Involuntary treatment of schizophrenia patients 2004-2010 in Denmark
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Involuntary treatment of schizophrenia patients 2004–2010 in Denmark


Objective: Treatment of schizophrenia is frequently complicated by patients’ ambivalence and lack of insight into the disease, occasionally warranting involuntary treatment. This study aims to describe involuntary treatment in Danish schizophrenia patients.

Method: Patients diagnosed with a lifetime ICD-10 F20 schizophrenia diagnosis and alive in the period 2004–2010 were identified in the Danish Psychiatric Central Research Register, and data were linked to The Registry of Coercive Measures in Psychiatric Treatment.

Results: Within the study period, a total of 18,599 admitted patients were identified, 3,078 of which underwent involuntary treatment. The incidence rate for any involuntary treatment was 2.1 per in-patient year and 1.7 and 0.3 per in-patient year for rapid tranquilization and involuntary treatments, respectively. Somatic diseases comprised 34.5% of all involuntary treatments. Psychotropics comprised 56.9% with antipsychotics as the most common drug class (99.5%). Olanzapine was the most commonly used antipsychotic drug (33.2%). Treatment with depot injection and clozapine comprised only 13% and 4.8% of the antipsychotics used, respectively. Electroconvulsive therapy comprised 4.8% of all involuntary treatment.

Conclusion: Involuntary treatment involved a wide range of somatic treatment. Antipsychotic medicine was the most common psychotropic used. Involuntary treatment with depot antipsychotics and clozapine were rare.

Significant outcomes

- One-third of all involuntary treatments included somatic treatment or procedures, with treatment of acetaminophen overdose and compulsory feeding as the most common.
- Schizophrenia patients only rarely are subjected to involuntary treatment with clozapine or depot antipsychotics.
- Patients subjected to involuntary treatment had a history of more psychiatric admissions and an earlier onset of schizophrenia.

Limitations

- The mental health acts differ between countries, and therefore, the conclusions of this study may not be generalizable.
- Description of symptoms or indication for the involuntary treatment was not available.
- Data from The Registry of Coercive Measures in Psychiatric Treatment were only available from 2004 until end of 2010.
Introduction

Schizophrenia is a debilitating and social disruptive disease affecting 0.5–1.0% of the population and often it have a chronic course with 10% being institutionalized (1–3). Besides being tormented by psychotic symptoms, schizophrenia patients more often live alone (4) and are having comorbid substance misuse (5).

In addition schizophrenia is a life-shortening disease with up to 25 years reduction of lifespan compared with the background population (6). Lifetime risk for committing suicide is approximately 5% (7). Lifestyle related conditions such as inactivity, obesity, smoking contribute significantly to increased mortality causing increased risk of cardiovascular diseases (8). Studies also have shown that schizophrenia patients are less likely to receive the proper somatic treatment (9).

Antipsychotics are considered the cornerstone in treatment, but patients’ ambivalence and lack of insight often tend to complicate treatment (10, 11). Up to 50% of the patients are non-compliant to the medication (12). Lack of insight may cause refusal of receiving antipsychotic medications, leading to failure of initiation or continuation of therapy and worsening of the outcome (13). Involuntary treatment may thus be warranted to avert risk of suicide, treating a life-threatening medical condition, aggressiveness or to facilitate insight into the disease, to consequently accept the necessity of treatment. Especially, substance abuse, lack of insight and male sex seems to increase the risk of involuntary admission (14–16).

The use of involuntary treatment in psychiatry is highly controversial and has been extensively debated (15, 17–19). Essential of this discussion is the issue of loss of autonomy versus necessity of treatment both from society and patient’s health points of view.

Furthermore, involuntary treatment may keep patients from seeking proper treatment later on (20).

