2000, 2001, and 2002 with a total of 60 cases; which was called group II. The other population was formed with an identical number of cases recorded during the years 1992, 1993 and 1994, date of the onset of this type of interventions in our center, on a total of 77, this was group I.

To gather the data, a specific questionnaire was elaborated with the following features:

1. Sociodemographic data: age, gender, type of cohabitation (alone, origin family, own family, institution, others).
2. Personal background: previous psychiatric history, history in our center, toxic consumption.
3. Proposal of the request (social services, family, resident's association, court).
4. Origin of request (incapacity process from the district attorney, court authorization of ordinary admission, subjection to penal treatment, civil causes).
5. Reason for request (physical disease, mental disease, garbage accumulation, forced entry).
6. Place of intervention (in the mental health center, in the patient's home, in the street, intervention was not possible).
7. Use of other resources (police, firemen, others).
8. ICD-9 diagnoses.
9. Result of the intervention (admission to the Psychiatry Acute Unit, out-patient follow-up in our center, referral to other services, no indication of treatment, incapacity report, not located).
10. Evaluation at 5 months of the intervention (they continue in our center, loss to follow-up after hospital discharge, diverted to other resources).

The data were processed statistically with the SPSS 11.0 program for Windows. A Student's *t* test was performed for the age variable and chi squared for the qualitative variables.

RESULTS

Although age ranges were similar in both groups (18-81 years, for the first and 19-81 years for the second), significant differences were found for the means ($p > 0.000$) with more advanced ages in the second group ($\bar{x} 39.1$ SD 15.4 and $\bar{x} 53.6$ SD 16.4 in the latter). Demands of women have also significantly increased ($p > 0.05$) in recent years.

There was no significant difference regarding type of cohabitation in both groups, although we observed a greater percentage of those who lived alone in the second group (28.3 % versus 18.3 %), decreasing both cohabitation with the origin family (38.3 % versus 46.7 %) and own family (18.3% versus 21.7%).

There were no significant differences in regards to psychiatric background (71.7% group I and 61.7% group II) or in the previous history in our center (60% group I and 48.3% group II). We also found no differences in toxic consumption, however, it must be stressed that this information does not appear in 20 % of the reports of group I and in 10% of those of group II.

Although we found no significant differences regarding the entity from which the initial proposal of the court or district attorney petition arose, we have seen greater initiative of the resident's association in group II (16.7% versus 8.3%), with a decrease in the family petitions (43.3% versus 51.7% of group I) and the social services (10% versus 13.3%).

Interestingly, the same number of incapacity procedures was requested from the District Attorney in both groups, 23.3%, and there was also the same percentage of submissions to penal treatment, 6.7%, the percentage of ordinary authorizations of admissions from the court in group II decreasing very slightly (66.7% versus 70% of group I). There were 2 cases (3.3%) in the latter group in which the intervention requested was based on a psychiatric report for civil lawsuits.

On reviewing the last reasons why the intervention was requested, we found that the same number of cases in which the problem was psychiatric was maintained with 41.6% in both groups, however the demands in the second group for reasons secondary to toxics, that is, alcohol or drugs decreased from 21.6% in group I to 6.6% in group II. The remaining cases were distributed as seen in [table 1](#).

We found significant differences ($p < 0.05$) in regards to site of the psychiatric intervention. While 60% occurred in the patient's home in group I compared to 23.3% in group II, in the latter, they had the majority with 70% of the interventions in the mental health center compared to 33.3% of group I. Anecdotally, we state that 3 interventions were performed in the street as they dealt with vagabonds and one had to be carried out in the work site of the supposed patient.

TABLE 1.

<i>Reason for action</i>	<i>Group I</i>	<i>Group II</i>
Psychiatric	25 (41.6%)	25 (41.6%)
Toxic	13 (21.6%)	4 (6.6%)
Non-cerebral organic diseases	3 (5%)	2 (3.3%)
Dementia	2 (3.3%)	2 (3.3%)
Mental weakness	5 (8.3%)	7 (11.6%)
Social problem	3 (5%)	1 (1.6%)
Garbage accumulation	0	2 (3.3%)
Forced entry	0	4 (6.6%)
Absence of data	8 (13.3%)	11 (18.3%)
Civil petition of separation	0	2 (3.3%)

Most of the interventions, in 95% of group I and 85% of group II were carried out by the mental health center staff, that is psychiatrist and social worker without the support of the police or another other type.