In Denmark involuntary treatment is governed by the Mental Health Act. All involuntary interventions are registered on specified coercive protocols and reported electronically to a nation-wide register. Involuntary treatments are restricted to inpatient status. Continuation during outpatient status thus is not allowed, and consequently effectiveness of the involuntary treatment is pending on the patients gaining insight into their disease during treatment, thereby possibly gaining a more positive attitude and larger acceptance of the needed medications.

In Denmark, involuntary treatment is divided in two different groups and registered on two different coercive protocols. Involuntary treatment involving treatment of psychosis or a life-threatening medical condition (Coercive Protocol 2) compared with rapid tranquilization used for treating severe agitation in the emergency settings (Coercive Protocol 3). The Coercive Protocol is the piece of paper where the psychiatrist documents the involuntary measure. Each type of involuntary measure has a specific protocol reflecting the different clauses in the Mental Health Act. Measures governed by Coercive Protocol 3 can only be used once per protocol, whereas involuntary treatment by Coercive Protocol 2 makes it possible to apply the treatment once or several times per day until the condition has been cured or the patient accepts the treatment.

Rapid tranquilization can be applied by any doctor in the psychiatric ward were as involuntary treatment (Coercive Protocol 2) warrants accept from a psychiatric consultant. Only well-known drugs are permitted, and dosage should be within the recommended dose range. The use of involuntary treatment should always be proportionate to the goal pursued. Whenever possible, minor steps should be taken and accordingly involuntary treatment is divided in two measures: The main and the subsidiary treatment. The main treatment is less intrusive for the patient and usually is an orally administered drug, that is, tablets, orally disintegrating tablets or draught. If completing the main treatment is not possible, for example the patient refuses to take the tablets, the subsidiary treatment is used, usually an injectable drug. Long-acting depot antipsychotics only are allowed under certain circumstances, such as recurring discontinuation of treatment with relapse.

In life-threatening conditions the Mental Health Act permits specific involuntary measures, such as electroconvulsive therapy (ECT) or specific and necessary treatment of physical disease. Treatments of life-threatening physical disease warrant accept from both a psychiatric and a somatic consultant.

All patients subjected to involuntary measures are offered the assistance of a patient counsellor, through which patients may complain, and for the exception of life-threatening conditions, or severe violence, treatment is postponed until approved by the Patients’ Complaints Board. Rapid tranquilization does not warrant approval by Patients’ Complaints Board but patients can complain afterwards. Obtaining sufficient treatment in schizophrenia and avoiding relapse is considered
important and may even improve the long-term outcome of the disease (2, 21). Little, however, is
known about involuntary treatment.

Aims of the study
This study aims to enlighten current practice by analysing types of treatment, the kind of drugs
used, as well as their dosage.

Material and methods
Sample and registers
The population consisted of patients alive in the period 2004–2010 with a lifetime diagnosis of
Schizophrenia (ICD10 F20.0–9). Patients were identified in the Danish Psychiatric Central
Research Register (DPCRR) (22). The DPCRR contains information of all psychiatric admissions
from 1969 and outpatient contacts from 1995 and onwards. The DPCRR has extensively been used
for research and the validity is high (2, 23). Data were linked to The Registry of Coercive Measures
in Psychiatric Treatment using the unique personal ID number. The reporting is based on paper proto-
cols until January 01 2005; afterwards, the reporting is done electronically from the hospitals. The regis-
try contains information on all involuntary measures from all psychiatric hospitals in Denmark.
Only involuntary measures initiated during the study period where included. The National Health
Service, Statistics Denmark and The Danish Data Protection Agency approved the use of the data for
the study. Data were accessed anonymously through a remote access to Statistics Denmark.

Outcome variables
This study includes two measures, involuntary treatment of psychosis or medical condition (Coer-
cive Protocol 2) and rapid tranquilization (Coercive Protocol 3). Drugs used for rapid
tranquilization were not specified on the protocol, and for this reason only incidence rates could be
reported. Coercive Protocol 2 includes a text string named ‘type and volume’. This text string was
deciphered into following variables: drug name, start and end dose. All of these variables were
coded for both the main and the subsidiary treatment. Psychotropics were coded by their
Anatomical Therapeutic Class (ATC) code, and classes of psychotropics were defined as: antipsy-
chotics (N05A except N05AN01), antidepressants (N06A), stimulants (N06B), benzodiazepines
(N03AE01 & N05BA), anticholinergic (N04A) and mood stabilizers including lithium (N05AN01),
valproate (N03AG01), carbamazepine (N03AF01) and lamotrigine (N03AX09).

The recommended dose range for each antipsychotic drug was identified from the Danish sum-
mary of product characteristics (SPC), which was obtained from either the Danish Medicines Agency
or European Medicines Agency. This was carried out to calculate the number of patients and per-
centage of those receiving higher dosages than the recommended range. Treatment including more
than one psychotropic was registered as polypharmacy, and each drug was included in the table. Thus,
the total number of drugs used exceeds the number of involuntary treatments.

For patients having more than one involuntary treatment, demographic data were registered dur-
ing their first period. Demographics and treatment history were compared with patients not undergo-
ing involuntary treatment or rapid tranquilization within the study period. For these controls, the
index time was set to their first psychiatric admission within the study period, to calculate (e.g.)
numbers of previous admissions and duration of illness.

For other analyses than demographics, all epi-
sodes of involuntary treatment within the study
period were used in the analysis. Types of somatic
treatment were manually categorized in relevant
types of treatment.

Statistics
Statistical calculations were taken with stata
version 12.0. Mean values were compared, using
unpaired student t-test. In case of non-normal dis-
btribution, the variables were transformed. Binary
variables were compared by chi-squared test.

Only double-sided test results were reported and
only P-values less than 0.05 were considered statis-
tically significant. Observation time for incidence
rate analysis were defined as from 0 to 1st of Janu-
ary 2004 or onset of schizophrenia if later, until
death or end of register 31 December 2010 which-
ever came first. Incidence rates were reported for
multiple episodes, that is patients with more than
one episode had all episodes included in the
analysis.

Results
Descriptive analysis
During the study period, a total of 34 898 people
had a lifetime diagnosis of schizophrenia, and
18 599 had at least one psychiatric admission
within the study period and were considered the study population.

In total 3078 patients (16.5%) of the admitted patients underwent involuntary treatment or rapid tranquilization. Total number of registrations of rapid tranquilization was 16 364 by 2574 patients (median 2.0 treatments per person; 25–75 percentiles 1–6; range, 1–270). Corresponding figure of involuntary treatment was 3151 treatments by 1384 patients (median 1 treatment per person; 25–75 percentiles 1–2, range 1–35). Eight hundred and eighty patients had both at least one episode of rapid tranquilization and one involuntary treatment.

The total observation time was 195 929 patient years with 9363 in-patient years. The incidence rate for any involuntary treatment was 2.1 per in-patient year and 1.7 and 0.3 per in-patient year for rapid tranquilization and involuntary treatments, respectively. Demographics of patients subjected to any involuntary treatment vs. admitted patients not receiving involuntary treatment are shown in Table 1. Patients undergoing involuntary treatment were younger, with earlier onset of both schizophrenia and any psychiatric disease, and more prior psychiatric admissions compared with admitted patients not receiving involuntary treatment as shown in Table 1.

Psychotropics comprised 56.9% of all involuntary treatments as shown in Table 2. Mean number of times the medication was administered involuntarily was 27 (25–75 percentiles 8–61, range, 0–822) times. Electroconvulsive therapy, of which 25% was given ‘en bloc’ (daily treatment for three consecutive days, bilaterally), comprised 4.8% of all involuntary treatments.

In 18% per cent of the protocols, data were blank or insufficiently registered, meaning the description in the protocol was not explicit enough for anyone else but the physician himself to decipher what treatment to be administered.