A psychiatric diagnosis could be made in 35 cases of group I (58.3%) and 34 of group II (56.7%). The largest proportion was for schizophrenic and paranoid disorders with 48.6% in group I and 35.3% in group II. Manic depressive psychosis was only diagnosed in the second group in 11.8% of the cases but in none of the former. Other diagnoses were: problems secondary to alcohol and drugs (22.9% group I, 14.7% group II) mental weakness (11.4% group I and 14.7% group II) personality disorders (5.7% group I and 11.8% group II) and rest of the diagnoses (11.4% group I and 11.8% group II).

Regarding the result of the intervention, it must be stressed that almost the same percentage of cases was admitted in both groups (40% group I and 36.7% group II). Furthermore, 18.3% of the group II cases and 16.7% of group I cases could not be located so that no intervention was possible. However, it should be stressed that the percentage of cases that remained in the beginning in the outpatient clinic in our center (21.7% group I and 8.3% group II), as well as the referrals to other services (13.3% group I and 3.3% group II) decreased considerably. On the other hand, in group II, the cases in which neither compulsory admission nor admission were indicated increased (20% versus 8.3%), and in which only an incapacity report was made (11.7% versus 0% in group I).

The evaluation of the cases at 5 months of the first intervention in 46 cases of group I and 48 of group II in which follow-up had to be performed did not show significant differences. A total of 54.3% of the first group and 41.7% of the second one continued treatment in our center; 15.2% of the first and 20.8% of the second did not come to the outpatient treatment after hospital discharge and 30.4% of group I and 37.5% of group II were referred to other resources.

DISCUSSION

The first problem we faced on gathering the data for this study was that we observed that, on the contrary to

other activities of the center, the actions on court demand were not by protocol, so that there were deficiencies in the registry system. This meant that there were more interventions than those stated in the specific file however, we could not identify them because the documents were included in the patient's clinical record. An attempt was made to repair the possible bias by choosing a population called group II, corresponding to the last 60 cases recorded in the years 2000-2001-2002 and an identical number of cases corresponding to the first 60 patients seen in the years 1992-1993-1994. This was our group I.

Another difficulty due to this absence of protocol was to obtain data from the reports. The intervention of eight psychiatrists, some of whom have changed in recent years, made it very difficult to homogenize the reports; thus it was necessary to use the clinical record in the cases in which the patient had previously had treatment or had initiated treatment in our center after the intervention or hospital discharge.

The significant increase in mean age of group II could be explained by possible aging of the population while the significant increase in number of intervention petitions in group II for women could be interpreted as a major generalization of incapacity as well as court authorization processes. It could be supposed that in the first years of the study, which coincided with a new mental health center that had just begun to function in the district, that the first interventions requested, mainly by the family, were for young males with more disruptive and potentially dangerous processes. In the present older group, it is possible that not only situations of deteriorating mental disease but also associated factors such as abandonment, isolation and absence of family members participate more. This last hypothesis agrees with the finding in the sociodemographic variable on the type of cohabitation. In the present group, there was a greater number of patients who lived alone compared to the greater number who lived either with their origin family or with their own family in group I, although the difference was not significant.

No differences were found regarding the presentation of psychiatric background, having a previous history in the center or previous consumption of toxics between both groups. However, this finding must be considered with reservation since it could be an artifact produced by deficient registry. It could be suspected that many more cases have been recorded after more than ten years of functioning of the center and that the fact that the reports of some of the interventions of patients known are filed in the clinical record and not in the specific file leads to erroneous data. However, it could also occur that the population on which the court interventions are requested was different from that which spontaneously comes to treatment and this would explain the absence of differences between group I and II.

The great ease with which any citizen can make a request for compulsory admission of another person in the competent Court of Law⁸, without their identity being

made known to the supposed patient, that is, not even giving it to the mental health center to which the intervention request is made, could explain the increase in proposals initiated by neighbors at present compared to those initiated by family members or the social services.