### Table 1. Demographics of admitted schizophrenia patients

<table>
<thead>
<tr>
<th></th>
<th>No involuntary treatment</th>
<th>Any involuntary treatment</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male sex</td>
<td>8 967 (57.9%)</td>
<td>1777 (57.7%)</td>
<td>0.96</td>
</tr>
<tr>
<td>Age (years)</td>
<td>38.7 (SD = 15.5)</td>
<td>34.4 (SD = 11.7)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Age at first psychiatric contact (years)</td>
<td>26.1 (SD = 11.0)</td>
<td>24.4 (SD = 8.3)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Age at onset of schizophrenia (years)</td>
<td>33.0 (SD = 12.7)</td>
<td>29.0 (SD = 13.1)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Duration of psychiatric illness (years)</td>
<td>12.9 (SD = 11.6)</td>
<td>12.5 (SD = 9.9)</td>
<td>0.038</td>
</tr>
<tr>
<td>Duration of schizophrenia (years)</td>
<td>10.6 (SD = 10.6)</td>
<td>9.3 (SD = 8.6)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Number of previous psychiatric admissions (= 25–75 percentiles)</td>
<td>4 (0–11)</td>
<td>7 (2–17)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Percentage of hospitalization during course of schizophrenia (percentage, 25–75 percentiles)</td>
<td>5.6 (1.2–15.2)</td>
<td>10.0 (2.6–23.7)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Time from hospitalization to decision on involuntary treatment (days)</td>
<td>–</td>
<td>6.1 (SD = 20.0)</td>
<td>–</td>
</tr>
</tbody>
</table>

### Table 2. Types of involuntary treatment (Coercive Protocol 2)

<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>Total Subtotal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>3151 (100.0%)</td>
</tr>
<tr>
<td>Any kind of ECT</td>
<td>152 (4.8%)</td>
</tr>
<tr>
<td>ECT</td>
<td>114 (3.5%)</td>
</tr>
<tr>
<td>ECT-en bloc</td>
<td>38 (1.2%)</td>
</tr>
<tr>
<td>Somatic treatment/procedures</td>
<td>640 (20.3%)</td>
</tr>
<tr>
<td>Acetaminophen overdose</td>
<td>151 (4.7%)</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>29 (0.9%)</td>
</tr>
<tr>
<td>Anticoagulant therapy</td>
<td>30 (0.9%)</td>
</tr>
<tr>
<td>Blood sampling</td>
<td>37 (1.2%)</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>6 (0.2%)</td>
</tr>
<tr>
<td>Compulsory Feeding</td>
<td>109 (3.5%)</td>
</tr>
<tr>
<td>Diagnostic imaging</td>
<td>6 (0.2%)</td>
</tr>
<tr>
<td>Fluid replacement therapy</td>
<td>46 (1.5%)</td>
</tr>
<tr>
<td>Gastroscopy</td>
<td>8 (0.2%)</td>
</tr>
<tr>
<td>Insulin</td>
<td>24 (0.8%)</td>
</tr>
<tr>
<td>Surgical</td>
<td>46 (1.5%)</td>
</tr>
<tr>
<td>Treatment of withdrawal symptoms</td>
<td>9 (0.3%)</td>
</tr>
<tr>
<td>Other overdose</td>
<td>63 (2.0%)</td>
</tr>
<tr>
<td>Other/unspecified</td>
<td>76 (2.4%)</td>
</tr>
<tr>
<td>Psychotropics*</td>
<td>1792 (56.9%)</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>1783 (99.6%)</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>9 (0.5%)</td>
</tr>
<tr>
<td>Mood stabilizers</td>
<td>11 (0.6%)</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>38 (2.1%)</td>
</tr>
<tr>
<td>Anticholinergic</td>
<td>87 (4.9%)</td>
</tr>
<tr>
<td>Stimulants</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Unsatisfied filled out</td>
<td>567 (18.0%)</td>
</tr>
<tr>
<td>Blank</td>
<td>512 (16.0%)</td>
</tr>
<tr>
<td>Lack of information</td>
<td>55 (1.8%)</td>
</tr>
</tbody>
</table>

*The total percentage of the individual drug groups is higher than 100% because some patients are treated with polypharmacy.*

Involuntary psychopharmacological treatment

Antipsychotics comprised 99.5% of all involuntary treatments involving psychotropics as shown in Table 2. Olanzapine was the most commonly administered antipsychotic drug (33.2%) (cf. Table 3). Of the 1792 involuntary treatments, 163 (9.1%) treatments included polypharmacy. Antipsychotic polypharmacy comprised 46 (28.2%) of the total number of treatments involving polypharmacy. Other combinations of polypharmacy were antipsychotic + anticholinergic 87 (53.4%), antipsychotic + benzodiazepines 38 (23.3%) and antipsychotic + moodstabilizer 10 (6.1%).

In total 203 involuntary treatments (13.0%) involved long-acting depot injections.
(zuclopenthixol acetate not included). Especially for olanzapine, quetiapine and ziprasidone large portion of the oral treatment exceeded the maximum recommended dose.

**Pharmaceutical form**

Solid tablets were most commonly administered for main treatment, whereas short-acting injection was the most common for the subsidiary treatment (cf. Table 4.) Other orally administered pharmaceutical forms were also commonly administered for the main treatment, that is orally disintegrating tablets (22.2%) and draught (16.5%). Gastric tubes were used in less than 1% of cases for both main and subsidiary treatment and were mainly used for clozapine treatment.

### Table 3. Antipsychotic drugs used in involuntary treatment

<table>
<thead>
<tr>
<th>Drug</th>
<th>Mean maximum dose</th>
<th>Above recommended dose</th>
<th>Maximum allowed dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amisulpride</td>
<td>711.1 (SD = 318.0)</td>
<td>0 (0.0%)</td>
<td>1200 mg</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>238 (SD = 10.3)</td>
<td>6 (5.2%)</td>
<td>30 mg</td>
</tr>
<tr>
<td>Chlorprothixene</td>
<td>87.5 (SD = 44.3)</td>
<td>0 (0.0%)</td>
<td>600 mg</td>
</tr>
<tr>
<td>Clozapine</td>
<td>430.9 (SD = 246.9)</td>
<td>0 (0.0%)</td>
<td>900 mg</td>
</tr>
<tr>
<td>Flupentixol</td>
<td>22.8 (SD = 14.8)</td>
<td>0 (0.0%)</td>
<td>40 mg</td>
</tr>
<tr>
<td>Levomepromazine</td>
<td>215.0 (SD = 230.2)</td>
<td>1 (20.0%)</td>
<td>300 mg</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>17.9 (SD = 10.8)</td>
<td>7 (6.7%)</td>