Although the initial subjective impression we had was that there had been an increase in incapacity petitions in recent years, we have found the same number of them in both groups. However, it must be stressed that no urgent authorization of compulsory admission occurred, all the court authorizations having an ordinary character of admission. In both groups, four cases were referred to be given treatment by court order and, although in a minimum percentage, given their complexity, we bring up the question if a mental health center, as it is designed, is the adequate device for the control and treatment of persons who do not come on their own but rather by court pressure.

The new law aims to speed up the necessary steps to avoid the destitution of the supposed mental patient, favoring his admission to a psychiatric institution if there is no other treatment alternative. However, its incomplete application may give rise to the contrary effect, that is, infringement of the persons' rights. In its article 10.5, the General Health Acts states that everyone has the right «to be given complete and continued, verbal and written information on his process, including diagnosis, prognosis and treatment alternatives in terms that are understandable for him (the patient) and his family members or close relatives.» And its articles 4 and 6 recognize the right of the patient to know all the information in the health area and the information on all the health care actions⁶. However, going deeper into the subject in question, article 763 on compulsory admission due to psychic disorder of the new Civil Procedure Law states that: «Before granting authorization or ratifying an admission already done, the court will hear the person affected by the decision, the Public Prosecutor's Office or any other person whose appearance is considered to be convenient or is requested by the person affected by the measure. In addition, and without prejudice to the practice of any other test estimated in the case, the court should examine the person whose admission is in question and hear the opinion of a physician designated by it. In all the actions, the person affected by the compulsory admission measure should have representation and defense in the terms mentioned in article 758 of the present law. In every case, the decision adopted by the court in relationship with the compulsory admission will be susceptible to appeal to the supreme court»^{1,8,12}.

However, in practice and in spite of being ordinary authorizations of admission, the competent court had not required the presence of the affected subject or informed him of his rights in any of the cases revised. This has given rise to real situations such as the following. A mental patient under treatment in our center with a diagnosis of paranoia requested the admission of her neighbor, claiming mental disease and dangerousness. The court, automatically, issued a court authorization of

compulsory admission against a mentally healthy person, a process that was paralyzed in our center totally by chance as it was the patient herself who brought us the document in hand from the court.

If we compare our data with those reported by Cañete et al. on compulsory admissions with court authorization in Cadiz in the years 1992-1993-1994 for a population of 406,000 inhabitants in a hospitalization unit that received patients from three mental health centers of adults and one child-adolescent center, we find that in comparison to the 11 cases that they reported, we carried out 24 compulsory admissions with court authorization in the same period for 197,064 inhabitants, which means twice the admissions for somewhat less than half of the population¹³.

Although in a greater percentage of cases in both groups, the main reason for the court authorization of compulsory admission was mental disease, as could be supposed, we want to stress such other diverse reasons outside of the psychiatric therapeutic function such as admitting patients who present physical diseases and who do not want to come to the hospital voluntarily, mediate in public health problems as in persons with the «Diogenes Syndrome» who are denounced by the residents because of accumulation of garbage, in situations of social abandonment or, what is even worse, being simple witnesses together with court officers in «forced entry» legal processes. The previous findings make us begin to question if no abuse is being carried out when the psychiatrist is used in functions that should clearly be carried out by the forensic body of the State, the Primary Health Care physicians and other specialists, as well as the General Social Services with serious harm to the attention of the mental health center patients, which should be our objective.

The fact that only the name and last names of a person together with an address that is often incomplete or incorrect are on the court authorization of compulsory admission explains why there were significantly more interventions in the home of the supposed patient in group I. Experience has made us much more careful. As it is easy to imagine, going to the home of an unknown person to proceed to a psychopathological evaluation and possible admission in a psychiatric unit, even when the medical report can be legally required for the admission¹⁴, when the patient has not been informed of the process and his rights, is an important physical risk for the professionals and does not seem to be the best mechanism to obtain reliable examination data. It must be remembered that 40% of group I and 50% of group II were persons who were not known in the mental health center. That is why, at present, after hard detective type work by the social workers of the center, we try to inform the affected subject of what the court requires previously by telephone and convince him to come to our medical office for the examination. Home visits are reserved for those cases that refuse to come or for those in whom contact cannot be made.