<td>30 mg</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>27.7 (SD = 15.6)</td>
<td>197 (43.9%)</td>
<td>20 mg</td>
</tr>
<tr>
<td>Paliperidone</td>
<td>8.3 (SD = 3.3)</td>
<td>0 (0.0%)</td>
<td>12 mg</td>
</tr>
<tr>
<td>Perphenazine</td>
<td>26.3 (SD = 13.8)</td>
<td>0 (0.0%)</td>
<td>64 mg</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>754.6 (SD = 522.6)</td>
<td>23 (26.7%)</td>
<td>800 mg</td>
</tr>
<tr>
<td>Risperidone</td>
<td>5.7 (SD = 3.0)</td>
<td>0 (0.0%)</td>
<td>16 mg</td>
</tr>
<tr>
<td>Sertindole</td>
<td>15.6 (SD = 6.4)</td>
<td>0 (0.0%)</td>
<td>24 mg</td>
</tr>
<tr>
<td>Sulpride</td>
<td>1800.0 (SD = –)</td>
<td>0 (0.0%)</td>
<td>1800 mg</td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>166.1 (SD = 65.1)</td>
<td>11 (22.4%)</td>
<td>160 mg</td>
</tr>
<tr>
<td>Zuclopenthixol</td>
<td>228 (SD = 15.8)</td>
<td>19 (8.4%)</td>
<td>40 mg</td>
</tr>
<tr>
<td>Injection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>15.3 (SD = 8.6)</td>
<td>0 (0.0%)</td>
<td>29.3 mg</td>
</tr>
<tr>
<td>Chlorpromazine</td>
<td>350.0 (SD = 70.7)</td>
<td>0 (0.0%)</td>
<td>300 mg</td>
</tr>
<tr>
<td>Levomepromazine</td>
<td>11.3 (SD = 204.9)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>11.1 (SD = 8.1)</td>
<td>8 (3.1%)</td>
<td>30 mg</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>15.7 (SD = 9.5)</td>
<td>35 (7.6%)</td>
<td>20 mg</td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>34.4 (SD = 32.7)</td>
<td>14 (10.4%)</td>
<td>40 mg</td>
</tr>
<tr>
<td>Zuclopenthixol</td>
<td>16.8 (SD = 9.1)</td>
<td>0 (0.0%)</td>
<td>80 mg</td>
</tr>
<tr>
<td>Depot injection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flupentixol</td>
<td>120.0 (SD = 75.8)</td>
<td>0 (0.0%)</td>
<td>200 mg/2w</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>262.2 (SD = 62.3)</td>
<td>30 (66.7%)</td>
<td>200 mg/2w</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>338.2 (SD = 53.0)</td>
<td>0 (0.0%)</td>
<td>450 mg/2w</td>
</tr>
<tr>
<td>Perphenazine</td>
<td>180.7 (SD = 99.8)</td>
<td>0 (0.0%)</td>
<td>400 mg/2w</td>
</tr>
<tr>
<td>Sertindole</td>
<td>53.1 (SD = 17.6)</td>
<td>23 (26.7%)</td>
<td>50 mg/2w</td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>93.3 (SD = 41.4)</td>
<td>1 (1.3%)</td>
<td>225 mg/3d</td>
</tr>
<tr>
<td>Zuclopenthixol</td>
<td>263.9 (SD = 147.3)</td>
<td>5 (6.5%)</td>
<td>400 mg/2w</td>
</tr>
</tbody>
</table>