In spite of the undeniable risk of these interventions for the professionals, especially the home ones, atten-

tion can be drawn to the limited number of police support requested, hardly in six interventions for group I and in four for group II. This is because even when it could be logical to request it in unknown cases or in those in which risk is suspected, it is unviable in the usual practice. As the communication to the District Commissioner of the court authorization of compulsory admission has an ordinary and non-urgent character, the police officers do not begin to act until they are free from other services. This, taking into account that the health care pressure of the mental health center, would mean putting off the visit for an unlimited time, with the harm that this could mean for many of the patients. This leads the professionals to be exposed, by court order, to frequent risk situations that exceed our function. And I ask: who would be responsible if anything irreparable occurs to us?

Attention is not drawn to the fact that the greatest number of psychiatric diagnoses, with almost 50 % in both groups, are psychotic disorders, since, as Blánquez points out, the psychotic disorder and serious affective disorder would be absolute clinical criteria of compulsory admission, other criteria to consider being behavioral disorders that put the patient or third persons at risk, or social criteria of the dependent person who cannot be cared for by their family^{4,7,15}. However, this second criterion could be called into question, in consequence, in the new Civil Procedure Law, only protection of health and the subject's life could give rise to a compulsory admission, not including supposed dangerousness towards third parties as a motive of it. Only the Penal Code includes, as a safety measure, the admission of patients who have committed an act considered a crime and in those in whom the probability of committing new crimes can be predicted¹².

Attention is drawn to the fact that the patient could not be located in 10 cases (16.7%) in the first group and in 11 (18.3%) in the second, most of the times because the court had provided incorrect data and in others because the delay in the incapacity procedures by the District Attorney gave rise to the fact that the patient had changed addresses. It is also important that in 5 cases of the first group (8.3%) but in 12 of the second (20%), the intervention did not require any type of psychiatric treatment of the person affected, which would speak for an inappropriate intervention, that could have been avoided if that indicated by the law regarding getting information of the interested party had been applied. However, for the rest, the court authorization of admission took for granted the automatic authorization of treatment, this fact being independent, and that, according to the opinion of many authors, would require the informed consent of the patient^{9,12} or, in its defect, of a court authorization of treatment, a fact that could only occur in two situations: life risk or risk for public health¹⁶.

In the 5 month follow-up after the intervention, it stands out that 15.2 % of the patients in group one and 20.8 % of the patients in group two who were admitted to the Acute Unit did not come to the outpatient follow-up after discharge. These are significant percentages

that would speak of a deficient coordination between the different health care mechanisms and that contrasts with the comments of Nuria López, District Attorney of the Section of Incapacities of the Supreme Court of Justice of Madrid who, on referring to the need to continue care after the hospital discharge stated: «The two judges and two district attorneys who participate in this type of questions in Madrid use - under guaranteed conditions - obligatory out-patient treatment, so that the hospital admission discharge is subject to compliance of this treatment by the patient and is reversed if the patient does not come to the programmed visits¹⁶. In none of the cases studied did this reversal of the discharge occur, regardless of whether the patient came to treatment or not.»

CONCLUSIONS

1. It is necessary to review the action guidelines in the case of persons without known psychiatric background when the court authorization of admission is issued by the corresponding court to respect the rights of the persons involved as much as possible.
2. In the capital of Madrid, it would be desirable to review and specify the agreements made at the beginning of the 1990's between Court no. 30 and those responsible for Mental Health regarding the forensic and Madrid Regional Community psychiatrists responsibilities.
3. Given the important amount of interventions on persons without known psychiatric background in the capital of Madrid, it would be logical for the competent authorities to propose the need to create a specific and specialized team having adequate means to deal with them.
4. In regards to the competence of the health care mechanisms in our district, we should propose better coordination between the hospitalization Unit and out-patient one to avoid such a high number of losses to follow-up.

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