**Discussion**

This is the first study to ever investigate involuntary treatment of schizophrenia patients in Denmark. Treatment with psychotropics comprised only 56.9% of the total number of involuntary treatments. Somatic involuntary measures thus comprised 20.3%, overdose being the most frequent somatic condition. Somatic involuntary treatment included a wide variety of conditions from minor interventions, for example hydration, or more severe interventions such as amputation of limbs.

The average age of patients who have been undergoing involuntary treatment was mid-thirties as found in a previous study by Jarrett (11). Although more males underwent involuntary treatment, their relative proportion was similar to admitted patients not undergoing involuntary treatment. Patients with earlier onset of schizophrenia were more likely to have involuntary treatment, which may be explained by the poorer outcome of this patient group (24).

Antipsychotics, as expected, comprised the most frequent class of drugs for involuntary treatment in this patient group. Olanzapine was the atypical antipsychotic drug most frequently used, in consistency with general use of antipsychotics (25). The relatively high numbers, in involuntary treatment, of zuclopenthixol, olanzapine and haloperidol may reflect the fact that parenteral route of administration is available for these drugs.

For olanzapine 44% and quetiapine, 27% of the patients received higher than recommended dosages. Such is controversial in involuntary treatment where patients do not have the option to refuse the treatment and because of the current legislation. In addition, treatments including more than one psychotropic comprised 9.1% of all treatments. Evidence for beneficial effects from doses above the recommended range, as well as from polypharmacy, remains sparse (26). In treatment resistant cases clozapine is a more evidence-based
patients can easily cheat (38). On the downside, the coercion is not possible, because oral medications
Thirdly, avoiding parenteral depot medication by injections compared with oral treatment (37).
also be stressful for patients, objecting to treatment. In involuntary treatment, psychiatrists should aim for
The unique effect of clozapine, including higher level of insight into the disease and thereby longer
call for prescription of clozapine after non-response to two or three different antipsychotics, even when involuntary treatment is warranted. Involuntary treatment with clozapine should be practicable using a stomach tube or having injectable clozapine manufactured.
Several of the atypical short-acting injectable drugs are only licensed for three consecutive days which often led to alternation between two kinds of injectable antipsychotics. From a pharmacological point of view, this is inappropriate and future studies investigating the safety of injectable antipsychotics beyond three days should be carried out.
Electroconvulsive therapy (ECT) comprised almost 5% of all involuntary treatments, which is rather high based on the sparse evidence for ECT in patients with schizophrenia (35). Unfortunately, indication for ECT or description of symptoms was not available. However, some evidence exists for treatment refractory schizophrenia, catatonic symptoms and from acute relapse when a more rapid improvement is desired (35, 36).
Only 13% of the involuntary treatment (main treatment) included depot injection. In involuntary treatment, long-acting antipsychotics have several advantages. Depot injections every 2–4 weeks should be less stressful for patients, objecting to medicine, compared with daily injections or tablets. Also, in general, the amount of time before discontinuation is higher for treatment with depot injections compared with oral treatment (37).
Thirdly, avoiding parenteral depot medication by coercion is not possible, because oral medications patients can easily cheat (38). On the downside, the palettes of parenteral atypical antipsychotics depots remain limited, but the availability may increase in the future.
More studies are warranted to investigate the effects of involuntary treatment with depot injections, and legislators should be aware of the potential effect of such interventions on compliance and course.
This study should be interpreted within its limitations. A large portion of the protocols was not sufficiently completed or blank, which could be due to lack of reporting. Regarding involuntary somatic treatment, data and description often were wide and non-specific (e.g. ‘treatment of physical disease’) containing no information on drug or dosage. Indications for psychotropics were not available, which frequently makes it impossible to distinguish, for instance, whether antiepileptics are used for seizure control or mood stabilizing. Unfortunately, drugs used for rapid tranquilization were not specified in the protocol.
Comparing this study to other studies is restricted because of the lack of existing literature within this field and international differences in mental health acts and procedures of involuntary treatment. Most studies have investigated the effects of involuntary community treatment, which was not allowed during in Denmark during the study period (39). One study investigating the short-term effect of involuntary treatment during hospitalization revealed that no differences at time of discharge as regards to psychopathology and level of functioning (40). Since lack of insight is an important risk factor for non-adherence and involuntary admission, psychiatrists should aim for remission of psychotic symptoms, try to involve the patient in decision making and provide psycho-education to increase the patient’s level of insight into the disease and thereby increase the likelihood of continuing treatment after discharge (41).
A Cochrane study concluded that compulsory community treatment did not result in any significant difference in service use, social functioning or quality of life patients sentenced to involuntary community treatment compared with standard care, although they were less likely to be involved in serious crime (39). Other studies have concluded that involuntary out-patient treatment is effective and can easily be managed with rarely use of physical force (42). Our study only aimed to describe current use of involuntary treatment among schizophrenia inpatients and thus further investigation of the long-term effects, both as regards to compliance and to the psychological effects is beyond its scope.
In conclusion, 16.5% of all psychiatric admitted patients with schizophrenia during a 7-year study.
period underwent involuntary treatment. More studies investigating involuntary treatment is warranted to obtain knowledge on feasibility of involuntary treatment and the outcome of such treatment.

Declaration of interest

J. Nielsen has received research grants from H. Lundbeck, Pfizer and Champaq for clinical trials and received speaking fees from Bristol-Myers Squibb, Astra Zeneca, Lundbeck, Janssen-Cilag, Hemocue, and Eli-Lilly. Other authors report no conflict of interest.

References


Involuntary treatment of schizophrenia